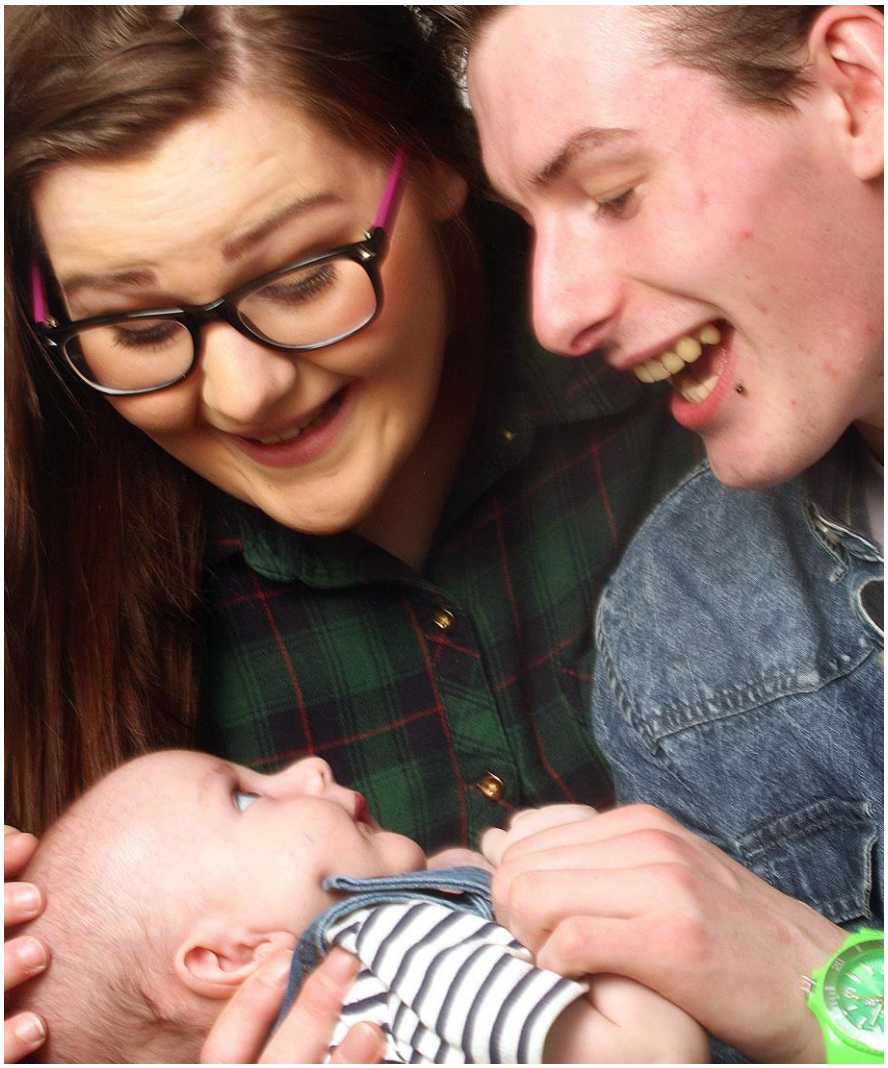
Public Health Agency Response to the Re-valuation of Family Nurse Partnership in Northern Ireland



Improving your health and wellbeing

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Summary

Family Nurse Partnership (FNP) in Northern Ireland was first commissioned by the Public Health Agency (PHA) in 2010. Expansion led to all five Health and Social Care Trusts (HSCTs) having a FNP team by 2015. The regional FNP caseload at 30th July 2017 was 307 clients, covering approximately one third of eligible young parents. The core regional FNP service is made up of 27 family nurses and five supervisors.

FNP is underpinned by theories of attachment, self-efficacy and human ecology. Local evaluations have highlighted benefits to first time mothers under the age of 20 years living in areas of deprivation and/or facing adversity. These findings are in keeping with strong international evidence base[1]. However, the Building Blocks Randomised Control Trial (RCT) (DoH England, 2015), raised questions about FNP efficacy in the UK context. This prompted the PHA to commission an independent evaluation of FNP by Learning Studio Ltd in partnership with AD Research & Analysis and the Strategic Investment Board NI. This involved revaluation, a structured participative methodology, with data generated through storytelling by service users and providers as the primary source of evidence to explore value across system levels. Revaluation is in keeping with the FNP value of clients being expert in their own lives and experiences. Over 80 FNP Northern Ireland stories were collected. 69 stories were sufficiently detailed for analysis of which 23 were used for deep analysis.

A revaluation report was received by the PHA in November 2017. This provides assurance that FNP in Northern Ireland is providing an effective service to vulnerable young parents. A list of 43 vulnerability factors identified from FNP client stories by the revaluation team was used by family nurses to profile their current caseloads. Data analysis demonstrates that the average number of vulnerability factors per client is nine with the most prevalent being low income, relationship breakdown of parents, mental health problems, not in education, employment or training (NEET) and being poorly parented. Underlying family patterns are related to poverty, violence and abusive relationships.

[1] http://nfpinternational.ucdenver.edu/research

The revaluation process highlights value inherent in five key FNP components:

1. International, regional and local governance arrangements
2. Evidence base and continuous data analysis
3. Effective recruitment and intensive training programme for family nurses
4. Comprehensive programme materials delivered with fidelity
5. Professional techniques and approaches

Revaluation stories illustrate life course improvements for young parents from disadvantaged areas who have experienced multiple adversities. In short, FNP was found to be breaking cycles of inter-generational disadvantage. A desire expressed in most of the stories to be 'a good mummy', alongside unconditional supportive and intense professional relationships with family nurses who use FNP approaches, paves the way for life changing alterations in personal trajectories. Positive outcomes in relation to child development, maternal mental health, better informed parents, ability to put the child's needs first, self-efficacy, better engagement with community and statutory services, and higher expectations for the future as a result of the programme have been repeatedly illustrated within the stories.

"The greatest impact is with the children and young people. The babies are confident happy children. That's what every mother wants. Notably the mums with the lowest psychological or physical health resources are the ones with secure, happy children, even though mum's life's not like that. There are some mums who excel and flourish on the programme, and others who show little change – but all their babies look happy" **[Central FNP team member].**

Evidence in relation to the economic benefits of early intervention and financial burden of late intervention is increasing. The greatest economic benefits are arguably from breaking the inter-generational cycles of negative and harmful parenting. The highest short term savings as a result of FNP are associated with the cost of child protection and looked after child systems. Longer term savings associated with the costs accruing from poor health and morbidity, poor educational attainment, crime need to be considered (beyond the scope of the

revaluation). The value of FNP from a financial perspective has been explored by the revaluation team by considering 'paths not taken' by FNP clients and applying UK reference costs. The revaluation team is of the view that the annual cost per client avoided as a result of FNP is in the range of approximately £40k - £485k. Most potential savings are from reduction in fostering and residential places and reduced demand on other services. As a minimum, FNP pays for itself financially and is cost effective.

PHA Recommendations

1. A business case that includes an option to offer all first time eligible mothers with a place on the FNP programme needs to be developed.
2. A regional communication strategy involving FNP Family Advisory Boards (FABs) needs to be developed and implemented so that the wider system understands the FNP programme and can learn from its theoretical approaches and how these are implemented in practice.
3. The learning from this Revaluation should be shared with the Safeguarding Board for Northern Ireland (SBNI) to inform its work on Adverse Childhood Experiences (ACEs), and with Children and Young Peoples Strategic Partnership (CYPSP) who have a key responsibility in ensuring that services for all children and families are available and effective.
4. The PHA central FNP team should facilitate a further testing of multi-disciplinary value conferencing as a means to sharing the concept of FNP and acquiring new approaches to defining value using monetary and non-monetary terms.
5. The FNP data system should be improved so that it supports regular reporting against 'breaking cycles' outcomes by practitioner, team and regional levels.
6. The PHA central team should work with finance colleagues to capacitate the visible and invisible value of early intervention services including FNP.

Introduction

The Public Health Agency (PHA) has a statutory responsibility to ensure that health and social care services are safe, effective, and meet people's needs. The PHA must also ensure that resources allocated deliver the agreed outcomes, represent value for money, reduce inequalities in health outcomes and promote innovative and effective models of care. It is in this context that the PHA commissioned the 'Revaluation' of Family Nurse Partnership (FNP) in Northern Ireland.

FNP Programme Overview

FNP has been developed by Professor David Olds and colleagues at the University of Colorado (known as Nurse Family Partnership outside the UK) and is informed by over 30 years of extensive research[2]. It is a licensed, preventative programme, which aims to improve outcomes for young first time mothers and their children. It is delivered by specially trained family nurses using a structured programme of home visits from pregnancy until the child is two years-old.

The FNP programme integrates attachment, self-efficacy and human ecology theories to achieve three key goals:

1. To improve pregnancy outcomes by improving women's prenatal health
2. To improve child health and development by reducing the amount of dysfunctional caregiving for infants, and,
3. To improve the mothers' life course by helping them develop a vision for their futures, plan future pregnancies, stay in school and employment.

Application of theory into FNP practice is supported through comprehensive supervision provided by FNP supervisors, psychologists and safeguarding children nurse specialists. Supervision regularly addresses the need for organised parent-child attachment given that this is now widely recognised as the basis of effective self-regulation throughout life.

In 2010, the PHA commissioned Western HSCT to implement the initial pilot phase

[2] Olds, D et al (2014) Effects of Home Visits by Paraprofessionals and by nurses on Children; Age –Six and Nine Follow up of a Randomised Trial JAMA Paediatrics 2014:168(2)114-21

of FNP in Northern Ireland. Expansion of FNP to Belfast and Southern HSCTs was commissioned by the PHA in 2012. The most recent phase of expansion to the Northern and South Eastern HSC Trusts was commissioned by the Health and Social Care Board (HSCB) meaning that from 2015 all five HSCTs have had one FNP team providing intensive early intervention help to young parents from deprived areas and/or with complex social and emotional needs. The PHA, as FNP license holder, has facilitated a regional approach to implementation and is responsible for ensuring adherence to FNP fidelity measures and license requirements.

Previous evaluations of FNP

Three independent FNP evaluations have been commissioned by the PHA. The first two evaluations were carried out in the Western HSCT[3],[4], and refer to programme efficacy, challenges in the early stage of implementation, and the strong sense from clients and networked professionals of the difference that FNP was making to the lives of vulnerable young mothers involved with the programme. Findings from these evaluations are in keeping with the Early Intervention Foundation Review of seventy five early intervention programmes in the UK that awarded FNP, one of just two programmes, the highest possible 4+ rating for evidence.

"FNP has established evidence (Level 4+) of improving a variety of child and parent outcomes, including attachment security in the short term, children's early language development and reduced risk of preventable death in early adulthood."[5]

FNP has also been rated as having the highest level of effectiveness by the National Academy of Parenting Research at King's College in relation to achieving:

- Improved pregnancy health and behaviours
- Reduced child abuse and neglect
- Improved school readiness
- Increased maternal employment and economic self sufficiency

[3] McLaughlin, R et al(2013) Family Nurse Partnership Evaluation
[4] McGuigan, K et al (2016) Family Nurse Partnership Programme Graduation Focus
[5] EIF (July 2016) EIF Programme Report Family Nurse Partnership www.eif.org.uk/uploads/2016/17
[6]National Academy for Parenting Research (Kings College London) as cited by Family Nurse Partnership at www.fnp.nhs.uk

- Reduced closely spaced subsequent pregnancies[6].

Revaluation

The most recent evaluation has been provided by Learning Studio Ltd in partnership with AD Research & Analysis and the Strategic Investment Board NI (November 2017) using an innovative evaluation process called revaluation . This revaluation is the subject of this report.

Revaluation methodology was particularly attractive to the PHA because the FNP license requires that evaluations be underpinned by the social change values, recognising that service users are expert in their own lives and public service accountability to them. Revaluation methodology complies with this requirement as it depends on a structured approach to story-telling and gives young parents and family nurses a voice as the primary sources of evidence and learning.

The revaluation team has provided independent evaluation. This is important given concerns about FNP's effectiveness raised within the Building Blocks RCT in England[7]. The Building Blocks RCT showed that FNP has positive effects on early child development and helps to identify safeguarding risks at an earlier stage. The trial also found that clients engaged well with FNP and especially valued the long-term relationship they had with their family nurse, however, showed no effect on the short-term outcomes being measured in the trial. The PHA is aware of anecdotal reports of some retraction of FNP in England in recent years, whilst in contrast, the Scottish Government has committed to expanding FNP to make it available to all eligible pregnant women.

The PHA has received a series of reports from the revaluation team which set out their findings and highlighting the significant, and in many cases life changing, contribution that FNP is making to young parents in Northern Ireland at a critical time in their lives. The value of FNP to young parents with high levels of vulnerability has been clearly evidenced. This value is associated with FNP's theoretical underpinnings and how these are rigorously incorporated into practice, as well as

[7] Robling, M et al (2015) Effectiveness of Nurse led Home Visitation Programme for First time teenage mothers (Building Blocks) LANCET 2015 :387(10014) 146-155

FNP’s value base, service model, practice tools, approaches and governance arrangements.

The PHA acknowledges the support provided by the FNP international team to commission the revaluation and encouragement to learn and share the learning from this. The PHA also acknowledges the thorough approach taken by the revaluation team and the time taken by them to understand the FNP system and its value. The PHA appreciates the high level of participation and reflection in the revaluation process by those engaging with the FNP system, and in particular FNP clients and family nurses.

This document summarises key findings from the revaluation and provides the PHA’s response and recommendations for the way forward.

Revaluation Methodology

Revaluation has provided the FNP system with an innovative approach to evaluation built on governing design principles:

- There are multiple perspectives on value at different levels of any complex system[8].
- Value is socially created/ co-produced/ between people.
- Managing/governing/making sense of value is best understood as a social process in real time rather than an ad hoc or 'post balance sheet' one - off event.
- Local 'actors' within a system, starting with service users, know best where the value of work is or is not on a day to day basis and are best placed to identify it.
- Local 'actors' within a system learn about and make sense of value through story-telling.
- Making sense of value requires moving beyond the traditional focus of evaluation on exclusively calculable, visible, monetary value, towards making visible the many calibrating judgments about value which are continuously being made, including value which capacitates the wider system context in which work is taking place.

Revaluation methodology is based on an intuitive process of storytelling through which data sets are collected and multiple perspectives about value adopted and explored. Participants move through cycles of iteration and socialisation of data/stories with the revaluation team facilitating through adding a third loop of observation and prompting[9]. The result is a participative process for generating change through exploring value. Given that evaluations are ultimately undertaken to increase the effectiveness of the intervention or other interventions in future, Revaluation is designed as an active input into the system under enquiry. Through revealing value, it creates further value, in real-time.

[8] Drawing on the work of Frank Geels on how change happens in complex social systems: Geels , F (2001) 'Technological transitions as evolutionary reconfiguration processes: A multi-level perspective and a case-study'. Paper presented at DRUID Nelson and Winter Conference, Aalborg, Denmark, June 2001.
[9] Drawing on Argyris and Schön's model of Double Loop Learning (1978)

Revaluation matches the approach to the system in question, recognising its networks, and relationships. In the case of FNP, this means understanding the sub systems that made up the system and the levels that make up the system. The sub systems follow those of the HSCTs so there are five 'local' partnerships, each operating under the license from the PHA.

The PHA's central FNP team members have participated throughout the Revaluation process and have been present during discussions and group reflections on the process. The central team is aware that participants found the process very different to previous evaluations, even uncomfortably different initially, but became more confident with the process as revaluation became more familiar. At the final workshop there was wide consensus that the revaluation had provided family nurses and other participants the opportunity to reflect regionally on the value of the FNP service and what this means to clients, families, communities, government and themselves. It has provided a useful opportunity for family nurses to develop a narrative about the value they so firmly believe in using an approach that they know well, a partnership approach with young parents.

The revaluation team refer to four levels within the FNP system: nano, micro, meso and macro (see Table 1).

Table 1: FNP System Levels

Level	Coverage	Rationale & implications
Nano	Client / mother, baby, client's partner /baby's father, and nurse.	Designed to help develop the picture of value in the inter-personal and intra-personal space between the nurse and the client, the baby and their family system.
Micro	Nurses & supervisors in their team.	Designed to explore value in the nurse: supervisor team level of the system. In some sub systems, the psychologist's voice was also brought into this.
Meso	Supervisors and members of Family Advisory Boards. (FABs).	Designed to explore the value in the local governance system, and the extent to which value is visible to local stakeholders' horizontal networks.
Macro	PHA. Programme for Government.	Designed to explore value in the networked relationships between the PHA and the rest of the HSC system, region-wide.

Revaluation explores value across system levels in three dimensions: Calculate, Calibrate and Capacitate. It also explores value in terms of visible and invisible value: visible is known, direct and existing or past value, whilst invisible value is knowable, indirect and emergent/future value.

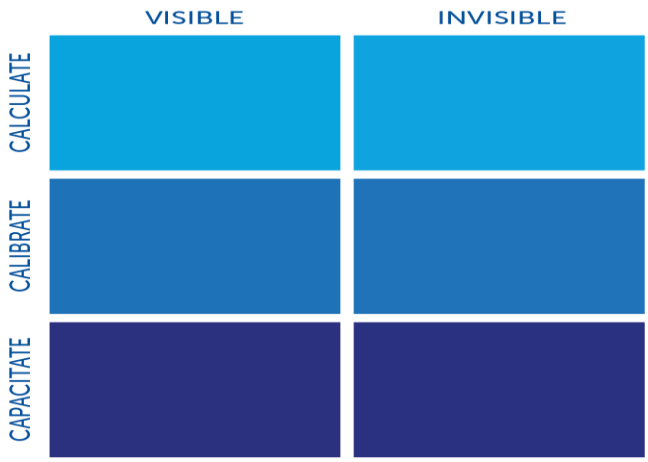
Calculate - presenting quantitative outputs and outcomes; manipulating numbers (summing, or converting using proxy data and 'multipliers') to arrive at a single figure, usually in £s. (the dominant metric in orthodox evaluation).

Calibrate - qualitative judgments about relative merits or cost/benefits of different actions and outcomes; based on how actors decide where to direct their efforts (and how much effort to make) as individual decision making and socialised in groups.

Capacitate - measuring the characteristics and capacity of a movement or network, plus the potential of that network to increase its future capacity and thus the value it can generate (emergent qualities); includes relational data, exploring the connections in a network including in space e.g. maps and time e.g. calendar.

Revaluation Six Box Model

Six boxes are used to represent the spine of the revaluation process.



These six boxes are used to structure the co-created stories and capture evidence of value. They serve as a dashboard through which to report value and give a quick readout of value generated during an activity or intervention.

Whilst completion of the six box dashboards might seem straightforward, the approach to achieving this is complex. Application requires collaboration, negotiation and agreement between those engaging with the service system across the system levels before a 'settled account' of the 'real value' can be co-produced. Guidance on completion of the use of the six box revaluation Dashboard is provided in Appendix 2.

Storytelling

The success of the FNP revaluation has been dependent on storytelling to draw out the knowledge and experiences of those providing and receiving the FNP programme. This has been effectively facilitated by the revaluation team. Family nurses have come together at local and regional levels throughout a six month process to describe, discuss, consider and tell the FNP journey to date. There has been much reflection on wider value including the contribution of FNP to achieving improved outcomes for children, families, communities and society.

The revaluation process has resulted in stories being iterated and cascaded:

- **Iterated**: in a process of dialogue and question and answer between the author of the story and a member of the revaluation team, and,
- **Cascaded**: where the story owners broaden the contributions and voices that are reflected in the story to ensure inclusion of the voices of other service professionals working with FNP families, as well as family members beyond the mother (client).

Trusting relationships between family nurses and clients has enabled the collection of over eighty stories from a group of young parents who have experienced adversity. Sixty nine of these stories were deemed to be sufficiently detailed for inclusion in the analysis stage. It was agreed across the FNP system, including the PHA's central team, that:

- Family nurses known to FNP clients are much better equipped than independent researchers to explore and follow up very sensitive, personal and emotive issues that are expected to arise within storytelling, and,
- It is the revaluation team's role to expertly facilitate and support family nurses with the story telling process and ensure that this skill is applied as intended.

Twenty three of the sixty nine stories were further 'deepened' through more detailed consideration involving iteration and rounds of re-iteration with the revaluation team and FNP supervisors, probing and encouraging deeper reflection. In the months since, family nurses have described how clients and their babies have moved on following FNP. The value of FNP to the clients after they complete the programme has not been addressed as part of this process, however, there is a growing and compelling body of evidence and acceptance that supporting parents to give children the best start in life through early interventions has long term value in relation to physical, social and emotional wellbeing and this is in the best interests of individuals, families, communities and society.

Data for understanding value was gathered at all system levels (See Table: 2).

Table 2: System Levels

Level	Story owner	Comment
Nano	Client and nurse	80+ clients stories originated by nurses and mothers, also some fathers and grandparents 69 stories analysed 23 of the 69 stories selected by family nurses to be further deepened (3-6 per FNP team)
Micro	Supervisors and nurses	Each of the nurses and supervisors working in the 5 teams
Meso	Supervisors and FAB	Each of the local FNP partnerships, coordinated by the supervisors, but contributed to by local stakeholders (especially FAB members)
Macro	PHA leaders	The core members of the PHA governance system for FNP contributed to a version of the macro story

FNP Caseloads

There are 27 family nurses and five supervisors employed within the five HSCT FNP teams. The FNP licence requires that family nurses do not have any more than 25 clients so as to ensure high quality and quantity of contacts necessary to achieve positive client outcomes and sustained positive lifestyle changes. This ratio is strictly adhered to in Northern Ireland. Supervisors have five clients allowing them to maintain and develop family nurse competencies whilst providing flexibility in relation to short term vacancies.

There has been a rolling average of 913 births to mothers under 20 years of age per year in Northern Ireland since 2011[10]. The teenage birth rate has decreased. There were 796 first time mothers under twenty years in 2016.

A total of 653 clients have enrolled on the FNP programme prior to 31st December 2016 (Figure 1). The FNP system is currently serving about one third of the potential client base of first-time mothers under twenty years of age. The latest information suggests that FNP is able to work with 43% of mothers of sixteen years and under, falling to 18% of mothers aged eighteen years. First-time mothers aged over twenty at last menstrual period are not offered FNP and receive universal services as per Healthy Child Healthy Future policy[11].

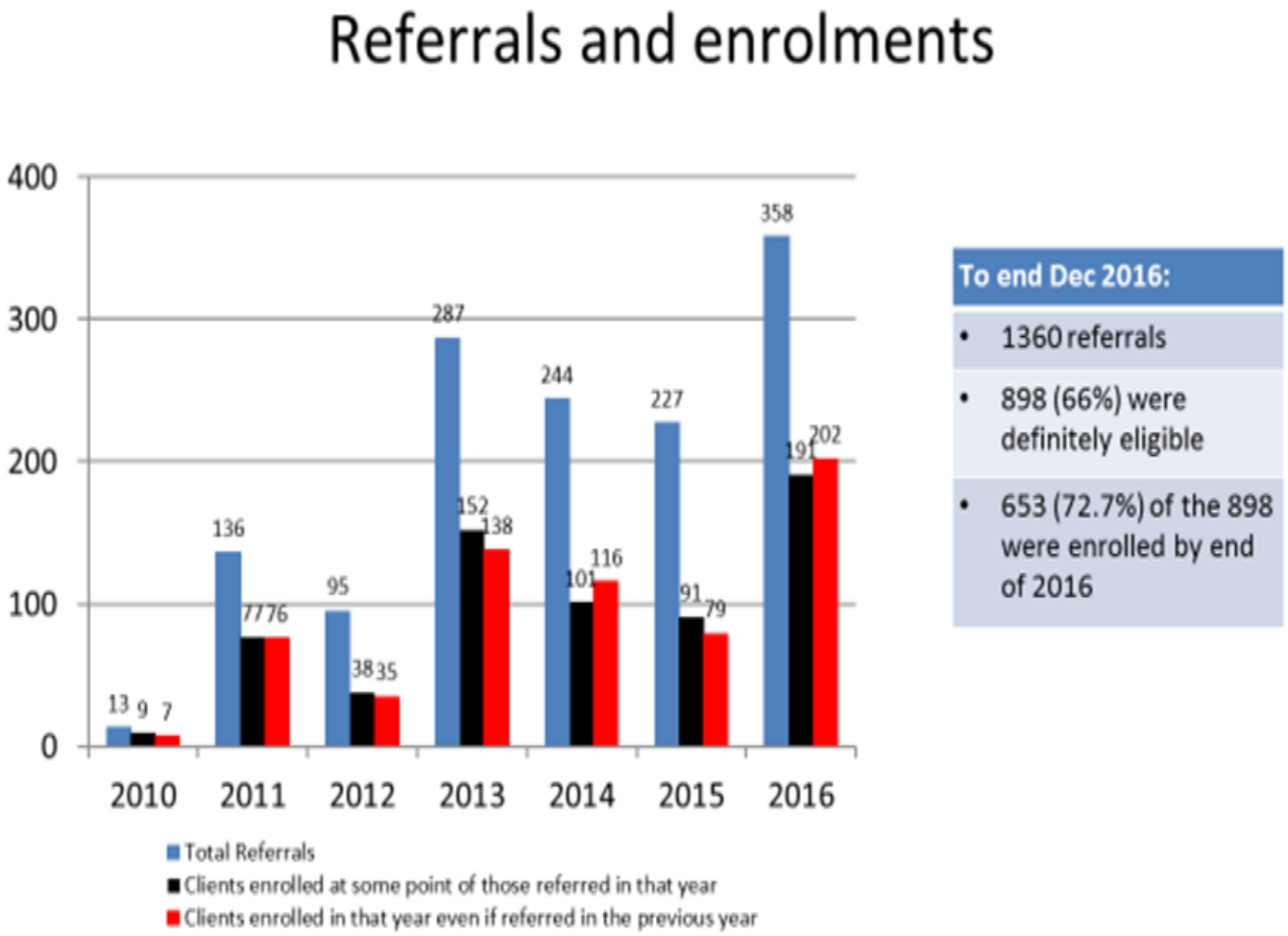
The regional FNP caseload was 307 clients on the 30th July 2017. These were live current cases and do not include clients who have left, become inactive or had already completed the programme. The rate of uptake to date by eligible clients ever offered the programme up to the end of 2016 was 73%. The low level of attrition[12] is reassuring and reflects a remarkable level of retention considering the challenging circumstances these young parents are experiencing.

It is one of the critical working principles of FNP that mothers-to-be enrol voluntarily, such that they commit to engaging with it, and staying the course. Demand for the FNP service outstrips existing service capacity in all five HSCTs. As a result, there

[10] Data in this section was provided to the Revaluation team as per the FNP Annual Review (2016).
[11] Healthy Child Healthy Future (DoH 2010).
[12] Overall, of the 653 clients ever enrolled by 31/12/2016, 8 (1.4%) left during pregnancy, 29 (7.3%) left during infancy and 22 (6.6%) left during toddlerhood.

are eligible teenage parents who are referred to FNP but cannot be offered a place. Family nurses and their supervisors face professional dilemmas on a regular basis when allocating and refusing places to eligible teenage mothers as a result of insufficient capacity. At different points in this work and at different levels of the system the revaluation team has been told about aspirations to extend FNP to a point where it is possible to work with all eligible first-time mothers.

Figure 1: FNP Referrals and enrolments to 31 December 2016



FNP Client Vulnerability

International evidence indicates that FNP is most effective for those in highest need. The FNP revaluation clearly demonstrates that FNP is being provided to the intended client group in Northern Ireland and this is contributing to its value and success. The perception of family nurses is that their case-mix is increasingly complex as they gain a reputation for being able to deal with the most 'difficult' families.

A list of 43 vulnerability factors was identified by the revaluation team based on the types of vulnerabilities that emerged through the process of collecting and reviewing the FNP client stories for the revaluation process. This list was also informed by the Understanding the Needs of Children in Northern Ireland Assessment Framework (UNOCINI)[13] and the Adverse Childhood Experiences (ACEs) Framework.[14] This work offers insight into the vulnerability of FNP clients in Northern Ireland and is likely to be of use to the Safeguarding Board for Northern Ireland (SBNI) that is leading the regional multi-agency approach to addressing ACEs. Whilst the 43 vulnerabilities are not directly comparable to ACEs, some of the vulnerability factors are the same, for example, experienced domestic violence, poor parenting or abuse.

Family nurses profiled all current clients (n=308[15]) against the 43 vulnerabilities based on whether they were aware if the client had experienced the vulnerability in the past or currently. This information was collated and analysed by the PHA's FNP Health Intelligence Officers.

The average number of vulnerability factors per client was nine. The most prevalent vulnerabilities were: low income (72%), relationship breakdown/separation parents (58%), mental health needs (46%), not in education, employment or training (NEET) (44%), experiences of poor parenting (38%), family known to social services (37%), no/low contact with own birth parents (33%), no/low contact with baby's father (27%) and unsuitable housing for baby or homeless (27%).

[13] https://www.health-ni.gov.uk/publications/understanding-needs-children-northern-ireland-unocini-guidance
[14] http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf
[15] There were 308 current clients when the vulnerability profile was completed.

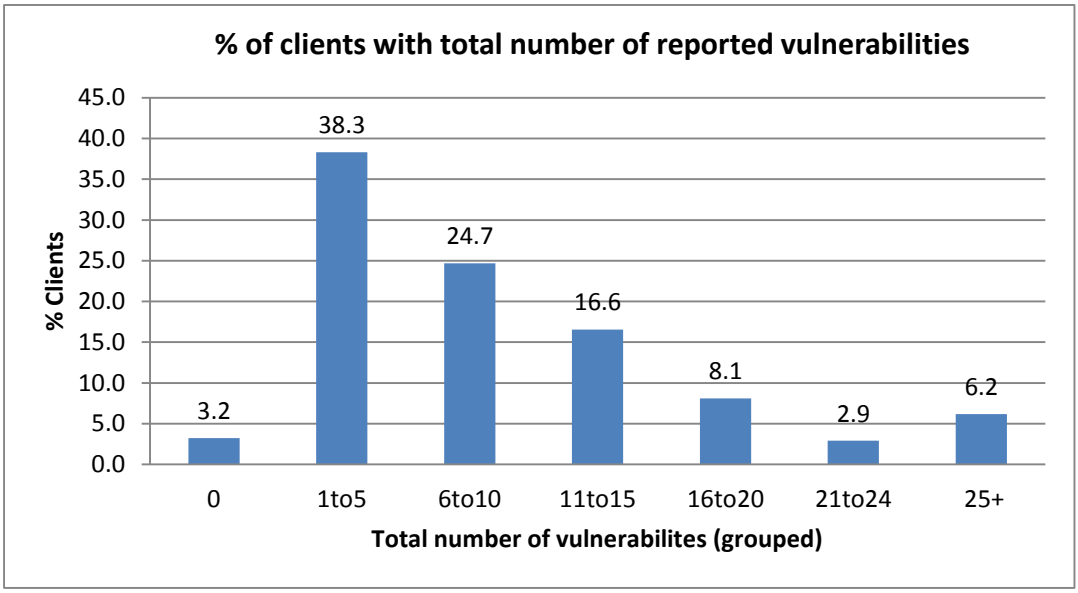
Table 3 below lists the vulnerabilities in order of percentage of clients who had reported the vulnerability.

Table 3: Overall vulnerabilities ranked

Vulnerability (N Clients = 308)	N clients	%	Vulnerability (N Clients = 308)	N clients	%
Low income / deprived community	222	72.1	Substance misuse by parents/parent's partner	57	18.5
Relationship breakdown/separation between parents	178	57.8	Experienced physical abuse (excluding physical abuse by partner)	54	17.5
Mental health needs / CAMHS	142	46.1	Having been or still being looked after child	54	17.5
NEET (or if School Aged, non-attending/disengaged)	136	44.2	Alcohol misuse	47	15.3
Experiences of poor parenting (other, self-reported – not specific	117	38.0	Drug misuse	46	14.9
Family known to social services	114	37.0	Experienced sexual abuse	41	13.3
No/low contact with either of own birth parents	103	33.4	Justice system interactions including Incarceration of client's partner	39	12.7
No/low contact with baby's father	86	27.9	Weight issues (obese / underweight)	37	12.0
Unsuitable housing for baby or homeless	84	27.3	Learning difficulties / special educational needs (Diagnosed by nurse/professional judgement	36	11.7
Client's partner is NEET	81	26.3	Justice system interactions	35	11.4
Domestic violence between parents/parent's partner (e.g. witness	80	26.0	Experienced child sexual exploitation	34	11.0
Experienced verbal abuse (excluding verbal abuse by partner)	78	25.3	Death of significant other (other than mother)	31	10.1
Experienced (parental/carer) neglect	78	25.3	Anticipated removal of child at birth due to safeguarding concerns	28	9.1
Attempted suicide and/or self-harm	77	25.0	Carer (for siblings, their babies, or dependent parents)	27	8.8
Parent/parent's partner has mental health issues	76	24.7	Referred into programme under 16	26	8.4
Involvement with social services (excluding any involvement already	73	23.7	Justice system interactions including incarceration of (one or more parents)parents partner	23	7.5
Victim of domestic violence / intimate partner violence	72	23.4	Paramilitary contact/influence	17	5.5
Client's partner known to social services	70	22.7	Client's partner in paramilitary contact/influence	14	4.5
Bullying / bullied at school	67	21.8	Previous miscarriage(s)	11	3.6
Being on CPR or having been on CPR	64	20.8	Death of client's mother	9	2.9
Client's partner has mental health issues	63	20.5	Parents/parent's partner in paramilitary contact/influence	6	1.9
Substance misuse by client's partner	61	19.8			

When the distribution of reported vulnerabilities was explored in more detail it was found that a majority of clients were reported to have had between 1-10 total vulnerabilities. 118 clients (38.3%) had a total of 1-5 vulnerabilities. 76 (24.7%) had 6-10 vulnerabilities. 19 (6.2%) had 25 or more vulnerabilities. Figure 2 below shows the distribution of total vulnerabilities for the 308 FNP clients.

Figure 2: % of clients with total number of reported vulnerabilities (grouped)



Vulnerability data for 19 clients with 25 or more vulnerabilities was reviewed. All 19 have experienced relationship breakdown/separation between their parents and poor parenting (100%). A high percentage of these clients have also experienced no/low contact with either of their birth parents (94.7%); parental/carer neglect (94.7%); verbal abuse (94.7%); being on Child Protection Register (CPR) or having been on CPR (94.7%); low income / deprived community (94.7%); mental health needs / Children and Adolescent Mental Health Service (CAMHS) (94.7%), and, justice system interactions including incarceration of client's partner (94.7%) (Appendix 3).

Vulnerability Factors associated with the Parents of FNP Clients

The three most commonly reported vulnerabilities recorded for the parents of FNP clients are relationship breakdown/separation (n=178; 57.8%), domestic violence (n=80; 26%) and mental health issues (n=76; 24.7%). Relationship

breakdown/separation between their parents, substance misuse and domestic violence were the most commonly identified vulnerabilities reported by the 19 clients with 25 or more vulnerabilities (Tables 4 & 5).

Table 4: Vulnerabilities associated with all parents of FNP clients

Vulnerability	N	%
Relationship breakdown/separation between parents	178	57.8
Domestic violence between parents/parent's partner	80	26.0
Parent/parent's partner has mental health issues	76	24.7
Substance misuse by parents/parent's partner	57	18.5
Death of significant other (other than mother)	31	10.1
Justice system interactions including Incarceration of (one or more)	23	7.5
Death of client's mother	9	2.9
Parents/parent's partner in paramilitary contact/influence	6	1.9

Table 5: Vulnerabilities associated with parents of FNP clients where clients have 25 or more vulnerabilities (n=19)

Vulnerability	N	%
Relationship breakdown/separation between parents	1	100
Substance misuse by parents/parent's partner	1	8
Domestic violence between parents/parent's partner	1	7
Parent/parent's partner has mental health issues	1	6
Justice system interactions including incarceration of (one or more)	1	5
Death of significant other (other than mother)	9	4
Parents/parent's partner in paramilitary contact/influence	<	-
Death of client's mother	<	-

Vulnerabilities associated with partners of FNP clients

The three most commonly reported vulnerabilities recorded for partners of FNP clients are NEET (n=81; 26.3%), being known to social services (n=70; 22.7%) and mental health issues (n=63; 20.5%) (Table 6).

Table 6: Vulnerabilities associated with partners of FNP clients

Vulnerability	Number	%
Client's partner is not in education/employment/ training	81	26.3
Client's partner known to social services	70	22.7
Client's partner has mental health issues	63	20.5
Substance misuse by client's partner	61	19.8
Justice system interactions including incarceration	39	12.7
Client's partner in paramilitary contact/influence	14	4.5

Data relating to partner vulnerability for clients with 25 or more vulnerabilities indicated that 94.7% (n=18) of partners of clients with 25 or more vulnerabilities had justice system interactions including incarceration of client's partner compared to 12.7% (39/308) of all partners. In addition, 89.5% (n=17) of these clients partners were known to social services and 89.5% (n=17) had substance misuse by clients partner (Table 7).

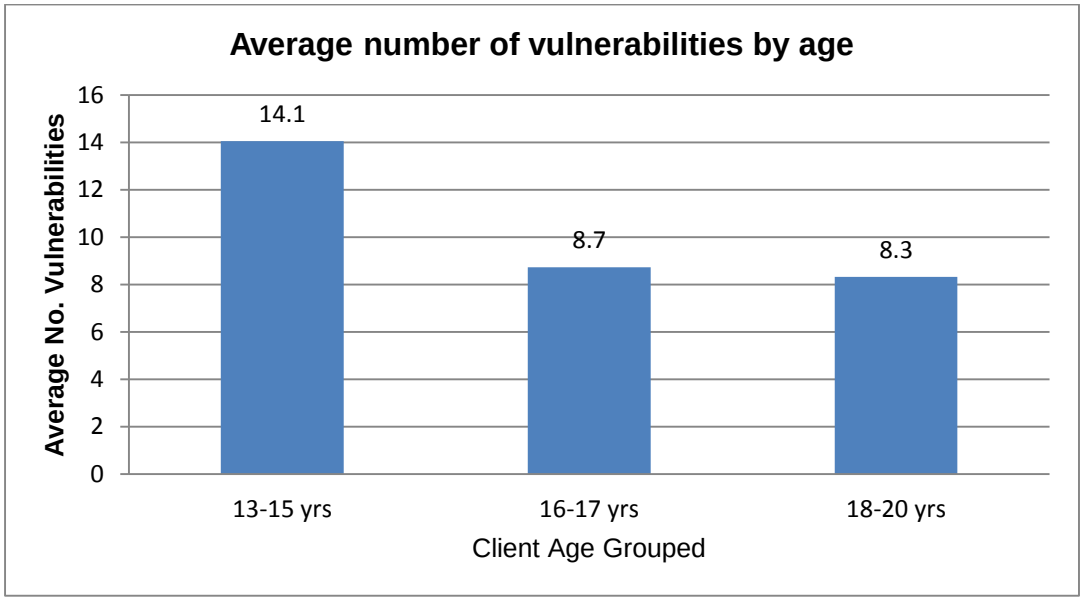
Table 7: Partner Vulnerabilities for clients with 25 or more vulnerabilities (N=19)

Vulnerability	N	%
Justice system interactions including incarceration of client's partner	1	94.7
Client's partner known to social services	1	89.5
Substance misuse by client's partner	1	89.5
Client's partner is NEET	1	78.9
Client's partner has mental health issues	1	68.4
Client's partner in paramilitary contact/influence	9	47.4

Vulnerabilities by Age

Identifiable data on age enrolled was available for 267 clients. It was found that the clients who enrolled onto FNP at a younger age had a higher average number of vulnerabilities. The number of vulnerabilities reduced as age enrolled increased. The average number of vulnerabilities for clients who were aged between 13-15 years old at enrolment was 14.1. This reduced to 8.7 vulnerabilities for clients who were aged 16-17 years and to 8.3 vulnerabilities for clients who were aged 18-20 years at enrolment (Figure 3).

Figure 3: Average number of vulnerabilities by age enrolled (grouped)



FNP Value

The revaluation team identified key categories of FNP value:

- Breaking cycle/s of behavior patterns that are negative, neglectful and harmful (implicit in this is the proposition that if a baby develops a secure attachment in their first 100 days they will have the capacity to develop as a responsible, empathic adult)
- Responding to multiple needs: co-morbidity, complexity, intractability
- Responding to vulnerability, and,
- Responding to a range of public health challenges e.g. smoking, not breast feeding.

Key interrelated components of FNP contribute to the creation of value for the benefit of the service user, their family and the FNP system. It is important that the wider system understand these so that value adding components can be considered, introduced and replicated where possible during the development and delivery of other programmes intending to effectively address vulnerability. Five key components include:

1. Governance
2. Regional data collection and analysis
3. Intensive recruitment and training programme
4. FNP programme materials, and,
5. Techniques and approaches (effective application of theory and evidence into practice using high level communications skills that facilitate a strengths based approach, agenda matching, intensive relationship building between the family nurse and the client and relationship building with the client's 'village of support').

FNP Governance

There is value in the FNP governance system itself. FNP is a licensed regulated programme. Professor David Olds licenses the FNP throughout the world from the University of Colorado. The PHA is the license holder and acts as the governing

authority in NI, reporting to Professor Olds and his international team regularly. Countries implementing FNP are expected to make some local adaptions for context, in collaboration with the international team and it is a licensing condition that research is undertaken to determine the impact of FNP within each country. This ensures that the fidelity of the programme is protected and that investment in the programme by a country is supported by evidence of impact. The revaluation research was commissioned to gain an understanding of the programme's impact in Northern Ireland. Implementation science has been utilized to develop recommended activities for the embedding and quality improvement of the programme over time[16]. Throughout the year, FNP presentations are given to HSCT senior managers and Boards. Public celebration events in all HSCTs are attended by children, parents, families, family nurses, HSCT representatives and the PHA central team where the benefits of FNP are visible for all to see.

The delivery and benefits of FNP are highlighted within annual reports as part of the FNP governance process. The regional annual report is shared at a regional inter-agency annual review meeting. Representatives from DoH, PHA, HSCTs and the voluntary and communication sectors attend. The gathering and analysis of data, with the expert support of local regional data analysis officers, is an important element of FNP as this demonstrates compliance with the license agreement; fidelity measures; the influence of FNP values and goals on practice; improvement plans, and, efforts to share learning internationally. Professor Olds and the international FNP team have regularly commended the high quality of implementation in Northern Ireland, and it is without doubt, that high expectations inherent in the license and contract have contributed to this, thus adding significant value. High quality implementation ensures that FNP practice is highly likely to achieve intended outcomes.

The PHA uses its resources to facilitate a regional approach to programme implementation. FNP teams also benefit from wider HSC Trust governance processes. The PHA requires each HSCT to have a FNP Family Advisory Board (FAB) as a local governance mechanism to encourage linkages to other services

[16] Hill, P and Olds, D (2013) "Improving Implementation of the Nurse-Family Partnership in the Process of Going to Scale" in Applying Implementation Science in Early Childhood Programs and Systems, Halle, Matz and Martinez-Beck(eds) Brookes publishing, Baltimore.

provided at Trust level. In practice, there is a high level of FNP engagement with health and social care services and in particular with general practitioners, health visiting, acute and community midwifery, child care social work, psychology and safeguarding children specialist teams. Each Trust has agreed 'targeting' criteria based on local knowledge of deprivation and need (Table 8).

Table 8: HSCT target locations for FNP

Trust area	Targeting Criteria
Western	Derry, Strabane and Limavady District Council areas
Northern	Trust wide coverage of eligible young mothers(mostly social services referrals)
Belfast	North Belfast-from January 2012 until September 2014; North Belfast and citywide Looked After Children-from September 2014; All over the city-from September 2016
South Eastern	Central Lisburn and Newtownards; and clients under 16
Southern	About 75% of the Trust area (not beyond Newry, down to Lurgan, Dungannon)

The revaluation team has indicated that more work is needed to understand the full role and value of FABs.

The revaluation team described the FNP system of governance in terms of its system levels and the differing purposes that it internalises at each level (Table 9):

Table 9: FNP Governance System

Level	Purpose	Mechanisms of governance	Supporting infrastructure
Macro	Meet license requirements; Advocate on behalf of FNP in government	Data management system; annual reporting	International visits; and assessment process
Meso	Meet license requirements; conduct the annual review; provide the infrastructure for embedding FNP in ecosystem of services for vulnerable families	FAB; informal professional networks; multi-disciplinary teams;	Contact between PHA lead, and supervisors
Micro	Support and supervision; hold family nurses to account; govern local delivery system on a day to day basis	Supervision system	Psychologist; HSCT head of service Named nurse for safe-guarding
Nano	Contain mothers: Develop capacity for regulation between mothers and babies; Support regulation of family systems	Relationships: family nurse and mother, mother and baby, family nurse and extended family. Theory: boundary management, programme resources	Supervision system

Regional Data Collection and Analysis

The FNP programme is an evidence based programme and the continuous collection and analysis of data is prerequisite to ongoing and learning licensing. It is the revaluation 's team view that FNP data requirements help to reinforce and substantiate aspects of the evidence base, and the 'international' provenance of the FNP model. As such fidelity measures reflect important sources of value creation within FNP for those engaging with FNP in Northern Ireland. Current data requirements are an essential component of the value creation system. The central team based within the PHA consists of a clinical lead, a health intelligence manager and research & information officer whose expertise and attention to detail is highly valued throughout the FNP system. The PHA has invested in a regional FNP

information system to support comprehensive data collection and analysis. This system is currently being enhanced. This will provide the basic foundation for fidelity, activity and outcome reporting and in the longer term will help inform future research. Regional and site level data analysis is currently included in an FNP International Annual Report and also regional annual reviews that are presented to a range of stake holders.

FNP Recruitment and Training Programme

FNP's ability to add value is contingent on its workforce and their training. There is strong competition for places in the FNP team meaning that family nurses are well suited to this role. Successfully passing the FNP's recruitment process is a source of considerable pride according to many family nurse stories.

FNP clients participate in the recruitment of family nurses. Their ability to contribute and astuteness is highly valued by FNP teams.

Family nurses have backgrounds in general nursing, health visiting, mental health nursing, midwifery and school nursing. Some have experience in a combination of these professional backgrounds. They are experienced professionals who are capable of contextualising their practice in relation to other HSC services. Common across all of their stories is the sense that being a family nurse is the most demanding role they have undertaken to date, and that they need to draw on all of their previous experience.

Family nurse training is provided by the FNP National Units in England or Scotland. Initial training is intensive and residential, and for most is unlike anything they have previously experienced. The 'powerfulness' of the training experience is related to the uniqueness of the role. The residential training offers family nurses-to-be an initiation into their new job and is followed by a process of ongoing learning as an inherent part of the role.

Family nurse stories frequently refer to a sense of personal and professional transformation, no less significant than that they seek to encourage in their clients. All FNP nurses report that they are beneficiaries from the programme. Family nurses have developed strong friendships with colleagues across HSCTs and get a deep

sense of personal effectiveness, self-efficacy. During FNP training family nurses meet and make friends with new family nurse colleagues, and it is apparent in the revaluation stories that many of those special pairings (training buddies) have lasted, even across team and HSCT boundaries. However, it is clear from family nurse stories that the essence of what they gain is the immense satisfaction from being allowed to build a close relationship with a client who then goes on to create a brighter future for herself and her baby.

"Having been in a teaching and advisory role as safeguarding nurse specialist I felt that as I approached the final years of a lengthy career it was time to return to practice. FNP has pulled together my entire career and all areas of expertise are most valuable in my day today working as a family nurse. It is an extremely challenging programme but most rewarding and I feel that my extensive training and experience throughout my career has equipped me to effectively manage complex situations and meet the goals of FNP".

"The role of the family nurse supervisor is demanding, difficult and requires commitment outside normal working hours. It is also the most rewarding job I have been employed to do to date."

This comment from a supervisor's story encapsulated her relationship with FNP and is typical of all the family nurses' and supervisors' responses to the revaluation team. The nurses are the main resource of the programme which is dependent on the time and effort they put in. All family nurses feel as though they are also beneficiaries from the programme. As the supervisor's comment makes clear, they invest far more in their work than they are contracted to do, and they receive much more than payment in return.

"FNP has been an opportunity to work in a different way, it has given me time with my clients and the increased time has enabled me to develop a relationship with my client, I have the opportunity to see the person instead of just a client."

The nurses' stories make clear that the essence of what they gain is the immense

satisfaction from being allowed to build a close relationship with a client, who then goes on to create a bright future for herself and her baby. As the revaluation process revealed, in cases with good outcomes the relationship between nurse and client is very close, and feels that way on both sides. As revealed by both the clients' and then the nurses' stories, it is a reciprocal relationship, based on a free and open exchange, in which the nurse is always careful not to set herself up as superior to the client. This is part of what is needed to build the client's self-efficacy, and resilience. We have already remarked how the client brings her own resources to the work, how she is contributor as well as beneficiary. The nurse, reciprocally, gains immensely from the work, as well as committing more of herself to it than she would previously have imagined.

Through group discussions, and their personal stories produced for the revaluation, family nurses have revealed a wide range of benefits which they receive from the programme, ranging from resources and know how, through to ongoing learning and a deep sense of personal effectiveness and self-efficacy. The revaluation team described this as 'echoing the benefits to the mothers'.

FNP Programme Materials

FNP licensed programme materials/resources and the sequencing of their delivery are key to FNP's success. The effective delivery of the programme by skilled family nurses using the materials with fidelity is key to FNP's success. FNP materials are well timed in that they are used at the right stage of pregnancy or motherhood, just when the family nurse needs them to support effective interventions. The revaluation team reported that they also appear to be well gauged to the needs of the clients in the programme. They are age-appropriate given that most clients are teenagers.

The FNP materials are a resource both to the client and family nurse. Family nurses described in group discussions how they only have to reach for the materials (which are compendious) and they will find the right thing for that exact moment, as the need arises in their work with their clients.

FNP Techniques and Approaches

The revaluation team were clear that FNP's distinctive strengths based approach, agenda matching and use of relationships are powerful delivery components. Both the strengths based and agenda matching approaches are consistent with the FNP value that 'the client is expert in her own life'.

"The client is made aware they are the expert in their own life, focusing on and building on their strengths" (*revaluation team*).

Strength Based Approach

One of the distinctive FNP ways of working, or nursing styles, is the strength based approach to engaging with clients. Family nurses describe how they have had to unlearn the tendency of a professional care worker to attempt to 'fix' clients and resolve their problems. The motivational interviewing phrase used is 'fighting the righting reflex'. For many new family nurses they experience this as 'physically' needing to stop themselves.

Being positive can be challenging, even for the most experienced family nurse, particularly when the family nurse is confronted by a life so complex that there appears only to be vulnerability. It is vital to the relationship that family nurses do find the positives no matter how concealed these may be.

"We're not asking people to change dramatically overnight… We're on a journey with them… You can find strengths even in the most dire situation."

Adopting a strengths based approach is closely related to the motivational interviewing[17] techniques used by family nurses. Client stories are full of praise for how positive family nurses are, and more profoundly, for 'believing in' them. Using a strengths based approach mobilises a client's resources. The client builds on what they already have so that when they achieve the outcomes they are looking for, with the nurse's guidance, they attribute the result to themselves.

[17] Miller & Rollnick (2013) Motivational Interviewing: Helping people Change, third edition. Guilford Press, New York.

Strength based working can be understood as an intensive, personalised form of asset-based approaches. As with effective community development, the result is resilience, however, here the process requires extreme self-regulation on behalf of the practitioner. As many family nurses commented, the strengths based approach is central to FNP ways of working, and one of the things that makes the programme different from health and social care services previously worked in.

"Family nurses are less risk focused and definitely strengths based, and this becomes very apparent when discussing cases with other professionals" (*revaluation team*).

Agenda Matching

Family nurses stress the power of agenda matching to create change. This is a high level skill that appears, from FNP stories, to gain prominence as family nurses spend time on the programme, and gain confidence in deploying a strengths based way of working. Agenda matching involves following the client's lead, or walking alongside them, encouraging them forward in particular directions but never telling them which way to go.

The opposite of agenda matching is forcing the agenda. This is something that comes out time and again in so many clients' stories. Young people appreciate how their nurse never forces the agenda.

"I feel that I'm able to say how I'm feeling if I want and not made to feel like I'm weird or something."

In another story, the client is mindful of the work the nurse is doing with the client's partner as well as with her. The client picks up on the family nurse's ability to observe as she explains to her:

"Most of all I like that you can read the situation and work out when it is ok to talk about certain things. I don't want to offend [partner] and I feel you respect that. You seem to pick the right times to discuss sensitive issues."

Agenda matching not only makes clients feel good, but it follows through into instrumental outcomes. For example, one of the clients came to the programme with a diagnosis of obesity. In her story, she relates her condition to eating habits she developed in earlier childhood, living in a chaotic household where food was not predictably available. She talked about how her experience of engaging with other people, especially social services, invariably involved blame, and how she felt ashamed by this. Her relationship with the family nurse was totally different:

"I now want to improve my weight. Before I just got angry when people mentioned it. My family nurse did not force the issue. It seemed like it was only important when it was important to me."

This is a classic example of an agenda matching approach, and it clearly worked in this case. The story ends with a thank you text from the client, the nurse having just given her a lift to a session with her new personal trainer.

Relationships

Revaluation has established that relationships are the driving force of FNP in NI, created and transformed at multiple levels.

"The value always comes back to the relationship" (revaluation team).

The revaluation revealed FNP as a complex system made up of nested subsystems. The client is a system in herself, and the baby is a subsystem initially inside, then beside her. Her person is a subsystem of her case, which includes her family nurse. The 'case' is a subsystem of a caseload, which is a subsystem of an FNP team, which is a subsystem both within a HSCT, and FNP Northern Ireland (PHA, HSCB, DoH), which itself is a subsystem of FNP internationally. This is a classic complex system structure, based on recursive two-way relationships between systems at different levels, which are effectively nested within one another. For the whole system to function effectively, each level needs to respond to changes in the next level. A simpler description has been provided by one of the team psychologists when she set out her tacit theory of change for FNP:

"Think about FNP as a network of overlapping concentric circles. At the

middle is the mother and baby; then the nurse and mother; and the nurse and supervisor. All of these circles offer a safe space for containment, and the safety in one circle can be carried across into another."

There revaluation research identified a number of key relationships:

Mother-Baby: defined by the attachment between mother and baby and the way they interact, as observed by family nurses, and measured at intervals using the DANCE (Dyadic Assessment of Naturalist Caregiver Experience) tool.

Mother-Family Nurse: this is the central relationship that powers the programme and which family nurses strive to build and strengthen at all times, and whose authenticity and reciprocity determines the outcomes a client can achieve during her time on the programme. Based on reciprocity, the relationship goes both ways and from the family nurse's perspective, could be termed a professional friendship. The family nurse is always being professional, and taking care to be so, but it is also critical that she is always genuine, authentic, and dependable. This is what provides the support role which so many clients have been missing, and which family nurses want the clients to learn from them, through modelling their behaviour, in order that they can become the dependable parent to their babies.

"FNP has been an opportunity to work in a different way, it has given me time with my clients and the increased time has enabled me to develop a relationship with my client, I have the opportunity to see the person instead of just a client."

Defining, and marking out, the boundaries is an inherent part of building an authentic and open relationship with a client. It is a part of doing the work, and through doing it, work can proceed together. The net result of walking the fine line is a very intimate relationship.

"This is the first time in my career, I feel my work directly makes an impact on a specific client group, the intense relationship means I see the changes they make, even small ones, and I feel so proud of the journeys my clients make in the most difficult of circumstances. They inspire me to be a better support for them."

Mother-Mothers: bringing clients together is not a regular element of the programme but happens through graduations and celebrations.

Mother-Wider Networks: producing a 'Village of Support' is one of the core tasks prescribed in FNP materials, and one which helps a client and her partner to see what possible opportunities for support she currently has, and could have. Building or rebuilding networks e.g. friendship groups is one way for a client to transition from child to mother, and to switch trajectories away from ongoing vulnerabilities.

Figure 4: Village of Support Map: Example of interagency relationships important to FNP

The village map indicates potential opportunities for enhanced collaboration.

Considering the vulnerabilities identified as part of the revaluation process, it might be that adult mental health services, drug and alcohol support and treatment services, and perhaps the emergency services and agencies of the criminal justice system, could be identified as future partners for collaboration. Meanwhile, by mapping the connections between the surrounding institutions, new connections could be made across the system, and new opportunities to link into other agencies' networks could be capitalised upon.

Nurse-Partner and Wider Family: the evidence of direct benefits to clients' wider family members created through revaluation is considerable and diverse. Benefits are both direct, through improved relationships between client, partner and wider family members, and indirect, being mediated through, or accelerated by, the family nurse.

Nurse-Supervisor-Psychologist: the networking of professionals together within the FNP team as subsystem allows for overlapping circles of containment, which ultimately support the total disclosure that can happen between client and nurse. The make-up of these subsystems will vary from team to team, based on the history, composition, skills, needs, and caseloads of the FNP team in question.

Nurse-Supervisor-Other Care Services: the value of the family nurse in re/engaging clients with the wider social care system shows the strength and breadth of the relationships between family nurses and their care system colleagues, which are most obvious at the level of the individual case.

The following testimonies show something of the breadth and depth of personal relationships where professionals have worked together on a shared case.

"My experience to date of FNP has been very positive. I feel that the family nurse and I have worked well in terms of our current shared case. The family see two services working closely together, being open and honest, highlighting strengths and worries in a supportive way. We work well together accessing services and sharing information which reduces duplication of work. The relationship that the family nurse has with the family is very important in terms of partnership working and this is supported by the

regular visits and educative work offered." **(Social Worker).**

"Positive. Good collaboration. Good to know there has been someone working closely in the home environment who can keep me updated about any mental health concerns." **(CAMHS Psychiatrist).**

"It's amazing to see the progress that … (family nurse) made with the mother. Community midwives don't need to deliver so much material. The family nurses have got more time to put it across. And when the midwife finishes, the family nurse continues on…" **(Community Midwifery Manager).**

"I am working with a young person who should still be in school but she reports sleeping all day. She goes to bed at 9am, having stayed up all night with her boyfriend. My role is to support her to complete her education, which we know is a priority for promoting her life chances therefore I have an agenda around education which she has been disillusioned with even before her pregnancy. This is a complicating factor in our relationship. I will continue to support her, but (the family nurse) has no agenda other than to support her in her pregnancy– (family nurse) can work around her chaotic sleep patterns and to address this with her, whereas I am seeing her as a young person who is losing an opportunity to gain some qualifications and begin to develop a pathway towards a positive future. Through networks with the FNP and regular contact with the family nurses, best practice has been achieved and a truly holistic support is offered to young mothers." **(School Aged Maternity Services Coordinator).**

FNP Value for Children, Parents & Families

In the revaluation framework ‘Calibrate Invisible’ includes direct benefits to individuals in a system, including those benefits which are emerging and can be seen as arising in the future based on the work to date. In FNP, the revaluation team saw babies themselves as the obvious example of this. Their happiness is very visible but their all-round development, including brain development, means they are more likely to grow up to be all-round healthy children and adults. Babies are the quintessence of an early intervention approach, hence FNP’s strapline, *Changing the World One Baby at a Time,* implying that improving the lives of babies is certain to change the world albeit, with a time lag. FNP mothers, who themselves are often legally defined as children, will also continue to grow up and enjoy new futures.

The revaluation team found that the bulk of visible calibrated evidence of value to clients and their families existed as self-reported benefits during reflections between the mother and her family nurse although they also saw as evidence numerous personal selfies, videos, photos, presentations by parents, handmade gifts and thank you cards on graduation. Invisible calibrated benefits include emergent effects on individuals such as changes in their lifestyles and trajectories which will result in new positive outcomes for them in future, for instance, a client reflecting on her new identity or prospects as a result of returning to education or training.

Highlights of the ‘calibrated value’ captured during the revaluation research have been evidenced in a number of ways and described as:

1. Child development
2. Happy babies
3. Good mummy identity
4. Maternal health
5. Self-efficacy
6. Freedom from anxiety
7. Self-regulation and putting baby first
8. Better informed parents and families
9. Trusting and open relationships

10. Benefits for partners
11. Benefits for the wider family
12. Benefits for Foster/adoptive parents
13. Engagement with statutory services
14. Value of FNP to family nurse

The explanations of the revaluation team for each of these themes id reproduced below:

Child Development

FNP's role in supporting parenting in a manner that results in children achieving positive developmental outcomes is at the core of the FNP programme and is probably its most significant success. In almost all client stories it is reported that children are either meeting or exceeding their expected developmental milestones despite the vulnerabilities of their mothers and the complex circumstances the babies are growing up in. In some of the client stories family nurses have contrasted a baby's keenness to learn to read with the poor literacy skills of its mother.

Given how critical child development is to FNP outcomes, understanding and encouraging a baby's development is a key part of the day to day work of the family nurse. The greater part of the family nurse's work here simply involves observation, and encouraging the mother to be observant too. It is not that the family nurse who causes strong development, rather she creates the conditions for strong development to happen, and observes it happening. This comes down to a combination of standing back, making sure it is the mother who enables the development by providing secure attachment to the child, observing then recording the results. Much of a family nurse's training is about helping parents to read their child's cues, promotion of sensitive, responsive mother-baby interaction, and supporting parents to understand the signals of strong development in the child.

The FNP programme uses evidence based tools with which to structure and record nursing observations including Ages and Stages Questionnaires (ASQ). This enables nurses to quantify their observations, report, and make comparisons.

However, it is notable that family nurses can feel something is lost in the push to quantify their observations.

"The babies are achieving a lot – Ages and Stages questionnaires capture some of the information but don't capture what the babies are doing above and beyond the normal range of development".

Underpinning these observations of child development is an understanding of the emerging scientific evidence on brain development. This is written into FNP training and programme materials which are shared with the mother. Mothers in several stories comment that this is one of the sections of information which made the strongest impression on them. The emphasis on brain development is not simply an indication of how the programme is designed in line with underpinning science and theory. Theory, science and practice are overlaid in the programme.

"We know that good attachment from birth builds a baby's resilience. It's about a parent meeting the child's need: the child experiences the need, the parent meets it. The child becomes able to trust their parent. It's a cycle of needs expressed leading to needs met. As a result, the child becomes confident, and that confidence gets wired in to their brain…. 'Attachment moments', simple things like reading a book together, will get wired into a baby's brain forever. There are these lovely brain scan images showing the brain of a neglected child against the brain of a child whose needs have been met. The neglected child has a tiny brain: that's what severe neglect looks like."

"The greatest impact is with the children and young people. The babies are confident happy children. That's what every mother wants. Notably the mums with the lowest psychological or physical health resources are the ones with secure, happy children, even though mum's life's not like that. There are some mums who excel and flourish on the programme, and others who show little change – but all their babies look happy." **(Central team member)**

Happy Babies

Like so many others who engage with FNP, the revaluation team noticed how content FNP babies are. Attending the FNP graduation is a signal moment in the life of the programme, not just because it recognises mothers' and babies' achievements and provides some closure, but because it is one of the few times when large numbers of FNP babies gather together. As films of these events attest, the babies are almost universally happy and at ease. Evidencing happiness is important if an evaluation is to give a full account of the value of FNP. Apart from real time observation, videos and photographs provide one of the best means to report on happy babies. The programme materials and the material gathered by each FNP team, for instance, to report to their FAB boards, or to launch their new services, are filled with smiling babies.

Maternal Health

While visits are structured by the core elements and programme materials, the approach is to treat the 'whole mother'. Treating the whole person, and in the context of her daily life, is consistent with the theoretical underpinnings of the programme, most obviously with human ecology theory, which takes a holistic view of the determinants of health behaviours. The direct benefits to mothers are reported in multiple dimensions including external observations of clients' physical health improving, most obviously cleaner lifestyles, but also changing to a healthier weight whether by weight gain, or weight loss. A wide range of benefits are reported by mothers with mental and emotional improvements being the predominant benefit.

'Good Mummy' Identity

The wish most frequently expressed by clients in their stories is to be 'a good mummy' now and in the future. The revaluation team have reported that this constant goal, both being and wanting to be a good mummy, is virtually universal across all client stories. Indeed, FNP could be simplistically summarised as a 'good mummy' programme, in which young people learn how to become mothers through the taught elements of the programme, and, through learning behaviours modeled by family nurses.

Many clients are keenly aware they have lacked a good mummy of their own as they

have been growing up. The vulnerabilities profiling data support this: 38% of clients in the current caseload have been observed by nurses to have experienced poor parenting. The link between having been poorly mothered and being determined to be a good mother is very clear in many of the clients' stories. In one story a family nurse relates how her client, who herself was on the CPR, appeared before a pre-birth case conference and said with determination:

"I want to do everything the opposite to what my mammy did"

For clients of this kind, their own mother serves as an anti-model for the kind of mother they would like to be, and which the nurse has shown them they can be. Again, it is the combination of being strengths based and agenda matching which seems to help these clients make progress. If the nurse believes in them, then they can believe in themselves. It is almost a case of if their family nurse says it is true, then it is so. Thus in one story the client says both:

"I want to be the best mum for [baby]. I am being a good mum. [baby] is developing well."

These sentences, said close together by the client, underline how being a good mummy is for now, and for the future, both at the same time. They also emphasise the family nurse's encouragement and validation are both vital.

Another client, who came to the programme when she was a looked after child, is explicit about the role of her family nurse:

"I like the relationship I have built with my family nurse. She has helped me make changes in my life by giving me confidence and helping me be a good mum. I always put my baby first and will continue to do this … I think I am really good at being a mum"

The self-efficacy the family nurse has helped to build is apparent in this story. The client's newfound confidence is centered on her baby as if this is the first time she has thought of herself as good at anything.

In the question of being a good mummy, belief is as important as some kind of

objective judgement. The client is the ultimate judge of her own mothering, the expert in her own, and her baby's, lives. A client claiming the 'good mother' identity is arguably more important than her being awarded it, although the two cannot be separated. That said, the evidence from third parties supports the claims and determinations made by the clients themselves. In one story, the family nurse explains her very young, and otherwise unsupported, client's rapid progress once she enrolled in FNP. Being a good mummy for this client has become a "*fact*".

"[Client] appeared to 'grow up' overnight and lost a lot of her friends as she had limited opportunity to go out and socialize. The crèche reported that [client] was one of the best mums they had ever worked with; [baby] was on time every day, her bag was always appropriately packed and the interactions between mum and baby were wonderful. I was so happy to have this positive feedback as I felt that [client] didn't have enough praise and encouragement for her achievements. I continuously provided [client] with the positive feedback and reminded her of her strengths and the fact that she was such a good mummy. "

Self-efficacy

Along with attachment, and human ecology, self-efficacy is one of the three key underpinning theories of the FNP programme, internationally. Self-efficacy strictly refers to a person's sense that they can achieve the outcomes they want by successfully undertaking a behaviour.

The stories of FNP clients and nurses are full of how people enter the programme with low confidence, not least through often having 'fallen' pregnant and all of the practical challenges and social stigma that this can bring. It is clear from the stories that, as well as attending to clients' immediate domestic and financial circumstances, building confidence is one of the first impacts a family nurse can have. It has already been noted that it is the family nurse's method to stand back and observe. This is part of what helps build self-efficacy in the client. The nurse does not tell them what to do, or do things to them. Instead, they do things with the client, and only when the client asks or agrees. The result is that a client makes the changes herself, and builds her own resilience, rather than becoming dependent on the family nurse.

Some family nurses speak about building the 'resilience' of their clients, their ability to withstand shocks and adapt to changing circumstances. To be able to do this, it is critical clients build up and draw on their own resources. This dynamic is not only apparent in how family nurses explain their work, but in how clients speak about their experience of the programme. Attending to FNP exit strategies from the outset, and being clear to clients that they will be leaving, when the child is two years old is also part of this method. Nurses use their own instrumental measures of increasing confidence, such as a client being able to join a Mothers and Toddlers group, or a Sure Start programme which can hold extra challenge for those with negative experiences of statutory services.

"I feel so much better in myself and am getting out and about and going to mums and tots and Rhythm and Rhyme in the library. I would not have ever dreamt I would have had the courage to walk into a room of strange people. I often felt anxious."

"The most important thing is someone believing that I would be a great mum and showing me the way as I faced small problems and hurdles. I think somewhere along the way I began to believe in me too."

"I suffered really badly from depression at that time and was in a very dark place. My family nurse gave me different ideas about how to make positive choices for myself and my baby. She gave me the belief that I could do it, she was so positive and believed in me when others didn't, that meant more than anything."

Freedom from Anxiety

Nurses indicated that nearly half of the current caseload (46%) have experienced mental health issues currently or in the past, and that a quarter (25%) of clients have self-harmed or attempted suicide. Drug misuse, both illegal and prescription, features in a number of client stories, and is near universal in those where multiple vulnerabilities are reported. This applies to both the clients quoted above. All this is layered on top of the low self-esteem that can affect a young person when she learns

she is pregnant. Numerous clients' voices attest to the immediate impact of the family nurse on their mental health, for instance:

"I was very low when we first met, but now I am in a happy place, being at home with my baby and my family."

"Excellent service. Feel it has been very beneficial to couple of my clients. ...Great to know they are getting the best chance to bond with baby and help with their ability to break the cycle of poor parenting. Have noticed better mental health with clients who have followed this programme." (Midwife)

Self-Regulation & Putting Baby First

Related to the underpinning theory about self- efficacy is the evidence of an increase in clients' ability to self-regulate. This is part of developing resilience to shocks. FNP clients are faced with considerable challenges as they need to develop fast from being children themselves. 'Putting baby first' is one of the core tenets of the programme, and one of the things that mothers report having learnt from their nurse in so many of the client stories:

"I like the relationship I have built with my family nurse. She has helped me make changes in my life by giving me confidence and helping me be a good mum. I always put my baby first and will continue to do this."

"I have unpleasant memories when I was with my mum. We never knew what was happening from day to day. She took drugs. We never knew when we were getting a meal. It was often fast food and I used to binge eat when food was available. My mum always put her drugs first. My baby will always be my top priority!!"

For many clients, putting baby first also means putting the relationship with their baby ahead of that with their partner. In some cases this is especially challenging, for instance where a client has been in care and has a dearth of positive supportive relationships to draw on, beyond that with their partner and in some of these cases,

there is evidence that the relationship is an unequal or abusive. Much of the family nurse's immediate work is to assess that relationship, and where it is positive, to strengthen it. Where it is less positive, indications of a client pushing back against the baby's father are seen as signs of progress, all in the cause of putting baby first.

"I want [infant] to grow up to be a nice child, I want him to be his own person, well- mannered and have a good relationship with me. I worry about the genes such as his father's who wasn't a good person. I do wonder could infant be like his dad? but honestly not if I can help it"!

The capacity to self-regulate is also of direct benefit to the mother. For instance, where a client brings unhealthy relationships with her on entry to the programme, being able to develop self-control is vital to making any progress. Addictions are a particular form of unhealthy relationships, and self-regulation is observed as a protective factor in helping clients stop smoking, get off drugs, or push away partners who refuse to get off drugs.

"I want to be with [client's partner] but he needs to make sure he stops taking drugs or else he can't be with us."

There are cases in which the mother and baby are separated through the looked after child or adoption processes. Even here, where the new relationship between mother and baby has broken down early on, self-regulation is vital. In one notable deep story of this kind, the mother decided herself, at the very end of the programme when her baby was two years of age, that she could not contain herself and organise her life and her habits to the point where she could put her baby first. The result was a voluntary removal, resulting from a decision by the mother based on deep self-knowledge, and paradoxically, an awareness of her own inability to self-regulate. As the family nurse in that case said:

"Sometimes the best thing for the baby is to refer them, or remove them. My sense was this mother understood this was the best thing for her child's future."

Better Informed

Family nurse visits are structured around FNP programme materials so that the programme achieves its positive effects as proven by research in other FNP areas. It is seen as important that the family nurse adheres to the programme contents, regularity structure. Clients speak of how much they have learned and some of their stories reference particular elements of the programme materials:

"I've definitely learnt a lot more than I thought I'd need to know. During my pregnancy you helped me understand health information… I found out information that helped keep me and my baby safe and well… I learnt about foods I couldn't eat, infections, body changes and my baby's development. You also spoke to me about feeding. I kinda wanted to breast feed but wasn't sure. I remember you gave me lots of information and let me decide"

For some clients, access to information is one of the main attractions of the programme. In one story, the family nurse asked the client what the best thing about the programme had been:

"All the things!! I have learnt something from every visit, I honestly do learn something new. I never feel like I can't ask something."

It is clear from this client's story, and many others, that what they are learning is a mixture of the information presented in the programme materials, and the less explicit ways of parenting which are modelled by the family nurse.

"I've learnt about what size my baby is, that it is important to have a relationship with my baby now. I've learnt about changes in my body and about new born babies. About routines, how important my own health is and that I can be a great mammy."

Revaluation has provided an additional opportunity for family nurses to check in with their clients about what they have learnt through the programme. The revaluation team noted that from week to week it can be hard for the family nurse to know precisely what has been learnt. In part this is down to some clients not being very attentive in their learning styles. 11% of clients are observed by nurses to

possibly have learning difficulties/special educational needs according to the vulnerabilities analysis and many more would say they had difficulties learning. 44% of the current caseload have disengaged from education or employment yet it is clear that the family nurses' tendency is to persist with the core content, even if it takes several attempts, or visits, to get it across.

"I think you've covered everything really, we had to go over some things a few times because I wouldn't listen (said laughing)."

In their group conversations and stories, many family nurses spoke of their uncertainty over whether the information they have given, let alone the good parenting and relating skills they have tried to model, have been taken in by the client. In part, this is another consequence of their ways of working: being always strengths-based, they cannot test the client's learning or make them re-learn units. They just have to be consistent, supportive, and wait. As one family nurse commented during a group discussion for the revaluation :

"What does success feel like? You listen out for change talk all the time. For example, I had a text the other day thanking me from a girl who's moved her baby into its own room for sleeping - this was a big change for her, a massive change. You look out for that kind of thing."

Trusting, Open Relationships

Clients' comments have explicitly referenced the strength of their relationship with their family nurse. The revaluation team's view of the programme is that it is all about relationships, at every level. The foundation of that is the closeness of the relationship between family nurse and client, such that a client can tell a family nurse absolutely everything, knowing that her trust will not be betrayed. For young people who have grown up without a dependable relationship of this kind the family nurse can quickly come to occupy the central position in their social world. In some cases, the nurse explicitly stands for the mother, whether the client's own relationship with her mother is absent, damaged or damaging. Clients often speak of the family nurse being her friend, or her best friend.

"My family nurse kept me sane when I was feeling very low. It was great to

have someone to listen to you, who didn't judge you or tell you what to do. It was like having a best friend who knew lots of things."

"I've really enjoyed having you visit and don't really want it to end. I know it has to but we've been through so much. You were the only person I really spoke to during the early days."

As with all close relationships, the friendship between client and family nurse can be expressed as much in sorrow as happiness. Family nurses are careful not to allow the client to build up dependency upon them, and part of this is being very clear that the relationship is time-bound, from the outset. Preparing for exit is then a regular part of the work together but it does not remove the sorrow at parting

"[Client] looked at me very sadly and said 'I can't believe that's it and you won't be visiting again!'"

Benefits to Partners

Partners feature prominently in the revaluation evidence. The starting point for the new relationship between mother and baby is the existing relationship between mother and partner, whether that is a steady relationship, on and off, or in the past. Family nurses are aware that the outcomes of their work with mother and baby will not be realised in isolation from the baby's father. Indeed, even in cases where there is little or no contact, and the relationship appears to be unproductive, family nurses work with their clients to prepare them for the contact most fathers will have with their babies.

The reported benefits to the partner can be as wide as those to the mother, spanning all aspects of their lives. It may be that the benefits are not as deep for the partner who is not the primary client, and the extent to which they are included or include themselves in the home visit appears to vary widely and even visit to visit. Nonetheless the extent of benefits to fathers is remarkable given their non-core role in the programme. In some stories, it appears fathers change more than the mother in response to the family nurse's support. The relationship between nurse and client's partner varies from case to case, though it appears that the starting position of the family nurse is to welcome the partner into the sessions as

much as they can, given the topics that are being discussed.

"We are young ourselves and trying to figure things out. …I don't know how I would have been able to talk to [client's partner] about that without you. I like that [client's partner] is present at every visit and you include him in the visits."

In cases such as this it is clear the partner is totally involved. In some stories the partners even have voice in the mother's story. In one such case, the dynamic of the partner and mother's relationship overlapping with the family nurse and client's relationship is clear and is clearly to the benefit of the new family, and baby:

[Partner]: ***I like how at FNP visits I am included. I often feel left out of things happening with the baby.***
[Mother]: ***I like [client's partner] being at visits and there is material for him to read and complete. It was fun doing our "villages of support" together and it helped us talk about things we would not otherwise talk about. We are getting to know each better through the work.***

When asked by their family nurse at the end of the story session what lessons stood out from FNP for them, both partners had their own, profound, comments:

[Mother]: ***How it is always important to look after myself in order to look after my baby.***
[Partner]: ***I can change if I want to. It's not down to others but to me.***

Specific benefits reported by fathers in the client stories include emotional benefits similar to those experienced by mothers. Increased confidence is a common result reported by and for partners where they have addictions, these are challenged, and often broken, in a similar way that they are by clients. One related outcome from the supportive relationship between family nurse and partner is better engagement, or re-engagement, with statutory services. As clients and partners build their own confidence, so they also build trust in the family nurse, and through her with other services. For example, when one client was asked to say in her story what the best bit of FNP had been, her answer spoke to the three-way relationship she was enjoying with her family nurse, and her partner:

"The advice, support, help, working things out and laughing together with me and [client's partner]."

In this story, the client goes on to relate how, due to the support of the family nurse, her partner was more prepared to engage with social services, when it became clear she would need to be referred in because of her past experiences, age, and vulnerabilities. She describes her partner as having become "*scared*" of social services due to previous contacts he had had with them.

As well as emotional benefits to the father, a range of physical benefits are apparent across different cases. In one story, the client speaks compellingly of how her family nurse helped the whole family when her partner was diagnosed with a serious illness. It appears that at this point a portion of the family nurse's visits was given over to nursing the partner, who had to travel for treatment, and had to stop working. Though this was not a structured element of the programme, it is clear that the family nurse could not continue delivering programme elements until this episode in the family's life was bridged. In reflecting on her experiences, the client herself identified substantial benefits from the episode, in terms of her own self efficacy:

"You can do anything if you really want to. I don't have to do it alone. I found out I was stronger than I thought, when [client's partner] got ill."

In this story, the partner recovered and returned to work. The mother had started working part time to fund a college course. Both client and partner had built up their resilience and set out on new lives together. The direct benefits to the couple are clear but in others, family nurses can be as unsure about the progress they are making with the partner. It is partly a consequence of the family nurse's teaching style that she cannot be sure what difference she is making week on week, but then, at an unanticipated moment, she will pick up on clues that the information has gone in, and the client has moved on. This time lag effect is particularly apparent in family nurse reflections on their work with partners.

As the stories make clear, partners often drift in and out of the sessions, sometimes literally, as they pass through the room where the family nurse and mother are working. Sometimes it is only a lot later when the family nurse

becomes sure of the impact she has had on the partner, especially where he has been somewhat aloof during visits. In one such situation, the partner was deeply connected to the client's vulnerabilities, including via their shared drug habits. During the programme he was reported always to have made himself scarce, or barely present, during the family nurse's visits. Yet by the end of the programme the mother, her partner and baby were reported to have strengthened their relationships, and to have developed a new positive lifestyle. During the follow-up revaluation visit, the client's partner classically puts his head round the door, and gave his view of the family nurse:

"[Family nurse] was sound - she made me feel at ease and didn't judge".

Benefits to the Wider Family

One of the advantages of adopting a story-led approach to evaluation is that it does not presume who the priority target audiences are. The suggested that in a complex intervention FNP, which could equally well be described as a programme for teenage mothers, their babies, or the new families which they are building, adopting a story- telling approach, has revealed wider beneficiaries of the programme extending beyond the immediate mother-partner-baby cluster. The clients' own stories make it clear that, in some cases, the family nurse is truly a 'family' nurse, meaning that she is providing care to the whole family of her client. In one story, when the client was invited to identify the best thing about FNP for her, she said:

"The relationship that has developed between my family nurse, me and my family….. Sometimes my mum sits in on the visits and enjoys the information shared. My family nurse includes everyone in our house, including the dog!!"

In the same way that the relationship between the client and her partner overlaps with the relationships between client and family nurse, and family nurse and partner, so the family nurse's support for the whole family can, over time, lead to her inclusion by the whole family. In another case, the client was nearing the end of the programme when she was asked to contribute her story, and finished by saying:

"You were part of the family and my mum keeps asking why you're not coming

back, I have to keep telling her it's finished when the first baby is 2 years old but she's still asking!"

Evidence such as this suggest that the family nurse's chief role is to help build families but that she also can rebuild the wider family around the new one she is employed to focus on. The revaluation suggests that many different family members can benefit from the family nurse's visits:

Clients' parents

Like the client's partner, client's parents can receive direct support from the family nurse. There is one story that tells of where the client's father, who has had a long history of issues which have brought him into contact with services, monopolises the family nurse visits and she had to develop strategies to counteract this.

Clients' parents can also influence how much benefit their daughter, the client, gets from the FNP programme. The maternal grandmother is something of a legendary persona in this regard. She often attains near mythical status in the stories as retold by the family nurse. On one level, she is a gatekeeper. If the client lives in the family house, the maternal grandmother can literally decide whether the nurse is let in. Then, once a visit has occurred, she can either reinforce and support that has been put across or totally undermine the information, should she choose to do so. She even has a pivotal role in deciding whether a young woman accepts the programme when it is first offered to her, and whether she stays on it. In one of the few stories we have captured which involved a client dropping out of the programme half way through, it was the maternal grandmother who ejected the Family Support Team from the house, and who then refused to admit the family nurse next time she called. The couple then did not re-contact the family nurse within the six month window allowed for a case to remain inactive, and so were discharged from the programme.

There are other stories in which the maternal grandmother is also not a benign presence, indeed, in some cases the nurse takes it as a sign of her client's growing confidence and resilience that she can stand up to her own mother when the grandmother's behaviour begins to threaten the wellbeing of the core family unit

(mother-baby-partner). By contrast, other stories have more positive outcomes and the maternal grandmother has played a constructive role by being explicit about the benefits she is receiving from the nurse's visits.

"It's been brilliant. When I had my children lots of the things about looking after the 'wains' (children) was very different, but you gave us all the new stuff which really helped with the children, and I will know more in the future to help [baby]."

Returning to the question of who in fact the programme is primarily intended for (mother, baby, or all the core family), in one instance the family nurse was clear that her work involved mother and daughter equally, even before baby arrived, and that this whole family relationship was key to the client achieving the positive outcomes that she did:

"Crucially what worked with this family was the impact of the relationship between [client], her mum and the nurse. I feel that I had two clients, [client] and her mum. [client's mum] was also interested and involved in the learning."

Siblings

Siblings feature in a number of client stories and though they do not have the pivotal role they can influence outcomes, in both positive and negative directions. Often this relates to where the couple and their baby live, and in many cases this involves sharing space with siblings, and by extension, their children. This common place family dynamic has extra significance in many of the FNP cases, because of the child protection or social care dimensions: siblings can offer a secure setting, and in cases where a baby needs to be put into care, a kinship placement. At the same time, if living with a sibling is not a stable option, the absence of family help can speed the move to a housing project, or independent accommodation. Although there are no reports of siblings being included in family nurse visits, there are cases where siblings receive indirect benefits. In one story, a client, herself only 16 when she joined the programme, uses her increasing parenting skills to guide and support her father, who in turn looks after his other two daughters who have special needs, and babies of their own. In a voice mixing pride and

determination, the client herself said:

"My sister has two children and sometimes she gives me advice but I am keen to listen to the guidance from the visits before I make my decision on things like feeding. Sometimes now I guide my sister!!"

Foster / Adoptive Parents

Stories have been recorded during the revaluation in which foster or adoptive parents for an FNP baby are indirect beneficiaries of FNP. Family nurses have been aware of anecdotal reports from their social worker colleagues that FNP babies are regarded differently from other babies in foster care. In short, they are seen as happy, contented children who settle well wherever they are placed. In one story, the FNP supervisor approached the manager of the Permanency Board in her HSCT for views on the story. The manager wrote back with her recollections of the case in some detail, ending:

"[Baby] has made the transition to her adoptive home, has settled well and it is hoped the relationship with her mother will continue as she grows up."

This evidence makes clear that the benefits to the baby from the family nurse's involvement continue beyond the duration of the programme, even where the mother and baby have been separated. This is an example of invisible value.

Engagement with statutory services

Part of clients' vulnerabilities relate to them being 'out of the reach' of social care services. This is a reinforcing feedback loop: their vulnerabilities put them out of touch with services and make them reluctant to engage yet whilst being out of reach makes them more vulnerable. It is this dynamic which family nurses often face when they come to enroll a potential client. Family nurses in revaluation group discussions commented how potential clients are wary of the family nurse because they have heard they are 'just like social workers'. Given their possible negative experiences, it is essential that the family nurse is seen as different if she is to be able to recruit the most vulnerable young women. The situation for many potential clients is summed up in one team story:

"Our clients don't feel threatened by us, though they often feel threatened by other services. They even have you back in after you've referred them. It's because they know we care about them."

Notably this quotation talks about referring a client to social services. This is potentially the most challenging form of cross-agency working to the trusting relationship built up between family nurse and client. But even here the relationship proves strong enough to overcome the hurdle of referral.

The benefit of being able to refer clients to other services, or to encourage them to engage or reengage with them, is that this unlocks the potential value in those other social care services, which would otherwise remain untapped by the most vulnerable girls and young women. This is invisible value on the part of FNP given that the programme is leveraging the value from investments in the social care system. More visibly, it is enabling clients freely to access services that will benefit them and their babies, now and in future. A family nurse illustrated this dynamic in a story about a very young client, and her partner, both of whom had been on the CPR, while he had been known to both social services and the police, with a history of anti-social behaviour and offending. When the family nurse first offered the programme to the young client, notably with her mother, the client was very receptive, and later told her social worker it was because…

"The family nurse didn't look down her nose at us and she didn't talk snobby".

Over the course of the programme the family nurse was able to build on this different sort of relationship in order to re-engage the couple with other social care services.

"As a family nurse I was able to help both [client] and [client's partner] see the benefits of working with other agencies i.e. social services and the domestic violence service. They both initially didn't understand how the other agencies could help, they then successfully completed programmes and this impacted on their relationship."

A similar account is given by another client who had had negative experiences of a range of services, including being in care briefly, and had tried to commit suicide on occasions, before entering the programme.

"I never really liked working with other people. I remember the school nurse calling before and I just would not even speak to her. I guess I did not give any other people a fair chance but then I feel they never really understood me."

By the time her story ends this client is in the final year of the programme, and is attending mother and toddler groups, and has joined dance classes. Her family nurse comments:

"[Client] can now enter unfamiliar groups with an air of quiet confidence, while previously she had great difficult with social settings and new introductions."

This is a material example of how the trusting relationship built up between client and family nurse builds the client's sense of self-efficacy, which in turn means she can engage with other services, and so be helped further.

These stories illustrate how one function of the family nurse is to bring vulnerable young people from the periphery of services, where they are more likely to be defined by their needs and risks to themselves and others, onto the continuum of mainstream services. There are numerous examples of clients developing confidence and being able to join in with the mainstream once more, suggesting FNP is not in itself a marginal programme, but is core for a specific target audience, who themselves have been marginalised.

Financial Value

The revaluation team has reported that there is knowledge within the FNP system about the costs and risks of late intervention as indicated by research studies and policy papers. As part of the process of populating the 'calculate invisible' box of the revaluation framework, the revaluation team worked with the nurses to reflect on the potential costs saved for their clients as a result of the FNP programme and the findings are summarized in this section of the report.

Expansion of FNP would result in economies of scale, for example, if a further 10 family nurses were to be appointed, they would be supervised within the existing arrangements. Whilst there would be a small license fee increase, no additional cost would be incurred by the regional team. Additional supervisors would not be required but there would be some impact on their capacity to be case holders. If a new team were to be established with an additional 5-7 family nurses this would require a supervisor and funding requirements will differ.

The Calculate Invisible boxes of the revaluation framework completed during the FNP revaluation process include evidence of where financial gain is achieved:

1. Breaking the inter-generational cycle/s of behaviour (patterns of negative, neglectful, harmful parenting) and implicit in this is the proposition that if babies develop a secure attachment in their first 1001 days, they will have gained the capacity to develop as a responsible and empathic adult
2. Responding to multiple needs including co-morbidity, complexity, intractability
3. Responding to vulnerability
4. Responding to teenage pregnancy
5. Responding to a range of public health challenges, for example, smoking, not breast feeding
6. Reducing the likelihood that the babies will experience adverse childhood experiences
7. Reducing the likelihood of teenage mothers experiencing any further adverse experiences, themselves, and,
8. Helping young mothers to get out of abusive relationships.

It could be argued that all clients who graduate successfully from FNP will break cycles to some extent and this creates cost savings. The majority of clients live in areas of deprivation and appear locked into the consequences of disadvantage when they enter the programme yet their stories show evidence that they have broken from this by the time they complete FNP.

In exploring emergent outcomes, revaluation uses the idea of clients' trajectories to model cost savings using 'roads not taken'. As well as costs averted through changes in direction, there are also gains acquired. The FNP revaluation uses savings resulting from observable changes in direction in a client's life due to their interaction with the programme to illustrate financial value. Likewise in looking at future trajectories, the revaluation team does not speculate about whether and where a client might end up but looks at the current path the mother and baby is actually on at the time of leaving the programme, and where that client may progress to, and contrast that with where she might otherwise have ended up.

Clients wrote their revaluation stories at different points in the FNP programme: some are just beginning, some were just beginning and were still in the pregnancy phase; most had their babies, and some were nearing the end of their time on FNP. In terms of instrumental outcomes at the level of clients' 'careers' we should expect them all to be in different places. Some are full-time mothers, many of whom are adapting to a newborn baby and only beginning to think about their next steps (this may be planning a second baby or taking contraception while they see how things settle). Other mothers are working part time. Most of the mothers are either back in school or college, or thinking about returning. The revaluation team suggested that there appears to be a greater value of the role of education once clients have engaged in the programme though partly this is in recognition that they themselves will need to provide for their baby, whatever else happens. Many mothers know they need further qualifications, or for the large group who have disengaged from education before or when they became pregnant to acquire qualifications. Qualifications are seen as essential to pursuing many of the careers the clients talk about including beauticians, hairdressers or air hostesses. A small number of mothers say in their stories that they would like to be midwives or health visitors. Some clients are back in school or university full-time, or preparing to take exams

with a view to going to university. These clients tend to have fewer vulnerabilities and to be from wider families which are more supportive, and less fragmented than more vulnerable clients. The noted that it is to the credit of family nurses that these young mothers are in full time education, and that they have been supported to find ways to continue their progress through the education system without being derailed by pregnancy and having a child.

One of the things that the revaluation team found striking from this tour of clients' endpoints, interim positions, and possible trajectories derived from the deepened stories is that clients are talking about their intentions for the future, they have pathways in mind. This is a remarkable considering that nearly half of all clients come onto the programme as NEETs or having stopped going to school.

The overall current FNP case mix vulnerability data collated within the revaluation process indicates that some of clients are particularly vulnerable young mothers and families. Their deepened client stories shows that this group have, on average, about twice the level of presenting maternal vulnerability compared with the overall current caseload. They are highly likely to require a range of public services over a protracted period of time. The stories of their involvement indicate that effective delivery of FNP has avoided children being taken into care as a result of complex safeguarding children concerns.

Roads Not Taken

A process of enquiry using the 23 deepened client stories has been used by the revaluation team to estimate the financial value of FNP in Northern Ireland based on 'roads not taken'. All of the 23 stories demonstrate value. Vulnerabilities have been used to identify the most prevalent 'cycles' based on their prevalence across the current caseload. These cycles which are being broken are listed below, based on the revaluation team's analysis of the vulnerabilities in the collected stories, additional subsets of vulnerabilities were noted;

1. Poor parenting: 38% of current caseload; 100% of those with 25+ vulnerabilities
2. Domestic violence between parents 26%; between them and a partner 23%, rising to 90% of those with 25+ vulnerabilities

3. CPR: 21% of the current caseload; 95% of those with 25+ vulnerabilities
4. LAC: 18% of the current caseload; 84% of those with 25+ vulnerabilities
5. Drug abuse: 15% of the current caseload; 90% of those with 25+ vulnerabilities, and,
6. Crime, antisocial behaviour, paramilitary experiences: criminal justice system contact 11% of the current caseload; paramilitary involvement 5% of current caseload, rising to 42% of those with 25+ vulnerabilities.

By far the most material driver of potential costs saved as a result of FNP is costs associated with child protection processes, and in particular a child being taken into care. UK Government costings[18] indicate that the average cost of a LAC care package is £66,064 based on 2014/15 prices. The average cost of a child protection plan is £5,298 per year. The average cost of young offender service per person for one year is £8,937. These costs, and the value / outcomes provided by these services need to be benchmarked against FNP.

To illustrate, for the purpose of this report, three of the 23 deepened case studies have been selected for sharing. Whilst the families have consented to sharing their stories, care has been taken to protect identities in the selection of the stories process and by anonymizing these[19]:

Story 1: Anne and Brian's story: this story has been selected because it is 'fairly typical' of the stories told by FNP clients.

Story 2: Catherine's story: this story has been selected because has there are two babies born and both were considered for care option.

Story 3: Claire's story: this story has been selected because it involved the family nurse working in with a young mother who experienced domestic violence.

A brief summary of each story is provided (these do not do justice to the complexity and trauma experienced by the young people and are for illustration purposes only). The story has then been transferred onto the revaluation six box value framework in order to illustrate potential short term savings. The costings applied within the

[18] https://www.pssru.ac.uk/pub/uc/uc2016/community-based-social-care-staff.pdf
[19] The Revaluation report of the client stories considered by the team as raw data will not be shared given the highly sensitive information in many stories and the high likelihood that this makes some clients identifiable.

Financial Value & Assumptions section are deemed to be moderate by the revaluation team, central team and family nurses. Families in similar situations who struggle to make progress can find themselves in a lifetime of vulnerability affecting their physical, social and emotional health and wellbeing and in need of public services and financial assistance, for example, employment benefits, disability living allowance, legal aid, social services, education welfare officers.

Cost assumptions are based on UK reference costs as Northern Ireland costs are not available:

1. Foster care per week £636
2. Foster care per six months £16050
3. Residential care per week £2964
4. Residential care per six months £77,050
5. Neonatal bed per day £750; high dependency £1500; ICU £3000
6. Community addictions £169 per contact
7. Suicide attempt - hospital admission £1805
8. Social work referral assessment and involvement for 6 months (CPR) £5298
9. Hospital in-patient drug addictions per week £3505
10. Domestic violence incident requiring multi-agency response £2766
11. Perinatal mental health services £2148
12. Criminal incident £647
13. NEET £4528
14. CAMHS assessment and one year intervention plan £2148

Case Example 1 - Anne's Story

Anne was enrolled onto the FNP programme at 16 weeks gestation. Her partner is Brian. Anne has a history of attention deficit hyperactivity disorder (ADHD) and attended CAMHS from age of 5yrs; a history of depression since the age of 13yrs including admission to an Inpatient Unit having overdosed following three miscarriages; diagnosis of mild/moderate depression and attachment disorder; history of domestic violence with a previous ex-boyfriend when she was assaulted and suffered a broken nose; difficult relationship with her mother; grandmother described as her 'mother figure' died recently.

Brian has a diagnosis of ADHD and dyslexia; was in foster and reports a difficult relationship with both parents; exposed to parental domestic violence and substance misuse as a child; had a drug induced psychosis (heroin / methadone / diazepam / ecstasy); had received punishment beatings from paramilitary groups due to unpaid debt.

A pre-birth assessment was carried out by Social Services Gateway Team and social services where the level of involvement was agreed at family support. Social workers are clear that the level of risk associated with the vulnerability/risk factors warranted an initial case conference, registration and child protection plan had the FNP programme not been available to the couple.

Anne gave birth to a two healthy children whilst on the programme. Both children were breast fed. The children continue to meet their developmental milestones.

Anne's mood and anxiety levels were stable throughout her pregnancies despite being off her medication. Anne made changes regarding general health including improved nutrition and reduction in smoking during pregnancy.

Brian has remained off drugs, avoided bad influences (previous group of friends) and avoided criminal behaviour, ensuring a safe environment for baby.

Having explored positive and responsive parenting/attachment with their family nurse, Anne and Brian have become attentive and responsive parents. They handle and interact with their children in a warm, safe manner with good visual engagement, excellent verbal quality and lots of positive praise.

Both parents have explored their upbringing, their village of support and attachment experiences. Having reflected on their own lives, they made a conscious effort to "break the cycle" to avoid the need for social services input in their family life and in particular, the child protection / LAC system. They do not need social services involvement and continue to access relevant health services as required. Both parents have been encouraged to explore and develop their hopes and aspirations for the future regarding further study and employment.

Paths Not Taken

The risks inherent in this case would have resulted in a child protection case conference. Given the age of the parents, lack of family support and complexity associated with vulnerability factors it is likely that a residential parenting assessment would have been implemented, preferably within a foster placement for both the mother (who was a child i.e. under 18 years) and the baby. This approach is highly likely to have resulted in a one year (minimum) child protection process involving multidisciplinary case conference, a further case conference at 3 months and a further case conference 6 months later. A child protection plan would have involved a range of agencies to address key vulnerabilities, all at a cost:

1. Mental health appointments for mother – community mental health team
2. Mental health appointments for father – addictions services
3. Specialist infant mental health appointments
4. Targeted health visiting service
5. Domestic violence e.g. Women's Aid
6. Bereavement counselling – voluntary / community sector, and,
7. Probation / justice service

The consistent respectful and positive approach of the family nurse enabled the couple to develop their self-efficacy and confidence to become effective parents able to give their children the best start in life. Both parents acknowledge the impact of their Family nurse in helping them break the cycle:

"You showed us respect and helped us build ourselves up and showed us how to be the parents we could be!"

Table 10: Revaluation Case Study: 6 boxes

Revaluation : Anne's Story		
	Visible Value	**Invisible Value**
CALCULATE	✓ Child not in care system, not on CPR ✓ Child not requiring behavioural services/CAMHS ✓ Increased school readiness resulting in optimum educational achievement, contributing to society, not on benefits ✓ Not in criminal justice system ✓ No drug and alcohol abuse ✓ Improved parental mental health- no hospital admissions due to self- harm/drug psychosis, suicide ✓ Improved health of mother and child due to breastfeeding ✓ Health improvements for clients, reduction in smoking (during pregnancy) dietary improvements and weight loss	✓ Child developmental milestones achieved ✓ Child being brought up with both parents in stable home environment with appropriate care ✓ Improved infant mental health/no childhood trauma ✓ A child who will be ready for school, much more likely to achieve optimum educational outcomes ✓ Client has supported friends in the safeguarding arena ✓ Child being parented by a mother who has made safe choices in relation to her lifestyle. ✓ Positive parenting experience ✓ Increase resilience, self-esteem and confidence. ✓ Using evidence based practice/enhancing practice/quality service delivery
CALIBRATE	✓ Excellent engagement with both parents despite history of poor engagement with support services and history of ADHD/dyslexia ✓ Use of agenda matching visual aids and FNP resources ✓ Good therapeutic relationship with client and nurse- open/honest/trusting/genuine/non-judgmental ✓ Exploration of childhood experiences/attachment ✓ Strengthened family relationships/village of support/networks ✓ Contented, happy child ✓ Family nurse relationship with multi agencies ✓ Gained knowledge and skills, learning from practice, reflection and supervision	✓ Achieving goals-hopes for future ✓ Wanting to break the cycle of needing/having social services input and having reached that goal/succeeding in life ✓ Increased confidence/pride/self-worth/self-esteem for achieving their goals ✓ Working hard with child as their focus/child cantered ✓ Avoiding life stressors/avoiding risk taking behaviours ✓ Job satisfaction for family nurse/motivated to continue to work in a highly emotional and complex role ✓ Celebrating success/positive affirmations
CAPACITATE	✓ Achieving fidelity-time spent with clients ✓ Relationship building ✓ Mother/father and baby attachment/bond, assessing with DANCE ✓ Role modelling/parallel process of good relationships/mirroring good communication skills- mirrored to child, extended family, friends and wider community	✓ Strength based working being viewed by other professionals/multiagency ✓ Motivational working/positive thinking and mindfulness in the workplace ✓ Transference of skills to others and to own personal family life and filtering out into community

Table 11: Revaluation Case Study (Anne's Story): Financial Value and Assumptions

Vulnerabilities		Financial Value & Assumptions
Victim of domestic violence/intimate partner violence	Substance misuse by client's partner	Potential savings: Referral to social services and multidisciplinary assessment and plan 12 months CPR **£10,596** Mother in foster placement for 12 week assessment period **£7,632** Baby (first) in foster placement for 12 week assessment period **£7,632** Baby stay in specialist care neonatal 5 days £750/day = **£3,750** Weekly community addictions appointments for 12 weeks @£169 per contact = **£2,028** Domestic violence education programme with Women's Aid **= £100** Community maternal mental health team assessment, treatment plan and monitoring 12 weeks @£169 per contact = **£2,028** Additional 24 health visiting home visits – weekly for first 12 weeks, fortnightly for further 8 weeks and monthly until 1 year = **£1,056**[20] Specialist infant mental health appointments (Band 7 completing 6 week programme) **= £312** CAMHS service = **£4,895** Suicide/attempt - **£1,805** per hospital admission Young offender costs per year[21] = **£8,937** GP consultations **£35 per visit** plus GP prescribing costs per visit £27 **Potential Total Savings: £50,833**
Experienced physical abuse	Clients' partner in paramilitary contact / influence	
Experienced verbal abuse	Justice system interactions inc' incarceration of client's partner	
Been LAC	Client's partner know to social services	
Mental health needs / CAMHS	Experienced parental neglect	
Attempted suicide or self-harm	Mild learning difficulties	
NEET of if school aged, non- attending	Weight issues	
Low income / deprived community		
Involvement with social services		
Relationship breakdown / separation between parents		
No/low contact with own birth parents		
Death of significant other (other than mother)		
Experiences of poor parenting		
Previous miscarriages		
Number of vulnerabilities		21
UNOCINI Threshold Level		3

[20] Professional unit costs & CAMHS service per client – see https://www.pssru.ac.uk/pub/uc/uc2016/community-based-health-care-staff.pdf

[21] http://www.eif.org.uk/wp-content/uploads/2015/02/The-immediate-fiscal-cost-of-Late-Intervention-for-children-and-young-people1.pdf

Case Example 2 - Catherine's Story

Catherine has two daughters. She was initially referred to FNP by her social worker at age 17 and was enrolled onto the programme.

Background

Catherine and her younger brother experienced physical and emotional abuse and neglect. Their parent's relationship was characterised with domestic violence, alcohol and drug abuse. A series of allegations around the care of the children were investigated and Catherine's parents were convicted of cruelty and assault and gaoled. Catherine, and her brother, were placed in foster care where Catherine stayed until aged 15.

At 15 years of age, Catherine wanted to move out to live with her mum and re-establish contact with her dad's family. Her behaviour became increasingly challenging characterised by binge eating, stealing money for junk food, self-harm and sexualised behaviour with younger boys. She began to self -harm and threatened to continue to do this until she was moved out of her foster home.

Catherine was initially placed in a local children's home. During a visit she was repeatedly and brutally assaulted by a member of her extended family. This left Catherine feeling guilty and ostracised by most of her family and led to a significant escalation in severe self-harm and risk-taking behaviour.

Catherine's was referred to psychological services and diagnosed with post-traumatic stress disorder (PTSD). For her own safety, a secure accommodation order was sought and Catherine was admitted to secure accommodation where she assaulted a staff member. She was charged with assault, resisting arrest, criminal damage and assault.

Catherine was remanded to a juvenile justice centre and stayed there for nine months. She was bailed to her mum's address where she stayed for a short while before her relationship with her mother broke down completely. She was placed in a homeless hostel then an after care hostel where she was often reported as missing. Whilst in this placement she had a relationship with a young person who currently is serving time in prison. She became pregnant and was notified to FNP by her social worker.

Catherine enrolled with FNP. She had a social worker and a personal advisor as well a key worker in Housing Support and to each she had assigned separate roles according to her own perception.

A pre-birth case conference was held and it was agreed that the baby's name should be placed on the CPR at birth under the category of potential emotional abuse, potential physical abuse and potential neglect. Because of the concerns around Catherine's behaviour, history of aggression and reluctance to engage, it was agreed that the Trust should apply for an Emergency Protection Order (EPO). A suitable foster placement was sought through the fostering team. However, there was no mother and baby placement accommodation available to allow a safe period of assessment and in view of the history of aggression, Catherine was not deemed suitable for residential assessment.

Catherine was induced one month early for medical reasons. Her baby was delivered and weighed in at 5 lb 4 oz. Catherine breast fed her baby for one week but due to slow weight gain introduced formula milk. She remained in hospital for 9 days during which the hospital midwives assisted her in learning childcare tasks. Catherine displayed excellent attachment to her infant reflected in positive touch, verbal connectedness and visual engagement.

The Trust's application for an EPO was not granted. Catherine and baby were discharged into the community with a support package. Catherine was willing to engage with whatever was demanded of her in order to be given the opportunity to parent her child. Catherine disclosed a second pregnancy in 2015 as a result of a relationship which she had concealed from social services. This man was well known to social services and is currently serving time in prison. The Trust again applied for a care order which was not granted.

Both children are now subject to supervision orders. Both children's names are on the CPR in the category of potential emotional abuse.

FNP JOURNEY

Catherine's engagement with FNP was initially poor. She was extremely ambivalent and while she was present physically for almost all visits, she was not present emotionally. She presented as oppositional and angry. It was very difficult not to

aggravate her and she was very unpredictable. However, she never refused a visit and she often had health related questions. She initially appeared disinterested in many elements of the programme but over time it became clear that she read everything and was able to discuss and question appropriately. She was very particular about completing her facilitators.

Catherine had a difficult pregnancy and this was the focus of much FNP contact.

Catherine disengaged with mental health services but was taking a range of medications. She was referred to peri-natal mental health services and for forensic psychiatric evaluation by social services. Catherine has been supported to re-engage with mental health and psychology services. She now has an extremely good relationship with her psychologist who has been consistently available to her since initial referral.

Value

1. Positive health choices for her baby
2. Abstained from alcohol and drugs
3. Avoiding contact with those who may have impacted on this behaviour
4. Access appropriate health services in a timely manner
5. Strong attachment – both babies
6. Vigilant in managing her health issues
7. Both children are extremely contented and thriving
8. Healthy children meeting developmental milestones
9. Maintains her allocated home through NIHE in a local estate with pride
10. Home safety check has been completed by the local Council and appropriate equipment provided
11. Does not allow anyone to smoke around baby
12. Plans to return to tech in September to do a beauty course
13. Increasingly confident in articulating her needs
14. Continues to engage with her social worker and personal advisor for 16 plus team
15. No contact with the fathers of the children both of whom remain in prison
16. Recently expressed a wish to have contact with foster parents, and,
17. Highly motivated to be the best mummy

Paths Not Taken

The potential risks if FNP had not been involved are that Catherine may not have been in a position to parent her baby who would have gone into foster care.

The impact of this on maternal mental health and infant mental health would be significant. The separation would impact negatively on the attachment relationship and the long-term implications of this can be huge.

Table 12: Revaluation Case Study: 6 boxes

	Visible	Invisible
CALCULATE	✓ Children on CPR but not LAC ✓ Categories of registration reduced ✓ Savings made as children less likely to present with behaviours associated with a disorganised attachment and to need ongoing services such CAMHS ✓ Healthier lifestyle choices-savings on drug impacts on the mother's health therefore services not required ✓ Second pregnancy healthier than first ✓ Client no longer offending- savings to the criminal justice system. ✓ Impact on the client and her child's life of their increased stability and growing support network. ✓ Client engaged in positive protective parenting therefore better able to provide a safe and secure base for her children	✓ Strength for the client in the journey NOT taken eg LAC ✓ Babies in the care of their mother who is able to provide them with appropriate caregiving and a stable home environment. ✓ Baby's partially breastfed for 5 weeks-long-term health benefits of this-Impact of breast feeding on attachment relationships ✓ Excellent attachment-responsive parenting ✓ Children will be ready for school and more likely to achieve her optimum educational outcomes ✓ Family engaging more positively with social services ✓ Mother returning to education and eventually both she and the children will contribute to society ✓ Reduction in the likelihood of the child experiencing ongoing trauma as a child
CALIBRATE	✓ Nurse client relationship - client had previously experienced a lot of abandonment, initially tested the family nurse using dismissive attitude, aggression and anger. ✓ The family nurse tapped into the client's natural curiosity and her desire to be a good mum, and therapeutic relationship developed ✓ Engaged well with the programme materials, even though she did not want to do them initially-'just leave them there'-agenda matching, respect building trust ✓ Successful mother and baby unit assessment and protective parenting course	✓ Re-written the trajectory set out for the baby in pregnancy through positive parenting – avoiding LAC, criminal justice system, drug misuse & domestic violence ✓ Breaking cycle of neglect and lack of resilience as a result of disorganised attachment patterns ✓ A reduction in ACE factors likely to impact on the children and the potential negative impact of these throughout the children's life course ✓ Demonstrated good decision making when moved to independent living, budgeted well, prioritised her child's needs. ✓ Ongoing engagement with services ✓ Ability to refrain from previous risk taking behaviours drugs and alcohol, criminal behaviour ✓ Achieving goals increasing resilience and self-efficacy
CAPACITATE	✓ Excellent engagement and fidelity ✓ Consistent and meaningful engagement in FNP programme, social services, child protection plan, Sure Start and other support agencies. ✓ Improved relationships with professionals eventually extended into improved relationships with some extended family, increasing her world of support when she graduated from the programme ✓ Improved engagement with psychology has helped client understand the effect of domestic abuse witnessed as a child, and the physical and sexual abuse suffered. ✓ Contented securely attached children ✓ Increased confidence in accessing new services, able to understand the benefits of accessing supports that are available.	✓ Role modelling positive relationship which facilitated transference of this behaviour from the mother to baby AND mother to others-building trust- to allow her to see the services as supportive and not as retribution. ✓ Transference of skills to other professionally and personally ✓ Positive impact of good working relations between the multi-disciplinary team ✓ Strengths based approach with the potential positive impact that this will have for other clients going forward.

	Visible	Invisible
	✓ Baby registered on programme for 2 year olds on graduation from FNP - mum registered and accessing Sure Start Services. ✓ The family nurse uses her compassion to ensure self-care, using supervision, peer support and psychology and named nurse for safeguarding children, demonstrating commitment to training, commitment to clients and the commitment for ongoing development.	

Vulnerabilities		Value commentary and assumptions (nano level)
Victim of domestic violence/intimate partner violence	Weight issues	**Roads Taken Cost benefit** Client had an extremely traumatic childhood and adolescence marred by physical, emotional and sexual abuse. Her mental health was significantly challenged and she was involved with the criminal justice system. She was a high risk young person within the Trust in terms of her capacity for aggression to self and others. She had severe and complex attachment difficulties. It seemed inevitable that these children would have been removed for adoption. The FNP programme was able to tap into her intrinsic motivation to be a good mother and support her to work effectively with services and make the changes necessary to be allowed to parent her children. She learned how to trust and how to provide responsive parenting which has ensured her children are securely attached and living well in a safe home environment. This will have a lifelong positive impact on her children's lives. She has also re-engaged in education and her goal is to be self-sufficient in providing for her children. Given the breadth of services involved with this client the impact of FNP cannot readily be isolated. However, the acknowledged impact of close co-working and excellent inter-professional relationships combined to produce very positive outcomes. **Value commentary and assumptions** On an annual basis, the roads not taken appear to be worth at minimum:
Experienced physical abuse	Clients' partner in paramilitary contact / influence	
Experienced verbal abuse	Justice system interactions inc incarceration of client's partner	
Being on CPR or having been on CPR	Client's partner known to social services	
Mental health needs / CAMHS	No/low contact FOB	
Attempted suicide or self-harm	Anticipated removal of baby at birth	
NEET of if school aged, non-attending	No contact with parents/foster parents	
Low income / deprived community	Drug misuse	
Involvement with social services		
Relationship breakdown / separation between parents	Partner substance misuse	
Domestic violence between parents / parent's partner	Partner NEET	
Substance misuse by parents / parent's partner	Partner paramilitary	
Parents / parent's partner in paramilitary contact / influence	Partner-incarcerated Client's parents incarcerated	
Death of significant other (other than mother)	Partner mental health issues	

	Visible		Invisible
Parent / parent's partner has mental health issues Family known to social services		Partner know to social services	Scenario 1: Children not in residential care- £2964/wk; £77,050/6mths x2=140,100.00 Children not in foster care- £636/week; £16,050/6mths; £33k/yr x 2 =£66000 Suicide/attempt averted- £1805.00 per hospital admission Client not using drugs- £3505 per inpatient week. Community addictions £169 per contact Baby number 2- well at birth and no stay in specialist care baby unit- neonatal bed £750/day; high dependency £1500/day; ICU £3000/DAY **Potential Total Savings £146,060**
Number of vulnerabilities 29		UNOCINI Level 4	

Case Example 3 - Claire's Story

Claire self-referred to FNP early in pregnancy (having met the FNP team at one of their Christmas events for clients) and was enrolled at 16 weeks gestation. During pregnancy Claire was hard to reach at times with multiple cancelled and attempted visits, however, when visits were completed she engaged very well was receptive.

Claire and her partner were in a relationship for approximately seven months before her pregnancy was confirmed. During the antenatal period Claire split her time living between her family and her partner's family. Her partner engaged in visits when possible.

Underlying tensions began to emerge. Claire reported that she had concerns about her partner's lack of relationship with her family and his negative comments about them. Client also reported regular arguments with her family and stated that she had been 'thrown out' of family home. Claire also reported that her partner was keen for her to spend all her time with him and told her that she "didn't need her friends." No disclosures of domestic violence or intimate partner violence were made at routine enquiry and Claire later reported that this was no longer a problem as she preferred to spend all her time with her partner and had lost touch with the majority of her friends anyway. Claire stopped attending college early in pregnancy. She had achieved a Level 2 qualification but stated that she did not enjoy it and her partner didn't want her going to tech as he "missed her".

Claire was observed to be experiencing high levels of anxiety and low mood during the late stage of pregnancy and reported that this was due to concerns about labour and delivery.

Issues identified following birth

1. Claire reported very little memory of birth experience
2. Partner not present for birth
3. Claire has extreme exhaustion
4. Claire was the main caregiver, night and day, as partner did not like to hold baby in case 'he hurt her
5. High risk for postnatal depression, and,
6. Intimate partner violence:

- Emotional abuse
- Physical abuse
- Name calling
- Threats
- Partner reportedly stated that he wished that baby dead.

Claire reports that she initially felt betrayed by her family nurse who made a referral to social services following her disclosure of domestic violence. However she since reports that she is glad about the UNOCINI process and her baby's name being on the CPR as the situation would have deteriorated further and may have resulted in her and her baby no longer being together. She states that the family nurse helped to prepare her for the case conference and ensured that her child protection plan was achievable and meaningful.

Claire has stated that she found information and advice from her family nurse to be essential in keeping her focused on improving her parenting capacity and being the "best mum" for her baby. The family nurse observed and reported strong and sensitive bonding and attachment.

Paths Not Taken

Claire's baby at seven months old is happy, contented baby who is growing and developing within the normal developmental range. In this case the early detection of intimate partner violence as a result through the FNP programme ensured that the risks to the client and her baby were identified and managed appropriately. The trusting relationship the client had with her family nurse enabled Claire to reflect on her situation and remain engaged in the FNP programme.

Table 13: Revaluation Case Study: 6 boxes

	Visible	Invisible
CALCULATE	✓ Baby living with her mother - not LAC. ✓ Spent just 7 months on CPR ✓ Secure attachment not evident in early days following baby's birth as mum was experiencing challenges that included post- natal depression and domestic violence managed well ✓ Open and honest conversations that lead to early identification and disclosure of domestic violence ✓ Early intervention of social services ✓ Early identification and treatment of post-natal depression led to improvement in mental health and subsequent reduction of and eventual cessation of medication and support from general practitioner. ✓ Reduction in the likelihood of baby experiencing ongoing trauma as a child following parents' awareness of the adverse effects, both emotional and physical, of domestic violence on children. ✓ Parents have demonstrated significant improvement in positive, sensitive and responsive parenting.	✓ Strength for the client in the journey NOT taken – aware that Baby A would have been at risk as client recognises that she was unable to prioritise Baby A's needs and that she would not have experienced an improved, healthy and respectful relationship with her partner. ✓ More efficient use of education services ✓ Baby kept out of foster care ✓ High likelihood of mother and father being in education, employment or training ✓ Actual domestic violence incidents averted ✓ Future likelihood of domestic violence reduced significantly
CALIBRATE	✓ Despite mother being 'hard to reach' initially with a number of missed or cancelled visits, the client engaged with the programme, allowed the nurse to get 'in' and for the relationship to develop. This contributed to the family nurse's identification that 'something wasn't right' and subsequent disclosure of domestic violence by client ✓ The family nurse identified the client' natural curiosity and her desire to be a good mum, to offer her child the opportunity for a different experience of childhood than she had. ✓ Engaged well with the programme materials, despite appearing to be uninterested and missing visits.	✓ Re-written the trajectory set out for the baby in pregnancy. ✓ Baby is an extremely happy, interactive and well-adjusted child. Positive interactions between mum and baby observed and ongoing sensitive and responsive parenting. ✓ Childs development well on power with other children her age. ✓ Mother making SMART choices and planning for the future in relation to employment ✓ Mother demonstrated good decision making when she moved to independent living, budgeted well and prioritised her child's needs.
CAPACITATE	✓ Consistent and meaningful engagement in FNP programme, Social Services, child protection plan, Women's Aid, Sure Start (father's worker) and other support agencies ✓ The impact of good working relations between the multi-disciplinary team – the potential positive impact that this will have for other clients going forward. ✓ As the clients situation improved and her ability to maintain relationships with those around her changed so did her ability to be available to her child	✓ A reduction in the ACE factors likely to impact on the child, increasing resilience, self-esteem and confidence. ✓ Breaking cycle of neglect and lack of resilience as a result of disorganised attachment patterns. ✓ The improved working relations between the different professions supported a holistic approach that helped the client to engage and avail of the services offered to her to support her. The ability that she had to change to allow her to see the services as supportive and not as retribution.

Vulnerabilities

Victim of domestic violence/intimate partner violence	Substance misuse by client's partner
Experienced physical abuse	Clients' partner in paramilitary contact / influence
Experienced verbal abuse	Justice system interactions inc' incarceration of client's partner
Being on CPR or having been on CPR	Client's partner know to social services
Mental health needs / CAMHS	
Attempted suicide or self-harm	
NEET of if school aged, non- attending	
Low income / deprived community	
Involvement with social services	
Relationship breakdown / separation between parents	
Domestic violence between parents / parent's partner	
Substance misuse by parents / parent's partner	
Parents / parent's partner in paramilitary contact / influence	
Parent / parent's partner has mental health issues	
Death of significant other (other than mother)	

Number of vulnerabilities	19
UNOCINI level	4

Value commentary and assumptions (nano level)

Roads Taken	**Cost benefit**
More efficient use of education services	£1023 per child

There are clear, calculable benefits at the nano level – especially better mental health , better physical health, coming off the CPR, the high likelihood that the baby will not grow up in a home with domestic violence (and therefore the stress of this will not titrate into hampering her brain development, and life chances). These are difficult to cost, because of the challenge of getting reliable costs for social care, and arriving at shared professional judgements about probabilities and outcomes.

Value commentary and assumptions (system level)

At an HSC system level – some patterns of benefits are clear. And the indirect benefits appear to be greater than the direct. On an annual basis, the roads not taken appear to be worth at minimum:

Kept out of foster care	£2675 £2675 per month-£33,000 per annum	Saved
Mother kept out of CAMHS	£2148 per annum	Saved
NEET	£4,528	Saved
Domestic Violence incident averted	£2766 per incident	Saved

Potential Total Savings: £44,421 (not a net figure, net of the whole cost of provision of services).

Summary of the Financial Paper

As pointed out by the revaluation team, FNP costs what it costs in terms of direct financial outlay and there are other services who invest resources in the achievement of outcomes. However, there are other potential costs and savings at the level of each client story and case history that need to be considered if the value of FNP is to be fully understood. The relational strengths within the FNP model enables clients to mobilise and invest their personal resources, including the developmental resources of their babies. The bringing of client resources to bear on top of all other resources in the various systems in play is evident from the story material and is creating added value.

Case studies indicate predictable cost savings primarily to the health and social care sector. The long term savings are considerably more.

The revaluation team is of the view that:

1. The annual cost per case/client of services avoided as a result of FNP is in the range of approximately £40,000 - £485,000
2. Around 30-45 currently live cases are likely to be avoiding annualized costs each of £122,000 - £485,000
3. The indirect value will always exceed the direct
4. Savings arise in various places and forms in the HSC economy (mostly in direct savings of purchases e.g. fostering or residential places) but some will be experienced in reductions in likely demand e.g. early discharge, or mainstream/universal service take up avoided
5. The direct cost of FNP sits in one part of the HSC system but the benefits as expressed in cost savings arise elsewhere
6. FNP at least saves other services more than its current annual cost

The revaluation team has stressed how conservative their financial analysis is. Financial estimates only relate to reasonably foreseeable cost savings in the short term within the HSC system. The calculation of longer term/lifetime financial benefits of profoundly important 'roads taken' such as greater economic self-efficacy and employability of mother and child, secure attachment and changed 'lifestyle' choices to do with for example maternal/family addiction, reduced domestic violence,

improved mental health or reduced involvement in crime, or indeed the financial benefits of the 'calculate visible' success measures including breastfeeding and smoking cessation, is beyond the scope of this work.

Value Conferencing

Additional consideration of financial value was tested in one of the HSCTs using a 'value conferencing' approach to make informed judgments about costs avoided as a result of roads not taken. The process, co-designed by the revaluation team with family nurses and supervisors, involved convening around a particular client story with other service providers including senior HSCT managers and professionals to discuss the impact of FNP on the client, and on other service providers, before identifying and apportioning relevant cost savings to the intervention. The estimated values are considered by the revaluation team to be conservative as the family nurses tended to be shy of over-claiming their stake in the positive outcomes observed.

Based on 'Roads Not Taken' indicated in 10 of the 23 deepened client stories, the value conference team banded savings into high, medium and low:

1. High: £485k
2. Medium: £122K
3. Low: £39k

Even in the lowest band, it is clear that the return on investment at the level of an individual client is at least 6:1 rising to 97:1 in the biggest saving cases. Importantly, this is only counting short run savings from service use averted, and which are clearly attributable to the work of the family nurse.

In principle it is possible to provide estimates of financial savings from roads not taken for all of the cases. Analysis of the deepened stories suggests that some 10-15% of current FNP cases are likely to be in the high value band. The distribution of the remaining 85-90% of cases across the medium and low bands of savings has not yet been established.

Conclusion

The PHA has responsibility for ensuring that early intervention programmes are effective and meet the needs of the population group for which they are intended. Revaluation has provided the PHA and wider FNP system with an innovative process of evaluation. It has given young parents from disadvantaged areas in NI the a platform to share very personal stories through trusted family nurses so that their knowledge and experiences can influence decisions regarding the future of FNP and the development of other public services. Many of the young people's stories describe trauma, adversity, vulnerability and hopelessness. Yet with the support of a dedicated and skilled family nurse they have been able to break cycles, motivated by what seems to an innate desire to be a 'good mummy' and having someone who genuinely believes in them. These young parents, just like their family nurses and the wider FNP system, believe in the value of FNP. The PHA, as the lead public agency responsible for the introduction of FNP and for public participation in health services in NI, welcomes their voice and the revaluation approach that has facilitated this rich data.

Throughout the 80 stories, and in particular the 23 stories that were deepened, there is clear evidence of negative cycles associated with adversity and low expectation being broken. FNP has achieved this through respectful, powerful and non-judgmental relationships between experts: parents as experts in their own lives; family nurses as experts in professional practice; the PHA central team as experts in achieving regional implementation with fidelity and information analysis, and, the wider international FNP team that expertly guides implementation on the basis of a strong international evidence base. In partnership, these experts are achieving outcomes in the area of family health where it is particularly difficult to achieve change because of entrenched lifestyles and young people's skepticism of professional intent and attitudes.

As highlighted by the revaluation team, FNP is providing a lifeline to many young women, their partners and families at a significantly challenging time of their lives. There is clear evidence in revaluation stories that FNP plays a significant role in breaking cycles associated with:

1. Intergenerational trauma, including teenage pregnancy;
2. Deprivation
3. Exposure to multiple adverse childhood experiences
4. Involvement in crime and antisocial behaviour
5. Mitigating the effects of para-military violence
6. Domestic violence
7. Sexual abuse / Child Sexual Exploitation
8. Drug and alcohol addiction, and,
9. Idealisation of abusive parents.

Breaking such cycles is both in the interests of our society. Whilst the financial benefits was not the primary focus of the revaluation study, the revaluation team has concluded that FNP pays for itself in the short term, mostly through reduction of demand for child care social services and in particular looked after children services, CAMHs, mental health and probation services. The long term costs of breaking cycles by ensuring that FNP babies have the best start in life and are able to thrive in the care of motivated parents has not been estimated but is where the big savings are to be achieved.

Revaluation has highlighted key components of the FNP system that enable desirable outcomes to be achieved. Programme delivery through the unique relationship between a family nurse and young mother, supported by constructive relationships within the FNP system is at the core of FNPs success. The revaluation team has referred to as *"this relational infrastructure"* that includes the notion of dancing, not wrestling with clients, the working principle that acceptance leads to exploration of discrepancy and the assertion that therapeutic engagement is more than just being nice and friendly. Trust, truth, honesty, desire to change, theory, evidence, transformation, risk management, safe space, intensive interventions, practical support, fidelity, validated resources, effective recruitment, experts, learning, change, governance, psychology, safeguarding, testing boundaries in the context of a community network (known within FNP as 'villages of support') are key ingredients. These ingredients are reliably mixed with practical wisdom and delivered in informed doses, to break cycles. The revaluation team has defined this

as part of "*a system of structured, personalised support around the young family, in the context of their own family/social situation".*

'Breaking the cycle' of adversity and disadvantage is a shared goal throughout the FNP system. Most family nurses describe 'breaking the cycle' as the overall objective for their work. The phrase featured in nearly all family nurses micro stories, as well as being used by them in many of the client nano stories. The PHA central team told the revaluation team that breaking cycles of adversity was their ultimate objective for FNP when the revaluation process was introduced to the family nurses at a whole system event in late 2016. The revaluation team has also been conscious that developing and working on shared outcomes to make an impact on inter-generational disadvantage and social exclusion is central to the Programme for Government (PfG). It is the conclusion of the revaluation team that FNP is already contributing to 'breaking the cycle' for those young parents and their extended families who are fortunate enough to have been offered a place, and, that the value of FNP needs to be communicated clearly so that it understood by those who are responsible for improving health and social care outcomes. Learning from the FNP approach needs to be shared with the wider health and social care system, as well as other public service sectors, so as to inform the PfG transformational agenda.

The revaluation findings provide reassurance following serious questions on FNP effectiveness posed as a result of the Building Blocks RCT in England. FNP in Northern Ireland is delivered in a manner that significantly improves outcomes for young parents from disadvantaged communities who have experienced multiple adversities. The revaluation findings convincingly add to the evidence from previous international RCTs and local evaluations carried out in the Western HSCT and Scotland. FNP is an example of how the right to family life as outlined in Human Rights legislation and the United Nations Convention on the Rights of the Child (UNCRC) is being respected through safe, effective and compassionate practice. The expansion of the FNP service as indicated in the draft PfG and transformational plans is justified and in the wider public interest. All young people who need FNP should have access to it.

PHA Recommendations

1. A business case that includes an option to offer all first time eligible mothers with a place on the FNP programme needs to be developed.
2. A regional communication strategy involving FNP Family Advisory Boards needs to be developed and implemented so that the wider system understands the FNP programme and can learn from its theoretical approaches and how these are implemented in practice.
3. The learning from this revaluation should be shared with the SBNI to inform its work on ACEs, and with CYPSP who have a key responsibility in ensuring that services for all children and families are available and effective.
4. The PHA's central FNP team should facilitate a further testing of multi-disciplinary value conferencing as a means to sharing the concept of FNP and acquiring new approaches to defining value using monetary and non-monetary terms.
5. The FNP data system should be improved so that it supports regular reporting against 'breaking cycles' outcomes by practitioner, team and regional levels.
6. The PHA central team should work with finance colleagues to capacitate the visible and invisible value of early intervention services including FNP.

Appendix 1: List of Revaluation Reports and Exhibits

Papers and Exhibits are available on request from the PHA Children's and Young People's Nursing Team

Full Value Overview

Overview of Value

Discussion of Context and Value

Executive Summary

Value Conferencing: A Case Study

The financial or monetary value of FNP

The value added by Revaluation

Exhibits

Talking FNP

Theorising FNP

Valuing FNP

Governing FNP

Appendix 2: Revaluation Dashboard Guidance

	VISIBLE (measurable)	INVISIBLE (needs to be evaluated)
CALCULATE	How much - in numbers? *Calculate Visible is known data, particularly metrics, including pre-set targets and success measures. This value that can be objectively measured, for example, the number of clients per 1 WTE family nurse in relation to the workforce standard of 1 family nurse to 25 families.*	£ value of FNP *Calculate Invisible is knowable quantitative data, especially the £ value of the work the family nurses do with their clients e.g. savings from intensive early intervention provided by FNP including child protection processes avoided; mother and child not admitted to foster placement; strong attachment and self-regulation formed in early childhood reducing child/family engagement with legal system.*
CALIBRATE	Direct Benefits from FNP *Calibrate Visible includes known direct benefits, such as those reported by individuals in the system under enquiry. These benefits tend to be non-numerical and qualitative though they are sometimes 'scored' using indices – and can then become calculable e.g. child meets all developmental milestones; second baby benefits from confident mother; grandparents gain new insights into parenting practices; family nurses develop expert public health nursing skills.*	Indirect Benefits: Knowledge, Learning, Future Pathways *Calibrate Invisible is knowable qualitative benefits, but which are experienced collectively, such as shared learnings or understandings. e.g. benefits of professional supervision that result in enhanced client : nurse agenda matching and promotes a strengths based approach;* *Family nurses share their knowledge so that parents become competent in family planning enabling them to make informed choices about their future.*

CAPACITATE	Relational value of FNP *Capacitate Visible includes known measures of the current characteristics of the system under enquiry, size, shape, the quality of connections. These indicate its capacity to grow. Capacitate is interested in how they are connected relationally, both in time and space, e.g. the central role of the Mother-Nurse and Mother-Baby-Nurse relationship, and how that radiates out through the other relationships the Nurse has with her colleagues in the programme, and the rest of the social care system.*	Transformational Change, and other Innovations from FNP *Capacitate Invisible includes knowable data in relation to the qualities of the networks involved, particularly focusing on their emergent characteristics: what it is about them that will determine the kinds of change they can go on to generate in future e.g. developments that improve practice within FNP and other service areas e.g. FNP Northern Ireland Innovations. DANCE, PIPE & STAR contributing to international evidence base; Introduction of ASQ SE2 by health visiting as part of EITP Work Stream 1.*

Appendix 3: Vulnerability Factors experienced by FNP clients in order of frequency

Vulnerability (N Clients = 308)	N clients	%	Vulnerability (N Clients = 308)	N clients	%
Low income / deprived community	222	72.1	Substance misuse by parents/parent's partner	57	18.5
Relationship breakdown/separation between parents	178	57.8	Experienced physical abuse (excluding physical abuse by partner)	54	17.5
Mental health needs / CAMHS	142	46.1	Having been or still being looked after child	54	17.5
NEET (or if School Aged, Non-Attending/Disengaged)	136	44.2	Alcohol misuse	47	15.3
Experiences of poor parenting (other, self-reported – not specific	117	38.0	Drug misuse	46	14.9
Family known to social services	114	37.0	Experienced sexual abuse	41	13.3
No/low contact with (either of) own birth parents	103	33.4	Justice system interactions including Incarceration of client's partner	39	12.7
No/Low contact with baby-to-be's Father	86	27.9	Weight issues (obese / underweight)	37	12.0
Unsuitable Housing for baby or homeless	84	27.3	Learning difficulties / special educational needs (Diagnosed by nurse/professional judgement	36	11.7
Client's partner is NEET	81	26.3	Justice system interactions	35	11.4
Domestic violence between parents/parent's partner (e.g. witness	80	26.0	Experienced child sexual exploitation	34	11.0
Experienced verbal abuse (excluding verbal abuse by partner)	78	25.3	Death of significant other (other than mother)	31	10.1
Experienced (parental/carer) neglect	78	25.3	Anticipated removal of child at birth due to safeguarding concerns	28	9.1
Attempted suicide and/or self-harm	77	25.0	Carer (for siblings, their babies, or dependent parents)	27	8.8
Parent/parent's partner has mental health issues	76	24.7	Referred into programme under 16	26	8.4
Involvement with social services (excluding any involvement already	73	23.7	Justice system interactions inc incarceration of (one or more parents)parents partner	23	7.5
Victim of domestic violence / intimate partner violence	72	23.4	Paramilitary contact/influence	17	5.5
Client's partner known to social services	70	22.7	Client's partner in paramilitary contact/influence	14	4.5
Bullying / bullied at school	67	21.8	Previous miscarriage(s)	11	3.6
Being on CPR or having been on CPR	64	20.8	Death of client's mother	9	2.9
Client's partner has mental health issues	63	20.5	Parents/parent's partner in paramilitary contact/influence	6	1.9
Substance misuse by client's partner	61	19.8			

Vulnerability	N Clients	% Clients	**Vulnerability**	N Clients	% Clients
Relationship breakdown/separation between parents	19	100	Unsuitable housing for baby or homeless	15	78.9
Experiences of poor parenting (other, self-reported – not specified	19	100	Experienced child sexual exploitation	14	73.7
Justice system interactions inc incarceration of client's partner	18	94.7	Anticipated removal of child at birth due to safeguarding concerns	14	73.7
No/low contact with (either of) own birth parents	18	94.7	Client's partner has mental health issues	13	68.4
Low income / deprived community	18	94.7	Parent/parent's partner has mental health issues	13	68.4
Mental health needs / CAMHS	18	94.7	Justice system interactions	12	63.2
Being on CPR or having been on CPR	18	94.7	Experienced sexual abuse	12	63.2
Experienced verbal abuse (excluding verbal abuse by partner)	18	94.7	Justice system interactions inc incarceration of (one or more)	10	52.6
Experienced (parental/carer) neglect	18	94.7	Death of significant other (other than mother)	9	47.4
Substance misuse by client's partner	17	89.5	Client's partner in paramilitary contact/influence	9	47.4
Client's partner known to social services	17	89.5	Involvement with social services (excluding any involvement already described)	8	42.1
Family known to social services	17	89.5	Paramilitary contact/influence	8	42.1
Substance misuse by parents/parent's partner	17	89.5	No/sow contact with baby's father	7	36.8
NEET (or if School Aged, Non-Attending/Disengaged)	17	89.5	Bullying / bullied at school	5	26.3
Drug misuse	17	89.5	Weight issues (obese / underweight)	5	26.3
Victim of domestic violence / intimate partner violence	17	89.5	Previous miscarriage(s)	<5	-
Alcohol misuse	16	84.2	Carer (for siblings, their babies, or dependent parents)	<5	-
Attempted Suicide and/or Self Harm	16	84.2	Learning difficulties / special educational needs (Diagnosed by nurse/professional judgement)	<5	-
Having been or still being looked after child	16	84.2	Referred into programme under 16	<5	-
Experienced physical abuse (excluding physical abuse by partner)	16	84.2	Parents/parent's partner in paramilitary contact/influence	<5	-
Client's partner is NEET (or ed/employment/training status)	15	78.9	Death of client's mother	<5	-
Domestic Violence between parents/parent's partner (e.g. witness	15	78.9			

Appendix 4: FNP Northern Ireland: 6 Box Account of Full Value (October 2017)

	VISIBLE	INVISIBLE
CALCULATE	FNP in Numbers Caseload numbers (all time; current year) Current caseload profile (by Vulnerabilities) Caseload outcomes (all time; current year) Number completing or refusing Number who did not complete the programme Data – Delivery / KPIs Workforce: funded capacity, vacancies Programme capacity/undersupply £ budget – recurrent/non-recurrent £ cost per head	£ value of FNP £ value saved by 'roads not taken' to: Individuals Primary Care Health & Social Services Acute Care Education Justice
CALIBRATE	Direct Benefits from FNP Immunisation Child development Attachment Brain development Happy Babies Empowered, calm, self-regulating babies Informed parents Trusting clients ? Partner beliefs (as above) Wider family benefits e.g. second baby, MGM, MGF, siblings, foster carers Expert family nurses Professional pride and reputation	Indirect Benefits – Knowledge, Learning, Future Pathways Effective Supervision Strength Based Approaches Agenda Matching Approaches 'Good Mummy' identity Parental 'destinations' and pathways (family planning, housing, education, employment) Engagement and reengagement with statutory services 'Genuine' evidence & insight about and for the client

CAPACITATE	Relational value of FNP: in time and space The Central Role of Relationships in creating value: Mother-Baby Attachment (DANCE & observations) Nurse-Mother Mother-wider Networks ('village of support' entry vs exit) Nurse-Partner, and wider family Nurse-Supervisor-Psychologist Nurse-Supervisor-Other services (SW, HV, SAMs, Permanency…) Teams' village maps Extensive Networks	Transformational Change, and other Innovations from FNP FNP NI Innovations (e.g. DANCE, PIPE, STAR) Vulnerabilities Towards a new model of "Micro Commissioning': FN as hub for client-centred service provision 'Breaking the Cycle' (Turning the Curve'), or Cycles e.g. Poor Parenting Domestic Violence Being on CPR Being in Care Drug & Alcohol abuse Crime, ABS, Paramilitary, Experiences