Public Health England

Protecting and improving the nation's health

Best start in life and beyond

Improving public health outcomes for children, young people and families

Guidance to support commissioning of the Family Nurse Partnership programme

Contents

Background information on commissioning

This document supports local authorities in commissioning the Family Nurse Partnership (FNP) programme, an evidence based, intensive parenting support intervention, as part of delivering the 0 to 5 public health offer for children as detailed in the Healthy Child Programme.

This guidance should be read in conjunction with the guidance for the Healthy Child Programme, with the aim being to commission seamless and personalised services for all children 0 to 19 years of age (or 25 in the case of children with SEND, disabilities or highly vulnerable young people).

Public Health England (PHE) supports local authorities and the NHS in securing the greatest gains in health and wellbeing and reductions in health inequalities through evidence-based interventions. Ensuring every child has the best start in life is one of PHE's key priorities identified within the PHE 5-year strategy 2020 to 2025.

The foundations for virtually every aspect of human development including physical, intellectual and emotional, are established in pregnancy and early childhood. For families facing multiple challenges, the importance of appropriate support at this crucial time can have lifelong impact. Commissioning FNP supports the local system to improve outcomes and reduce inequalities by providing a personalised response for those children and families facing the highest levels of vulnerability.

The evidence

The Family Nurse Partnership (FNP) is an intensive, home visiting programme for vulnerable young women and their families that provides an evidence based and targeted service for vulnerable families.

Commissioning and providing FNP will improve the life chances of first-time young parents and their children, helping to break the cycle of disadvantage by:

- focussing on the 6 early years high impact areas
- supporting young mothers to build self-efficacy and engage with education, training and employment
- improving child health and development and early education outcomes particularly for boys, children of very young mothers and mothers who are not in education, training or employment
- delivering the Healthy Child Programme to first time young mothers
- helping young parents' access and engage with local services
- identifying safeguarding issues and working alongside statutory services to support interventions

The Early Intervention Foundation's Guidebook provides a summary of the evidence base for the Family Nurse Partnership programme:

'FNP has established evidence (Level 4 plus) 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.

Recent evidence from the Building Blocks 2 to 6 study (1) shows that the benefits of FNP are sustained with 'improved children's levels of schools readiness' (Early Years Foundation Stage) and 'increased reading scores' for all FNP children at Key Stage 1. 'Writing scores improved as a result of Family Nurse Partnership for boys, children of young mothers and mothers who were not in employment, education or training when first recruited to the study (in pregnancy)'. Further information about the evidence for FNP over the last 40 years can be found on the FNP website.

Specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities through targeted intervention for vulnerable and disadvantaged children and families (2). The FNP programme is delivered by specialist public health nurses who undertake additional training provided nationally by the FNP National Unit, PHE when they start working in an FNP team.

Each team is made up of:

- a Supervisor (AfC Band 8a) who leads and manages the team as well as contributing to the senior leadership of the organisation, bringing knowledge and skill in public health early intervention work with vulnerable clients to the wider system
- up to 8 WTE Family Nurses (AfC Band 7) who deliver the FNP programme and bring knowledge and expertise to the wider early years workforce in engaging and working with vulnerable families
- a Quality Support Officer (AfC Band 4) who provides administrative and data support to the team

FNP contributes to the Public Health Outcomes Framework (PHOF) for England update 2021 which focuses on:

- increased healthy life expectancy
- reduced differences in life expectancy
- healthy life expectancy between communities

Specifically, FNP contributes to achieving the 6 early years high impact areas set out in the Healthy Child Programme (HCP) 0 to 19:

- supporting transition to parenthood and the early weeks
- supporting maternal and infant mental health

- supporting breastfeeding (initiation and duration)
- supporting healthy weight and healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing and development – ready to learn, narrowing the ‘word gap’

FNP and wider system impact

The FNP model has the added value of providing local areas with a hub of best practice from which other services may be enhanced or developed. All sites receive support for continuous quality improvement, foundational and ongoing nurse and supervisor training, service development and national oversight via the FNP National Unit, thereby increasing its value to local systems.

Identifying the extent of need for FNP is undertaken at local level usually as part of the Joint Strategic Needs Assessment process. Data should include analysis of all conceptions leading to maternities in the eligible age range, not just teenage conceptions; this data will support service planning by identifying geographic distribution of eligible women, including local vulnerability data and social factors.

Where FNP is not currently commissioned, the FNP National Unit will assist local commissioners and providers to establish the service as part of their 0 to 19 public health offer and explore how this approach may be utilised to maximum effect within the local system.

National leadership

The FNP National Unit has a role in:

- advising local authorities and providers on high quality delivery of FNP and fidelity to the Core Model Elements of the programme
- working with commissioners and other stakeholders to develop commissioning plans that integrate FNP and FNP best practice into services for children and families
- supporting ongoing quality improvement through application of current best evidence in collaboration with commissioners, provider leads and local FNP teams
- delivering a comprehensive FNP learning strategy which encompasses provision of a learning programme for family nurses and supervisors and support for the ongoing learning and development of FNP practitioners
- providing bespoke site and local system support to facilitate the sharing of knowledge and skills from FNP with other services
- providing sub-licenses to organisations delivering FNP, to support effective implementation.
- quality assuring the programme nationally
- providing strategic direction for FNP, to influence decision and policy making and providing effective communications about FNP

- ensuring that the voices of young parents and their babies are heard and influence ongoing service improvement

Model specification

FNP aims to:

- improve pregnancy outcomes by enabling young women to improve their ante-natal health and the health of their unborn baby
- improve children's subsequent health and development by supporting parents to provide consistent, competent care for their children
- improve women's life course by planning subsequent pregnancies, and supporting access to education, training and employment

The License

FNP is a licensed programme, developed by Professor David Olds and his team at the University of Colorado Denver (UCD). The Secretary of State for Health and Social Care has entered into a licence agreement and has delegated day-to-day contract management to PHE. As part of these management duties PHE is authorised to sub-license the FNP programme to sub-licensee organisations on behalf of the Secretary of State.

The license supports replication of the original research that achieved outcomes and maintains the quality of the programme. The cost of the license is borne by PHE, aligned with its priority of supporting every child to have the best start in life. Each provider of FNP has a sub-license to deliver FNP, with the commissioner supporting the provider to deliver the service in accordance with this sub-license.

The FNP model

FNP is voluntary for eligible clients and offered assertively and in a strengths-based manner, in order to support engagement. The programme is designed for first time mothers, aged 19 (at last menstrual period) and under or 19 to 24 with additional risk factors. This reflects evidence about which groups will benefit most from FNP and also whose children are shown to be at highest risk of poor developmental outcomes. The aim is to enrol clients on the programme as early as possible in pregnancy (ideally before 16 weeks and, ordinarily no later than 28 weeks gestation) to enable key work to be done to support heathy pregnancy and to prepare for the transition to parenthood. The programme continues until the child is between 1 and 2 years of age.

The impact of wider family support in improving outcomes for both mother and child is recognised with family nurses working with clients' partners as well as the wider family. Where a mother is unable to care for her child and the father becomes the main carer, the nurse will continue to work with the father and deliver the programme. If an FNP client has a second or subsequent child while enrolled on the FNP programme, the family nurse will also deliver the HCP in relation to that subsequent child, until the first child reaches the age of 2, or graduates from the programme, whichever is sooner.

In addition to delivering all elements of the HCP, the family nurse, supports the development of the client's self-efficacy and ability to provide sensitive and responsive parenting. A variety of evidence-based tools, methods and materials are used within the programme to support positive parent- infant attachment and relationships. The consistent, therapeutic relationship between the family nurse and client is fundamental to this work.

As a prevention and early intervention programme, FNP is integrated into the local health and social care system and works in partnership with colleagues across these services.

Care pathway

The following is an outline of the FNP care pathway:

- women who meet the eligibility criteria are notified to the FNP team by midwives following pregnancy booking, or by other service providers, in order that allocation and recruitment can be undertaken in a timely way to meet the fidelity goal of 60% enrolment of eligible clients by 16 weeks
- young mothers enrolling on the programme will be visited, as far as possible, by the same family nurse until the completion of the programme when the child is between 1 and 2 years of age
- the programme will be delivered to young mothers within the context of the immediate and extended family, involving fathers and/or partners and grandparents
- young mothers who accept the programme will receive visits from the family nurse in line with the personalised FNP service delivery model
- the family nurse will work closely with the midwives who retain responsibility for the young mother's midwifery care
- the family nurse will deliver the Healthy Child programme throughout the time that the young mother and her baby are receiving the FNP programme
- before children reach the age of 2 years, the family nurse will liaise with the health visiting team to agree future service delivery
- families will be supported to access wider formal and informal support to meet their individual needs
- the FNP team will have systems in place for effective communication, audit and information sharing

- effective safeguarding is core to FNP practice and FNP teams will adhere to relevant local and national policy and be integrated into local multi-agency safeguarding arrangements
- local commissioners will need to be clear about the pathway for eligible women not offered or not wishing to take up FNP to ensure young mothers have access to midwifery and health visiting services

Location of service delivery

FNP is a home-based visiting programme but family nurses will occasionally meet clients in another appropriate location, for example, GP surgery. Maintaining engagement with vulnerable clients may sometimes, when feasible, require family nurses to follow clients across organisational and geographical boundaries.

Materials, tools, equipment and other technical requirements

FNP teams will require:

- suitable office accommodation, including storage and desk facilities and meeting space
- access to NHS IT systems, the internet and mobile technology for recording interventions and outcomes in local clinical record systems, Child Health Information Systems (CHIS) and Turas FNP England Information System
- FNP programme materials, clinical tools and equipment to support delivery of the FNP and HCP

Further details are available on FNP Online.

Measuring performance and outcomes

Clinical and performance activity within FNP is supported by a real-time FNP Information System, called Turas FNP England, which collects data on delivery, client characteristics and programme outcomes. This is managed and entirely funded by the FNP National Unit as part of its oversight and leadership role.

The Turas system supports commissioners with roles and responsibilities for monitoring and managing provider contracts for the delivery of FNP locally, and provider responsibilities for ensuring high quality delivery and clinical governance. Commissioners and providers have access to regular local delivery data reports from Turas FNP England as part of the local FNP Advisory Board's governance and oversight functions and to inform their contract management activity.

An FNP Annual Review is held which provides an opportunity for commissioners, the local FNP Advisory Board and the National Unit to review the service and its outcomes in depth, strengthen stakeholder relationships and develop an improvement plan for the following year.

Appendix 1: Licensing Core Model Elements and Fidelity

The FNP programme has developed over many years to become the highly respected evidence-based program that is being offered to disadvantaged families in 9 different countries.

The key features of the programme that need to be reproduced have been identified as Core Model Elements (CMEs) and each country or organisation provided with a license for FNP agrees to adhere to these as they implement the program within their own context. The CME's have been adapted for the UK setting as a result of the formative evaluation; experiences within UK FNP sites since 2007; learning from the Building Blocks Randomised Controlled Trial (3) and the programme adaptation project between 2017 and 2019. They have been approved as the UK licensing conditions by Professor David Olds at the University of Colorado.

Applying the CMEs in practice provides a high level of confidence that the outcomes achieved by families who enrol in the FNP programme will be comparable to those achieved by families in the initial 3 randomised controlled trials and outcomes from ongoing research on the programme.

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

Core model elements are prescribed in 4 areas of the programme:

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

Element 1 – client eligibility and enrolment

Client participates voluntarily in the Family Nurse Partnership programme

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

Eligible clients include first-time mothers only and sites use the eligibility criteria set out by the FNP NU

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

Sites enrol clients early in pregnancy and no later than the 28th week of pregnancy unless pregnancy concealed

Definition: A client is considered to be enrolled when they receive their first FNP visit and any necessary consent forms have been signed. Prior to this, FNP nurses may undertake pre-enrolment visits to assess a woman's eligibility, explain the program to the prospective client and invite them to participate. The 28th week of pregnancy is defined as no more than 28 weeks and 6 days of gestation. A concealed pregnancy is defined as where the mother is unbooked for antenatal care after 20 weeks (4), 'and a denied pregnancy, 'Where a female, through fear, ignorance or denial, does not accept or is unaware of the pregnancy in an appropriate way.' (5)

Each client enrolled is visited as far as possible by the same family nurse throughout her pregnancy and the first 2 years of her child's life or until graduated from programme if earlier

Definition: The process of developing and maintaining relationships is central to nursing professional practice. A specific type of relationship, the therapeutic relationship, is developed between the assigned FNP nurse and the client through the one-to-one home visits that occur over the duration of the programme. The overarching core competency for a FNP nurse is:

> 'The ability to support and maintain a therapeutic relationship with each client and use FNP programme methods to enable necessary changes in understanding, capabilities, and behaviours; ensuring the mother is able to nurture, develop and protect her child and herself from harm.'

The client is visited at home throughout her pregnancy and during the first 2 years of her child's life or until graduation, if earlier. Graduation before 2 years takes place following a process of assessment and discussion when the client and nurse agree that the client and her child are ready to leave the programme. The decision is supported by supervision between the nurse and supervisor

Definition: The client (partner, and/or family when appropriate) is visited throughout her pregnancy and the first 2 years of her child's life or until graduation if earlier. A schedule of visits with proposed content has been developed for the programme and the content is delivered in response to the needs and priorities of each client and her child. The process of purposefully personalising programme delivery to meet the needs of the client and her child over the course of the programme is supported by use of the New Mum Star. This is a collaborative Outcomes Star (Triangle Consulting) which supports collaborative ongoing assessment over the course of the programme in response to the changing needs of the client and her child.

Family Nurse Recruitment, Education and Working Practices

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

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

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

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

by the FNP National Unit as well as local opportunities for development identified by the organisations appraisal system.

FNP nurses, using professional knowledge, judgment and skill, utilise the programme materials personalising them to the strengths and risks of each family and apportioning time appropriately to provide a personalised programme

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

Actively participate in FNP supervision as specified

Definition: The process of supervision, as carried out through a safe, honest and trusting relationship and is as important an intervention, as is the direct work undertaken with the client (6).

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

The current model specifies weekly one-to-one supervision with FNP supervisor for each nurse and monthly (or equivalent) team learning sessions.

FNP nurses and supervisors apply the theoretical framework that underpins the programme (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the 3 FNP goals

Definition: The use of content that supports clients in developing the knowledge, skills and self-efficacy is supported by use of a trauma informed approach and key communication skills to enable the achievement of the 3 FNP programme goals:

- improved pregnancy outcomes through the practice of good health-related behaviours
- improved child health and development
- improved economic self-sufficiency

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

Definition: no more than 5 clients per working day per nurse.

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

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

The focus of family nurses and supervisors' work must be the delivery of the FNP programme and provide enough weekly hours to support safe and consistent service within licence

Definition: Effective local delivery of the FNP programme requires each Family Nurse to have the capacity to deliver the programme to clients and participate in supervision, team learning and wider learning. This also ensures consistent application of FNP skills and approach. Supervisors are required to have the capacity to lead and manage the team and provide strategic leadership within the local system. Ensuring this facilitates opportunities for the FNP team to impact on wider system workforce and service developments.

Current advice, based on learning from sites is as follows:

- 1 WTE Supervisor maximum of 8 WTE Family Nurses
- 1 WTE Family Nurse minimum 3 days / 0.6 WTE per week
- 1 WTE Supervisor minimum of 3 days / 0.6 WTE per week

Supervisor recruitment, education and working practices

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

Definition: Each supervisor can carry a supervisory load of no more than 8 WTE nurses (per full-time programme supervisor). It is expected that provider organisations will assure themselves that this process results in the employment of FNP supervisors with a valid NMC registration, degree level education and the desired skills, knowledge and abilities required to successfully deliver and lead the delivery of the local FNP programme. In addition to these academic qualifications, nurses must have personal qualities, values, and beliefs that will ensure that she is a good fit with the spirit of FNP.

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

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

Carry a small clinical caseload

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

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

Definition:

1. Provide one-to-one individual clinical supervision according to FNP National Unit guidelines for each nurse on a weekly basis (pro rata for part-time nurses) preferably in person, but by telephone or virtual contact where travel constraints limit nurse or supervisor mobility.
2. Facilitate the equivalent of 4 half-day team meetings per month: 2 to discuss programme implementation and/or skills practice and 2 case-based meetings to identify client challenges and solutions.
3. Develop an individualised learning plan for each nurse and lead the team-based learning activities, as specified in the FNP learning programme.
4. Make a minimum of one accompanied home visit every 4 months with each nurse for observed supervision purposes.

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

Local organisational infrastructure and resource and administrative support

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

Definition:

1. Each provider organisation will have an effective Care Quality Commission (CQC) registration and expertise in the provision of universal services to vulnerable families. Each strategic lead will convene a long-term FNP Advisory Board, or equivalent, chaired by a senior commissioner, that meets regularly to: facilitate programme development in the local system; promote programme quality and sustainability; scrutinise and monitor local governance arrangements; oversee quality improvement plans, and ensure the client's voice informs service development. This will be aligned to FNP National Unit guidance.
2. Each site will employ a dedicated administrator in line with the national job description to provide essential administrative services to enable effective delivery of the programme.
3. Each FNP team will access psychological consultancy monthly with an additional requirement for the supervisor to receive monthly one-to-one session as per FNP National Unit guidance.
4. Ensure that the necessary infrastructure and resources for the team, including office equipment, printed guideline materials and other resources, mobile devices, and so on. are made available.

Appendix 2: Eligibility criteria

Options for flexing eligibility criteria

The eligibility criteria are:

1. All first-time pregnant clients up to 28 weeks (and 6 days) gestation.
2. All first-time pregnant clients under 16 years old (at last menstrual period).
3. All first-time pregnant clients who are in the care system as Looked After, on a Child Protection Plan, Child in Need or who have ever been in care.
4. Living in the agreed commissioned area.
5. Eligible if previous pregnancy ended in stillbirth, miscarriage or termination.
6. Eligible if previous pregnancy resulted in removal at birth (parent did not have an opportunity to parent).
7. Clients who are 20 to 24 (at last menstrual period) with 2 or more additional vulnerabilities.*

   * Additional vulnerabilities may include the following:

Category of Vulnerability	**Description of Specific Vulnerability Factors**
History of Abuse	• Ever known to children's social care services (including LAC, CIN, or on a CPP plan) • History or suspicion of being victim of abuse (physical, sexual and/or emotional, or victim of grooming) • History or suspicion of being a victim of neglect (physical and/or emotional)
Low Educational Attainment/ Adolescence	• Aged is less than or equal to 16 years old • Has not achieved any formal academic or vocational qualifications • Learning disability or other condition affecting client's ability to care for herself or her baby
Mental Health	• Currently taking medication or under treatment for a mental health condition • Existing clinically diagnosed mental health condition, requiring acute psychiatric services • Previous clinically diagnosed mental health condition, requiring acute psychiatric services (for example, previously sectioned, previous suicide attempt, self-harm, and so on.) • Existing mild to moderate depression or anxiety, in receipt of community mental health services
Client Substance Use	Substance use by client • alcohol • drugs • smoking in pregnancy

Domestic Abuse	• History of being exposed to domestic abuse as a child • Currently experiencing domestic abuse/IPV • Currently a perpetrator of abuse • High conflict relationship with current or ex-partner
Family Dysfunction/ Chaotic home environment	• Unstable relationships within the home, and/or presence of transient members in the household • Frequent change of partners by the client • No emotional or financial support from immediate family • Unstable home address or inadequate housing • Client, partner or family member in household ever incarcerated or known to the justice system or associated services, including gang affiliation, county lines activity, and so on. • Partner or household member(s) engaging in substance misuse • High conflict environment in household currently
Other	Any other vulnerabilities not covered in the boxes above that represent risk for your client or are a high priority in your local system

These maternal risk factors predictive of poor child outcomes and readily identifiable in early pregnancy by midwives/maternity records and systems, are based on research by a literature review (7) and the ADAPT findings.

Appendix 3: Commissioning capacity

The FNP Core Model Elements state that a family nurse can carry no more than 25 families per full-time employee and a supervisor should carry a caseload of a minimum 2 to 3 families. To determine capacity at a site and national level, the FNP National Unit has worked to a model of 25 clients per family nurse (assuming that each nurse is one x WTE) and none for the supervisor, for example, a team of 4 with a supervisor would have a modelled maximum capacity of 100 places.

In practice, providers of FNP will need to consider how they will make provision for capacity in the case of staff absence, turnover, hours worked, as well as levels of client vulnerability and/or additional needs of clients, for example safeguarding, English as a second language, Looked After Children.

Locally agreed strategies need to be in place for keeping places open for transfers in and the geography and reallocation of clients. There may be discrepancies between current WTE and the modelled capacity at site level. Providers and commissioners should be aware of these discrepancies and agree a true capacity for each site as a priority. These discrepancies may have occurred where existing family nurses have changed their working hours, been appointed on a part-time basis or where there have been historic contracting or commissioning challenges. Commissioners should be commissioning FNP to a maximum (theoretical) capacity and not to actual caseloads.

Appendix 4: Materials and training

Materials and training to which PHE and/or DHSC retain rights, title and access in England to comprise

Unique English materials including:

- training materials and learning programme produced, procured or provided by FNP National Unit, PHE
- implementation management information
- evaluation and research reports
- other materials to be developed by FNP National Unit, PHE, including new additions to FNP guidelines - leaflets, case studies, newsletters and other communications materials introduced by FNP National Unit or PHE
- FNP extranet design
- design of forms to enable data collection

UCD Proprietary or derivative materials as amended by FNP National Unit or PHE, include:

- information system
- pregnancy, infancy and toddlerhood materials
- training materials, including those adapted by FNP National Unit or PHE for use in FNP in England

‘Proprietary Materials’ shall mean the items delivered to PHE under its agreements with UCD, including, without limitation, the Core Model Elements and any copyrighted materials. Proprietary Materials shall also mean all designs, methods, interventions, modifications, improvements, which are conceived and/or made under such agreements between PHE and UCD or any of their subcontractors and which are incorporated into the FNP programme or Proprietary Materials and, if developed by PHE, cannot be used on a stand-alone basis outside of the FNP programme.

‘Derivative Works’ shall mean all, designs, methods, interventions, modifications, improvements, which are conceived and/or made under the Head Licence by the Sub-licensor and/or UCD or any of their subcontractors and which are based on the Proprietary Materials.

‘Unique English Material’ shall mean material created, derived or developed solely by PHE, its subcontractors or sub-licensees, that is:

1. Not a Derivative Work.
2. Can be used on a stand-alone basis within England and is separate from and does not require the FNP programme, Proprietary Materials or Derivative Works for its use.

Appendix 5: Leaving FNP early

When a child and family leave the area, there will be a clear local protocol in place to ensure continuity of services for the family. This may include the client continuing to access FNP from another FNP team or continuing to provide the FNP programme into another local area.

As a programme working with clients who may at times find it difficult to engage with services, family nurses adopt a trauma informed approach and are persistent and skilled in efforts to maintain engagement. This includes clients who are living in unstable accommodation and may experience frequent moves. The levels of vulnerability in the client group require robust safeguarding processes to be in place in line with local and national safeguarding requirements.

Local sites will put into place local protocols to manage clients who are not accessing the programme to ensure that the children continue to receive the HCP and any other services required. Guidance for FNP Advisory Boards is provided by the FNP National Unit.

Appendix 6: Record keeping, data collection systems and information sharing

Providers employing FNP teams are responsible for the local protection of the FNP data for the service users/patients that they specifically provide treatment and care to.

Providers shall comply with all aspects of the Data Protection Legislation (GDPR), Data Protection Act 2018, Human Rights Act 1998, Freedom of Information Act 2000 and The Common Law Duty of Confidentiality. Additionally, clinicians must adhere to Nursing and Midwifery Council (NMC) standards for record keeping.

For FNP:

1. Mechanisms will need to be in place for the systematic collection of data to meet the core fidelity requirements for the FNP programme. Use of the Turas FNP England system are central to this requirement.
2. The supervisor will monitor the collection of the data and ensure its use to support clinical delivery.
3. The supervisor will generate and analyse reports on programme delivery using Turas FNP England to maintain and improve the quality of the programme.
4. The FNP team will use local CHIS systems to record information about each child including those required as part of statutory child health datasets.

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Published August 2021
PHE gateway number: GOV-8567

PHE supports the UN Sustainable Development Goals

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