

**Evaluation of Group Family Nurse Partnership  
Phase 3**

**Report to the Family Nurse Partnership National Unit**

Professor Jacqueline Barnes

Dr. Jane Stuart

Institute for the Study of Children, Families and Social Issues

Birkbeck, University of London

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The views expressed in this report are those of the authors' and do not necessarily reflect those of the Family Nurse Partnership National Unit or of the Department of Health.

## Executive Summary

The Family Nurse Partnership (FNP) is an intensive programme of structured support for young, disadvantaged women expecting their first baby, through pregnancy and the first two years of their child's life (Olds, 2006). The support is home based and delivered on a one-to-one basis by specially trained Family Nurses (FNs). Group FNP (gFNP), developed in collaboration with the University of Colorado, Denver, has similar aims and objectives but is adapted for delivery to a group of 8 to 12 women with similar expected delivery dates. They are not eligible for FNP either because they are under 20 and expecting a second or subsequent child, or they are 20 to 24 years old and expecting a first child. An additional criterion is applied to the 20 to 24 year olds, specifically low educational achievement. In the original model two Family Nurses delivered the programme one of whom was also a qualified midwife. The Phase 3 model of gFNP adopted a modified approach with a mix of facilitators: one Family Nurse acted as the lead facilitator throughout the programme with a local midwife as co-facilitator during the Pregnancy Stage and a local child and family support worker during the Infancy Stage. In addition partners were encouraged to attend group sessions. Phase 3 involved groups commencing in January 2012 in four sites, with the pregnancy stage of the programme running through to August/September 2012 and continuing with the infancy stage for the following twelve months.

### RECRUITMENT

**What issues have emerged during the current recruitment process with regard to the process of identifying potential gFNP participants and making referrals, the use of the current eligibility criteria and their effectiveness in being applied in a service setting?**

Overall FNs reported that, compared to recruiting for FNP it was more difficult to recruit for gFNP for two reasons: firstly the lack of information about the client and secondly, the introduction of the educational criterion to determine eligibility. A key issue was the problem of communication with the local community midwifery teams. The view was expressed that community midwives were either unaware of or unclear about the criteria for referral to gFNP, resulting in too few referrals, a lack of information on the referral slips and inappropriate referrals. In addition, referral forms from community midwifery did not usually provide details relevant to the gFNP educational criterion. Thus there was a substantial amount of work for FNP teams making telephone calls to prospective clients, many of whom did not meet the criteria.

FNs initially found it challenging to ask clients about their educational qualifications over the telephone but, over time and after preparing and practicing short scripts, they reported that the conversations became easier. FNs reported reservations about the utility of the educational criterion because they thought in some cases that the young women claimed to have qualifications they did not have, thus leading to inaccurate decisions of ineligibility. In other cases young women considered vulnerable and therefore suitable for gFNP met the other criteria for recruitment but were over-qualified educationally.

**What percentage of referred women was enrolled? What are the characteristics of enrolled and non-enrolled women and what are their reasons for accepting the offer?**

Acceptance of the offer of gFNP by those definitely eligible for the programme ranged from 11/27 (41%) in site 1 to 9/10 in site 4 (90%). The 39 clients enrolled in the programme had an average age of 20.7 (range 18 to 24) with nine (24%) under 20. The majority (23, 85%) were white British, with one Asian, one Black and two of mixed ethnic background. Just over half (15, 56%) were cohabiting, one was married (4%) and the remainder (11, 41%) were single. Clients were identified in part on the basis of having fewer than 5 GCSEs at grade C or. The average number of any GCSEs was 4.4 (range 0 to 13) and the average number of GCSEs at grade C or higher was 1.3 with a range from 1 to

10 The one client who had more than 5 was aged 18 and therefore would not have been required to fulfil this criterion. Thus the recruitment was successful with respect to this aspect of eligibility.

When asked either at individual interview or during the focus group sessions why they had accepted the offer of gFNP, the responses from clients were generally positive, they liked the idea of joining a group where they would meet other 'mums' like themselves and make new friends, thus reducing the isolation often felt by new mothers. They also expected that there would be an opportunity to learn about pregnancy and how to look after their babies. Their view was that discussion within a group setting would be more beneficial than in a one to one session because there would be a wider pool of experience and opinions to draw on. They also understood that gFNP would offer more than routine ante-natal care with the approach being more 'personal' with the clinical care provided by one midwife, with whom they could develop a relationship.

## **ROLES OF PROFESSIONALS**

### **What does each of the professionals involved think about their own role in delivering gFNP, and that of the other professionals?**

FNs saw their role as leading the delivery of gFNP and expected they would be supported in this task by the MWs and FSWs employed as their co-facilitators. This proved to be a challenge in that FNs felt responsible for the programme content and the style of delivery. They reported that they did not always feel adequately supported by their co-facilitators, especially in the ante-natal phase of programme delivery. This was because it was perceived that the MWs lacked sufficient knowledge and confidence regarding gFNP and also that time constraints were placed on the MWs due to commitments elsewhere. Thus FNs felt they carried the main burden of preparation, session delivery and subsequent paperwork in the ante-natal phase. After transition to the infancy stage, which could be problematic in itself as the group adjusted to a new facilitator, the situation eased. This was principally due to the greater experience of the FSW co-facilitators in delivering to groups and the fact that they were not subject to the same time constraints as the MWs, partly since their other employment was based in the Children's Centre where gFNP was delivered. On the whole FNs found it challenging to deliver the Phase 3 model of gFNP and all reported that they would have preferred to deliver the service alongside another FN.

Reflecting the FNs' views, MWs perceived their role as being primarily to provide the midwifery care to gFNP clients and then to support the FN to deliver the programme but they were aware that they were less familiar with the programme content. The FSWs saw their role as co-facilitating gFNP by sharing in the planning and delivery with the FN. Local Children's Centre Managers viewed part of their role as integrating gFNP into the broader public health strategy and gaining support amongst strategic partners. They did not express the same reservations about the programme content. They may have been able to focus more on that as they did not have a 'medical' role to fulfil.

### **What does each of the professionals think about their own preparation for the role, and support received to enable them to be facilitators of change?**

In terms of training, the FNs felt reasonably well-prepared for their role although they would have like more guidance about how to support co-workers less familiar with FNP. In contrast the MWs did not feel well-prepared after their training and lacked the confidence to deliver the teaching side of the programme and to use the motivational interviewing approach. Added to this, two MWs had reservations about encouraging the young women in their groups to carry out their own health checks, an integral element of gFNP. On the other hand, FSWs generally felt prepared for their role although the time lag between training and delivery was problematic; they had been trained at the same time as the MWs but did not enter the groups until several months later. Working in a non-directive way was new for them and a key realisation was that the role involved moving away from

being a 'fixer' to being a facilitator. In their professional role they tended to try and sort clients' problems out as quickly as possible rather than encouraging them to try and resolve situations for themselves. They would have appreciated more training on that aspect of the programme.

**What was the time involvement for each staff member as they prepared, plan and ran groups and the time involvement for their training and supervision?**

FNs reported that the time allocated to them for delivering the programme was inadequate and that in fact it took twice as long as expected. All four MWs reported being under time pressure not only because of commitments and full case-loads elsewhere but also because they faced difficulties carrying out their midwifery checks in the time allocated to the gFNP session. They acknowledged, supporting the reports of the FNs, that due to this time pressure they had to leave many of the duties associated with delivering the programme to the FN. Lack of time was not such an issue for the FSWs because they are usually based at the Children's Centre where gFNP sessions took place so could be more available for the planning before-hand and more easily stay and do the paperwork after each session or take part in the monthly supervision.

**What do associated professionals think about delivering gFNP using the Phase 3 model?**

Children's Centre Managers were optimistic about the impact of gFNP on maternal health because of the increased support given to the young women and in particular about the choices that were available to them. The strategy of trying to engage fathers was viewed as having a positive impact on future parenting; learning about attachment and infant needs were also expected to have a positive impact on the way children would be cared for. By holding the groups in Children's Centres families would become aware of where they could access support should they need it.

**CLIENT INVOLVEMENT**

**What was client participation over the entire course of the programme? Can any differences in participation be identified in comparison with Phase 1?**

Out of the 43 clients enrolled in the four sites, 7 never attended any sessions. The number of the 14 pregnancy sessions attended by the remaining 36 ranged from 1 to 14, with a mean of 8.2 (59%). The average proportion of sessions attended in pregnancy was 57% with a range from 7% to 100%. One quarter (9/36) had attended at least 80% of pregnancy sessions (the 1 to 1 recommendation) but the majority, nearly two thirds (23, 64%) had attended 9 or more of the 14 sessions. This is slightly lower than that recorded in Phase 1 for 22 phase 1 clients whose average number of pregnancy sessions attended was 10.4 (74%) and half (11) had attended at least 80% of the sessions.

By the beginning of infancy 27 Phase 3 clients remained and the mean number of sessions attended was 13.5 with a range from 1 to 29. However, one site stopped delivery of the programme before the end of infancy, after holding 7 infancy sessions. The number attended for the 24 clients in these sites ranged from 4 to 28 in these sites with an average of 14.5. It should be noted that none of these three sites held the maximum of 30 infancy sessions, offering 22, 26 and 29.

The average proportion of infancy sessions attended was 58% (range 14% to 100%) and these clients attended 62% of sessions in total in pregnancy and infancy (range 24% to 96%). Nearly half (13/27, 48%) attended at least 65% of the sessions offered with only six (22%) attending fewer than a third. More infancy sessions had been attended clients in one of the Phase 1 sites (average 19.4, range 2 to 29) but attendance in Phase 3 was similar to the other Phase 1 site (average 13.7, range 1 to 23). Thus the Phase 3 mode of delivering the programme does not appear to have markedly influenced attendance but there is some indication that the trend is for lower attendance than that documented for the Phase 1 model of delivery, with two Family Nurses.

Attrition during pregnancy for Phase 3 was noted for 7 of the 36 who attended at least one session (19%), but only a further 3 clients left during infancy (8%) with a total attrition rate of 27%. However there was considerable variation in attrition across the 4 sites (range 45% to 10%). The overall attrition rate is comparable to sites in Phase 1, where overall attrition was 30%, but in Phase 1 departure was less likely in pregnancy (13%) than in infancy (17%).

### **Can any client characteristics be associated with participation and retention?**

Client characteristics examined in relation to attendance were marital status, age group, ethnic background, employment status, educational qualifications and income. However, none could be statistically related to the extent of their attendance. There was a trend for clients with lower income to be more likely to attend and it is also possible that lower attendance is associated with membership of ethnic groups with groups other than white British, but the numbers are much too small in the current study to make any reliable predictions, and demographic information incomplete, was only available for 25 clients.

### **How did clients and professionals rate the sessions, and did this differ from phase 1?**

Clients were very positive about the sessions in their ratings, as positive as they had been in Phase 1 with most using the highest end point of the rating scale. They considered that they had been listened to, had been able to make comments when they wanted to and that in general the group all got on well with each other. Similarly, the nurses rated the involvement and understanding of Phase 3 clients highly, as they had in Phase 1, and reported very little conflict with the content of the material presented.

### **What factors, according to clients and professionals, impact on maintaining participation through to the programme's conclusion?**

Clients reported sustained efforts to maintain attendance through to the programme's conclusion. Most reasons for non-attendance concerned illness or unavoidable circumstances such as family holidays. Poor weather and transport issues was also mentioned and having employment also proved to be a stumbling block in that they did not want to risk their jobs by making requests to time off. The FNs reflected similar reasons for attrition, highlighting family circumstances and in particular having to deal with other children. They also commented that some women had stopped attending due to pressure from other family members. They suggested that organisational factors within the gFNP team leading to changes in staffing could also precipitate lower attendance.

## **PARTNER INVOLVEMENT**

### **What was the extent of partner involvement?**

Partner involvement cannot be compared with phase 1 since they were not invited to attend at all for that phase of the programme's delivery. From the data forms completed by the FNs it could be seen that mothers were accompanied by their partners to 16% of pregnancy sessions which had recorded this across the four sites (68/438) and 19% of the infancy sessions (94/505). Data are reported for 32 partners of the 36 clients attending sessions during the pregnancy phase and the average number of sessions attended was 2.1 (range 0 to 14). Data were available from 25 partners of the 27 clients attending any infancy sessions and their mean attendance in infancy was 3.8 sessions (range 0 to 25).

The involvement and understanding of partners in pregnancy (rated on a scales from 1 to 5) were said to be high (means: involvement 4.4, understanding 4.6) though slightly lower than that of mothers (means 4.7 and 4.8 respectively). The level of conflict partners expressed with the programme content throughout was reported to be low (mean 1.1) and the same as that of their

partners. During the infancy sessions partners' involvement and understanding were said to be slightly higher than in pregnancy (means: involvement 4.8, understanding 4.9) and not significantly different from that of the mothers (mean 4.9 for both).

### **What are the partners' views about being involved in the groups?**

Of the four sites, one had a regular group of partner attendees while other sites experiencing more sporadic partner attendance with perhaps just one attending from time to time. Where irregular attendance was the case some of the young men reported feeling excluded. They had not enjoyed being the only male present and this was likely to deter them from attending future sessions.

At the site where partner attendance was regular the young men reported the sessions were something they looked forward to; it was a social occasion for them as well as being helpful in giving them information that would allow them to support their partners during pregnancy and with their new baby. Some partners reported benefiting from all the sessions and others highlighted specific sessions such as those focusing on emotions and relationships. They talked about enjoying learning about the psychology of babies and felt that attending gFNP gave them an insight into future parenting. However, fathers particularly appreciated the opportunity to learn how to support the mothers in labour. The ante-natal session focussing on preparation for labour was the best attended by partners across all four sites.

### **What are the views of women participating in the programme about the inclusion of fathers or other partners in the groups?**

Most of the young women participating in the programme thought it was a good idea that partners were invited, whether or not they had a partner who attended with them. They thought it was especially useful for first-time fathers as it gave them an insight into pregnancy and labour. However there were reservations about partners being present during some sessions or parts of sessions where specific medical issues were being discussed which it was felt were 'private and personal' to the young women themselves. The concern was also expressed that there might be issues being discussed that partners might feel uncomfortable with, for example those concerned with sexuality. Some comments indicated that, if there was a majority view that the group functioned better with only the women present, then this should be conveyed to partners who should then only expect to attend for specific sessions which had content geared to them.

## **PROGRAMME CONTENT AND IMPACT**

### **What are women's views about receiving midwifery care as an integral part of the group and its contribution to their knowledge of pregnancy and their confidence as mothers-to-be and then mothers?**

There was a mixed response from women when asked how they felt about carrying out their own health checks. Some found that it gave them a sense of independence and control over their own pregnancies and others voiced the opinion they would rather a health professional carry out the tests. However they expressed appreciation that they regularly saw the same midwife, which was less likely with routine antenatal care. In addition a view was expressed that being able to hear their baby's heartbeat so frequently alleviated anxiety.

### **How do the gFNP approach, the materials and resources contribute to women's confidence and enjoyment of their infants?**

Women liked the fact that they could hear the views of other young parents in the group discussions which made the service one that was preferable to seeing a professional one-to-one. When asked which of the resources or materials had added to their confidence or enjoyment of their babies craft

activities and singing were favourites for many. Finding out about the experience of labour and the choices that were available to them was cited as particularly useful during the pregnancy phase and practical activities they could do with their babies to enhance their development were most popular during the infancy phase of the programme. They also particularly valued advice and information on infant feeding and weaning and being able to hear a range of views from the group members.

**What do clients perceive to be the likely impacts of participation in gFNP for maternal and child health and development?**

Clients reported that a direct impact of taking part in gFNP was an increase in their personal confidence and in ability to look after their babies. They attributed this to joining a group of people they did not know but who were going through a similar experience and gradually being able to speak out and express their own opinions. They also reported improvement in mental health from being less isolated and receiving more support from the health professionals and the other members of the group. Many described changing their health-related behaviour in terms of cutting down smoking whilst pregnant and taking a new approach to eating more fruit and vegetables as a family and preparing home-made food for their infants at the weaning stage.

Much of the reported impact, not surprisingly, was described as increased knowledge about being a parent and about babies and how they developed. The majority felt that they had learned a lot about parenting and that the programme had changed their lives, and as a consequence, their children's lives for the better. The activities that took place later in the infancy phase were perceived to be important in encouraging both physical development and infant exploration and cognitive development. It was also suggested that the particular combination of an expert presence in addition to the opportunity for socialising with other babies had been particularly beneficial. Having regular contact with health professionals was perceived as beneficial for infant health, both in terms of identifying potential problems early or alleviating anxiety, and also for making referrals to specialists where necessary.

**What are partners' views about the contribution of group involvement to their role supporting their partners during pregnancy and in caring for their new infants?**

Partners particularly mentioned that during the ante-natal stage they appreciated the opportunity to learn about what to do when their partner was in labour so they could support her. They also liked being better informed about potential risks such as cot death and how to encourage and safe sleeping. Learning about how to deal with situations such as infant crying was also mentioned, and about infant development in general, so that they were better prepared for their babies.

**What do the professionals perceive to be the likely impacts of participation in gFNP for maternal and child health and development?**

All the professionals reported observing positive impacts on maternal and infant health and on parenting, and also believed that clients would continue to benefit from what they had learnt during the programme in the long term. They were seen as gaining in confidence about their own parenting skills and their expertise in understanding their infants. Presenting information in a group context enabled different opinions to be shared and then discussed. There was a general view that taking part in the programme would have a positive influence on the young women in terms of future parenting, with behaviour changes already being observed during their time as co-facilitators. The professionals considered that taking part in the group contributed to making the young women feel valued and this would have a positive effect on future parenting skills and other aspects of their life such as relationships. While it was a challenge to change health related behaviours the mothers and fathers had been helped to understand how unhealthy eating, or the fact that they smoked, might impact on their children's development.

## Conclusions

There were some challenges for delivery of Phase 3. In common with earlier phases a stumbling block could be communication with community midwifery about the very particular eligibility requirements for gFNP and the need to receive a number of names in a short space of time. The inclusion of the educational requirements also led to difficulties in recruiting.

Involving non-FNP practitioners, new to Phase 3, provided some opportunities, such as widening awareness of gFNP in the locality with midwifery and enabling stronger links with Children's Centres. However the newness of the programme and the relatively brief time available for training meant that the FNP nurses took the major responsibility for planning and delivering programme content, especially in pregnancy and this placed additional stress on them.

Some recruited clients never attended any sessions and this issue is of concern, given that groups are of limited size. While this may not be specifically a Phase 3 model issue, there are some suggestions that if the midwives who are not also part of PNF are involved in recruitment that may not convey the details of the programme as successfully. This again indicates the need to more detailed preparation of non-FNP professionals before offering gFNP using this model.

There is no indication that the change-over of professionals from pregnancy to infancy or the characteristics of the clients in terms of demographic factors, led to lower attendance, resulting in the programme concluding prematurely in one location. It is more likely that each group brings together a unique mix of individuals, sometimes they consolidate into a cohesive a group and at other times this fails to take place. This will require more investigation in order to determine the processes that are most relevant to a group's ongoing successful functioning.

## Chapter 1 Introduction

### 1.1 Background to gFNP

The Family Nurse Partnership (FNP) is an intensive programme of structured support available in the UK for young, disadvantaged women expecting their first baby, through pregnancy and the first two years of their child's life (Olds, 2006). The support is home based and delivered on a one-to-one basis by specially trained Family Nurses (FNs). FNP has been developed in the US over a thirty year period (known there as the Nurse Family Partnership, NFP) and has good evidence of benefit over short, medium and long terms e.g. in respect of birth outcomes, child learning, development and behaviour, reductions in child injuries, neglect and abuse, mother's take up of employment, education and training.

FNP has been successfully offered and provided in England, with evidence of its acceptability to young first-time mothers, their partners and family members, and to the professionals providing the programme (Barnes et al., 2008; 2009; 2012). The availability of FNP has increased with the aim of providing at least 15,000 places by 2015. However there are mothers-to-be who might benefit from the programme but who cannot receive the intervention due to the USA specified inclusion criteria (first time mother, no previous live births; low SES) and the criteria applied in England (e.g. under 20 at conception in most areas, with a maximum age of 22 in selected areas). Following the success of group-based antenatal care such as the USA Centering Model, preferred to traditional care (Ickovics et al., 2003; 2007; Robertson, Aycock and Darnell, 2009) and leading to improved prenatal outcomes such as preterm births among high-risk women (Grady & Bloom, 2004; Williams, Zolotor & Kaufmann, 2009) some sites who are providing FNP have also been providing a new derivative of the programme known as Group FNP (gFNP) to mothers not eligible for FNP using current criteria. The programme is delivered by two facilitators in a group setting with about 10 other women due at a similar time, during pregnancy from about 16 weeks and up to the time that their infants are 12 months old.

Group FNP (gFNP) has been developed in collaboration with the University of Colorado, Denver and has similar aims and objectives as FNP, using many of the same materials but adapted for delivery within a group. The purpose of the new service is to provide a cost effective alternative to home based, one-to-one FNP that can be made available to a wider group of vulnerable women. The group provision is delivered by two professionals with training in the FNP materials. An additional element of gFNP is the provision of routine health checks of the mothers during pregnancy and of the infants during their first year within the group setting, with a focus on learning how to conduct their own health checks with support. Thus one of the facilitators, during the pregnancy phase of delivery, must also be a qualified and currently certified midwife.

The programme provides 14 meetings in pregnancy, weekly for one month and then fortnightly. In infancy, sessions are again weekly for one month and then fortnightly, with 30 in total. Meetings usually take place in a local Children's Centre. Sessions are designed to last for two hours, with an hour to 90 minutes dealing with FNP and the remainder of the time spent on medical checks. Clients are able to have one-to-one time with the midwife or health visitor at the end of the group sessions or if necessary at their home. The facilitators also make themselves available to answer queries or concerns by text or phone calls outside normal working hours.

Group FNP is in its development phase. In the first phases of delivery (Barnes & Henderson, 2012) it was provided by two fully trained family nurses (FNs), one of whom was also a qualified midwife. One of the evaluation questions has concerned the eligibility criteria. An initial formative evaluation in two sites concluded that the original eligibility criteria, either being 18-19 and expecting a second or subsequent child or aged 20 to 25 and expecting a first or second child, with gestation ideally 12 weeks at referral, were workable. The delivery dates needed to be within 6 to 8 weeks of each other

so that women would go through pregnancy and giving birth at about the same time. The main challenges were to identify a sufficient number with due dates close together and identifying women soon enough in their pregnancies. Very few referrals in either location had gestations of less than 12 weeks. A second round of groups in the same two sites (Phase 2, Barnes & Henderson, 2011) used an additional eligibility criterion of low or no educational qualifications and/or no employment (no GCSE qualifications at grade C or higher). However, due to a low number of women being identified in the time available (usually about 8 weeks), to make groups viable in size (at least 8) some clients were included who had more qualifications than the criterion. The evaluation report (Barnes & Henderson, 2011) suggested that the criterion regarding educational qualifications might need to be made less specific to recruit sufficient numbers for a group.

Once recruited, attendance in phase 1 was good in pregnancy, on average 74% in one site and 78% in the second. However, in both locations some enrolled clients never attended any meetings. It was suggested (Barnes & Henderson, 2012) that it might be sensible to over-recruit, with the expectation that some enrolled clients would change their mind. During infancy attendance was slightly lower, 70% in site one and 59% in site two, with a decrease after infants were 6 months of age although some clients reported making strenuous efforts to attend, with only illness keeping them away. Both clients and FNs indicated that the presence of the increasingly vocal and mobile infants in late infancy presented challenges. Attrition was, nevertheless, modest at 30% although with such small numbers it was too soon to draw firm conclusions.

The 'tone' of the interactions with the family nurses and clients and between the two nurses was commented upon by clients from the outset with praise for the relaxed atmosphere and the use of humour. They reported that they knew they were in the group to gain information but it was also a pleasant experience. Materials were well received by clients and they enjoyed all the 'hands-on' craft activities and the small group discussion. Coverage of challenging parenting issues such as weaning, for which there were many different viewpoints, had been particularly useful, highlighting a range of views and leading to valuable sharing of advice and experiences.

For family nurses the new way of working was exciting and offered them the opportunity to work in a different, more collaborative way, using previously acquired skills in group work in conjunction with the effective materials of the FNP programme. They noted that achieving 'transformational work' with clients was more important than large amounts of information being imparted. Therefore, after a few sessions they extended discussion time in sessions rather than worrying whether they were providing large amounts of information. In late infancy the focus was on supporting clients who had other responsibilities such as employment or education. For most of the clients it appeared that all of the content throughout infancy was important and attendance figures indicated that they continued to find it a valuable experience but it was suggested that for some (particularly those who were employed) a programme ending at 6 months might have been more appropriate.

## **1.2 Aims of the Phase 3 evaluation**

Phase 3, the focus of the present evaluation, involved groups in four sites commencing in January 2012, with the pregnancy stage of the programme running through to August/September 2012 and continuing with the infancy stage for the following twelve months. Almost the same eligibility criteria were used as in Phase 2 which were: under 20 and not first child, or 20 to 24 and first child but the education criterion was relaxed slightly so that rather than no GCSEs they could be recruited if they had fewer than 5 GCSE certificate qualifications at Grade C or higher. Fathers were not included in the Phase 1 groups, but were invited to attend in phase 2 and this was also the case for Phase 3 groups.

However there was one additional difference for Phase 3 compared to previous delivery of gFNP. While the programme was delivered in Phases 1 and 2 by two FNs, one of whom was also a registered midwife, in Phase 3 a different delivery model was used. One facilitator of the group was an FN and she was present throughout. During pregnancy sessions the second facilitator was a local community midwife (MW). She was replaced in infancy by a local Children's Centre child and family support worker (FSW). All the facilitators in Phase 3 (FNs MWs and FSWs) undertook training developed for the purpose of supporting them in group facilitation roles and the non-FNP facilitators were also provided with some knowledge of the FNP curriculum and strength-based mode of delivery. Thus, while some of the issues addressed in this evaluation are similar to the previous phases-looking at recruitment success and pathways, attendance and the potential of the programme in terms of impact for mothers, fathers and children, the unique focus of this report is on any differences that have emerged with the changed delivery model. Neither study is large enough to make statistical comparisons with the evaluation of Phases 1 and 2, but indicative quantitative variations will be highlighted.

This evaluation examined delivery of the Phase 3 model of gFNP in four locations for the period from commencement in January or February 2012 through to July 2013 when programme delivery was complete, covering both pregnancy and infancy sessions. In one of the four sites programme delivery ended in December 2012 due to low attendance. Specific research questions addressed are:

### **Recruitment**

1. What issues have emerged with regard to the process of identifying potential gFNP participants and making referrals?
2. What issues have emerged using the current eligibility criteria based on maternal age, parity and low educational achievement?
3. How easily and effectively can the current or revised eligibility criteria be applied in a service setting?
4. What percentage of referred women was enrolled?
5. What are the characteristics of enrolled and non-enrolled women and (if known) what are the reasons for accepting or declining the offer?

### **Roles of professionals**

6. What does each of the professionals involved in delivering gFNP in the Phase 3 model think about their own role, and that of other professionals?
7. What does each of the professionals think about their own preparation for the role, and support received to enable them to be facilitators of change?
8. What was the time involvement, and associated cost, for each staff member as they prepared, planned and ran groups and for their training and supervision? What were the incidental costs, such as for childcare at the venue, other expenses, travel etc.?
9. What do associated professionals (e.g. FNP supervisors, Children's Centre managers) think about delivering gFNP using the Phase 3 model?

### **Client involvement**

10. What was client participation over the entire course of the programme?
11. Can any client characteristics be associated with participation and retention?
12. Can any differences in participation be identified in comparison with Phase 1?
13. How did clients and professionals rate the sessions, and did this differ from phase 1?
14. What factors, according to clients and professionals, impact on maintaining participation through to the programme's conclusion?

### **Partner involvement**

15. What was the extent of partner involvement and how did they rate the sessions?
16. What are the partners' views about being involved in the groups?
17. What are the views of the women participating in the programme about the inclusion of fathers or partners in the groups?

### **Programme content and impact**

18. What are client's views about receiving midwifery care as an integral part of gFNP and about its contribution to their knowledge of pregnancy and their confidence as mothers-to-be and then mothers?
19. How do the specific gFNP approach, the materials and resources contribute to parents' confidence and enjoyment of their infants?
20. What do clients perceive to be the likely impacts of participation in gFNP for maternal and child health, child development and parenting?
21. What are the partners' views about the contribution of group involvement to their role supporting their partners during pregnancy and in caring for their new infants?
22. What are practitioners' views about the likely impacts of gFNP for maternal and child health and parenting?
23. Are there other impacts that clients, partners or professionals perceive in relation to participation in gFNP?

## **1.3 Methodology**

### **1.3.1 Referral dispositions**

The UK050G form lists all the referrals received with information on the referral source, maternal age (in some cases) and expected delivery date. Their dispositions are then given, with a number of different ineligibility criteria defined and information about whether eligible referrals accepted or declined the offer. For those eligible and who accepted the offer the enrolment date, maternal age and gestation at enrolment are listed.

### **1.3.2 Standardized programme data forms**

A number of standardised data forms are used with enrolled clients during delivery of the programme, similar to those used in the delivery of FNP. Those analysed for this report are:

<b>UK001G</b>	Attendance, partner attendance and involvement
<b>UK003G</b>	Telephone encounter, contact with FN outside the group sessions
<b>UK004G</b>	Change of status of clients (leaving or returning)
<b>UK005G</b>	Maternal health and well-being at intake
<b>UK006G</b>	Smoking, alcohol and drug use at intake and 36 weeks
<b>UK007G</b>	Relationships at intake
<b>UK008G</b>	Relationships at 36 weeks
<b>UK010G</b>	Maternal demographic characteristics at intake

### **1.3.3 Reflections after sessions**

#### **a) Clients**

Clients are asked to complete feedback forms after sessions. Several types of feedback were tried in Phase 3, and not all were used in all sites. A very brief one used a pictorial rating of the session (5 choices from 2 frowns to 2 smiling faces) and space to write ways the session could have been improved. A second, slightly longer form allowed for three ratings with five choices; did the FNs listen to them ('not at all', to 'all the time'), did they feel involved in group ('not involved', to 'involved with all group members') and did group members get on well ('not at all well', to 'really

enjoyed each other's company') and three open-ended questions (the best thing, ways to make the session better and other topics they would have like to cover).

A longer form was designed to be used intermittently during pregnancy sessions and was used in some sites. It covered what the client liked about the past 3-4 groups, anything they did not like or that would have made the sessions better, the same five-point pictorial rating of the most recent group, the same five point rating of whether they were listened to by the group leaders ('not at all', to 'all the time'), and a five point rating of how well the group worked together in the last session ('not at all', to 'worked well together all the time') with an open ended questions to explain what they gave that rating.

Additional questions asked what stage they were in their pregnancy, whether the amount of help with the self-care had been appropriate (five points from 'too much' to 'too little' help), and whether the amount of privacy had been appropriate (five points from 'too much' to 'too little'). In total 570 participant feedback forms were analysed, 489 completed by clients and 81 by partners.

#### b) Professionals

As soon as possible after each session FNs and co-facilitators completed a feedback form indicating their thoughts about how the session went. In one site each facilitator completed her own form and in the other sites the two facilitators completed one form jointly. Two different forms were available, one for pregnancy and the other for infancy, but in some locations the pregnancy one was used throughout. Both versions provided rating scales ranging from 1 to 10 for judgements of how interested the group had been and how engaged they were with learning and change. Open ended questions covered the overall group dynamics, relationships between group members, engagement with the content, the impact (if any) members being absent, whether all content was covered, reasons why it was not covered, the extent to which mothers participated in their own health checks and those of their infants, the facilitators' strengths and learning from the session, and any other reflections. The pregnancy questionnaire included open-ended questions about partner involvement. The infancy questionnaire included a question about the impact the presence of the babies had on the session but no question about the involvement of partners. In total 82 feedback forms were completed by professionals in pregnancy (55 by FNP staff or jointly with their co-facilitator and 27 by non-FNP staff) and 78 in infancy (55 by FNP staff or jointly with their co-facilitator and 23 by non-FNP staff).

### 1.3.4 Semi-structured interviews

#### a) Clients

Face to face interviews were conducted with 12 clients from all four sites and 3 of their partners during the early infancy phase of the programme. In addition telephone interviews were conducted with 9 clients from 3 sites after the completion of the programme, when their infants were 12 months old. In the fourth site telephone interviews were not conducted as the programme had finished some months earlier, soon after the first interviews, due to low attendance.

Questions in early infancy focused on the recruitment process, experience of the group (including any materials that contributed to their enjoyment of the sessions), and the nature of relationships within the group and with the facilitators, the acceptability of midwifery care within the sessions and how they felt about partners being included in the group. Questions after programme completion covered maintaining participation throughout programme delivery, perceived impacts of gFNP for themselves as parents and for their infants and contact with other professionals subsequent to the conclusion of gFNP.

## *b) Professionals*

In total 26 interviews were conducted with professionals. Two face-to-face semi-structured recorded interviews were conducted with each the four FNs delivering the programme (one from each site) and one final telephone interview with FNs in the three sites that offered gFNP until infants were 12 months, plus one supervisor who took the facilitator role. Interviews were also conducted with the four community midwives and the four local Children's Centre family support workers who co-facilitated the sessions with the FN during each stage. Two family Support workers also took part in telephone interviews at the conclusion of the programme. Additionally, four Children's Centre Managers were interviewed to gain a broader perspective within the context of children's services.

The first interview with the FNs and the midwives concentrated on the recruitment process including any issues with the community midwifery units who made the potential client referrals, availability of information about the clients, the eligibility criteria and any barriers to effective recruitment. There were also questions about the training provided for their role, time available for preparation and planning for each session, completing the required paperwork after the sessions, client engagement during the sessions, the handover at the end of the pregnancy stage of the programme and their relationships with their co-facilitators.

The second interview with the FNs focused on the changeover of facilitator between the pregnancy and infancy stages and how it affected them as session leaders, and their general perceptions of the revised model of delivering gFNP. The family support workers were asked about their training for the role of co-facilitator, how they felt about taking over from the midwife in the infancy stage, the time available for preparation for each session, their thoughts about the materials used and the engagement of clients and their partners. The third interview with FNs and FSWs focussed on participation to the end of the programme, the factors that they linked with high or low participation, possible impacts of gFNP and their role in delivery in infancy and any perceived gaps in training

Children's Centre manager interviews focused on their awareness of gFNP, the effect on other family services and impact on the young women and their babies who received gFNP.

### **1.3.5 Focus groups**

In early infancy clients and their partners were invited to take part in focus groups at each of the four sites, but due to programme discontinuation a focus group was not held in the fourth site. In total 16 clients plus their babies and 4 partners attended focus groups. Clients and their babies attending two of the groups and clients, babies and partners attended the third group. Themes for discussion within the focus groups were similar to those addressed within the individual interviews.

Three FNP supervisors took part in a group discussion after gFNP was completed in all sites to discuss specific issues pertaining to supervision for gFNP, the potential for the involvement of male professionals in delivering gFNP, and their thoughts on future delivery of gFNP using the phase 3 model.

### **1.3.6 Qualitative data analysis**

The interviews and focus groups were digitally recorded and then transcribed with appropriate anonymisation so that themes could be identified. They were read and re-read to identify themes relevant to the questions posed within each of the research question subheadings, namely: recruitment, role of professionals, client participation, partner participation, and potential programme impact in relation to the programme content and mode of delivery.

Given the small number of professionals interviewed at each site, to preserve anonymity quotations are identified only the nature of the professional and not by site or any identifying number (Family Nurse - FN, Midwife -MW, Family Support worker – FSW, FNP supervisor – Sup, Children’s Centre Manager – CCM).

To demonstrate that a range of views has been reported, clients’ quotations are identified by whether or not it is the first or second interview and the client’s random number, which is random and differs for first and second interviews and is also unrelated to the site, to assure anonymity (e.g. first face to face interview with client 3 - C1:3, second telephone interview with client 7- C2:7).

## Chapter 2 Recruitment

Referral to gFNP is reliant on robust pathways, a clear understanding by referrers of the eligibility criteria, the capacity of referrers to make a sufficient number of referrals in a short time, and the acceptability of the programme when offered to clients.

This chapter addresses the following questions and provides reflections on the recruitment pathway and processes:

- *What issues have emerged with regard to the process of identifying potential gFNP participants and making referrals?*
- *What issues have emerged using the current eligibility criteria based on maternal age, parity and low educational achievement?*
- *How easily and effectively can the current or revised eligibility criteria be applied in a service setting?*
- *What percentage of referred women was enrolled?*
- *What (if known) are the reasons for accepting or declining the offer and what are the characteristics of enrolled and non-enrolled women?*

### 2.1 Identifying potential participants

- *What issues have emerged with regard to the process of identifying potential gFNP participants and making referrals?*
- *What issues have emerged using the current eligibility criteria based on maternal age, parity and low educational achievement?*
- *How easily and effectively can the current or revised eligibility criteria be applied in a service setting?*

The recruitment process starts at the point the referrer, in these sites the community midwife, sends details of an expectant mother to the FNP team. To be viable a group needs to have at least eight members and can include up to twelve. The number of referrals to gain sufficient for a group [minimum of 8] ranged from 38 to 103 (see Table 2.1).

Some of the information about referred women is routinely available in midwifery records (e.g. age, parity, EDD, address) and was required by the gFNP team in order that they could proceed with contacting potential participants. This was not always the case. A key issue related to receiving referrals was that community midwives were either unaware of or unclear about the basic criteria for referral to gFNP, resulting in a lack of information on the referral slips and inappropriate referrals.

*"...maybe just a name and how many weeks pregnant, we didn't even know if she'd got other children, whether she worked or not, we didn't know any of this." (FN)*

Thus whilst at first it may have appeared that there were plenty of potential referrals, there was a substantial increase in the number of initial recruitment phone calls by the FN (and/or the gFNP MW) to prospective clients who did not meet the criteria. In particular the address was not always provided. This is important because one of the aims of gFNP is to bring together women living in similar areas, all able to reach the children's centre where the group was held. In three of the four areas the details forwarded to FNP teams included only women living in the appropriate postcodes, which meant that they would be sufficiently close to the Children's Centre where the programme was provided. However in the fourth area geographical location was not checked leading to more than one hundred names being sent to enable a group of eight to twelve to be recruited. Another issue regarding the client referral route was communication with community midwifery since there

was a lack of understanding that – given the narrow EDD range for the group – referrals had to be made promptly.

Only one site reported plenty of referrals from the local community midwifery team. Two sites in particular initially received an inadequate number, or received many that did not meet the criteria. In one site, when no referrals had been received, after a meeting with the gFNP supervisor, the local midwifery manager went to the clinics herself and looked through the ante-natal files for potential referrals and passed these on to the gFNP team. At another site the referrals were relatively numerous, but their expected delivery dates (EDDs) ranged over a span of about 4 months rather than the required six to eight weeks.

A different and more successful approach was taken in one site through developing a liaison with a health visitor in the local hospital midwifery unit. She was able to send details of almost all new pregnancies to the gFNP supervisor who then sifted through the numerous records to narrow the field for possible recruits.

Comparing the recruitment process for FNP with that for gFNP, one FN stated she had found it:

*“...much more challenging because we had a lot of issues with communication with community midwifery, so right at the beginning we weren’t getting the referrals through.”* (FN)

The recruitment process following a referral was mainly led by the FNs and assisted by the community midwives (MWs) designated to co-facilitate gFNP. FNs reported that, compared to recruiting for FNP, it was more difficult for two reasons: firstly because of the lack of information generally about the client including their telephone number and secondly, because of the introduction of the educational criterion. They felt that on occasion valuable time was wasted either on lengthy telephone calls or on home visits to ascertain client suitability for the programme only to find that they were not eligible.

Some referred women were never contactable but, of the remainder, between one third and one half were eligible (see Table 2.1) with the most common reason for ineligibility being that their educational qualifications exceeded the required level (28-40%), with a smaller number having experienced a miscarriage or exceeding the limit of 28 weeks gestation, suggesting that referrals made too early or too late can be an issue.

Educational qualifications are not routinely discussed in midwifery booking sessions (though the practice varies across the country) so it was understood that gFNP professionals would need to check that with 20 to 24 year olds prior to making an appointment to visit them at home. After receiving referrals and checking that the age, parity, EDD and address were appropriate, the next step was for the gFNP team to contact the referred women to determine complete eligibility – predominantly asking about educational qualifications – to explain in detail about the programme and then to see if they were interested in a home visit so that they could be told more about receiving gFNP.

Unnecessary home visits could be avoided by asking some preliminary questions over the telephone but FNs initially found it challenging to ask clients about their educational qualifications in this way. However, after preparing and practicing short scripts, they reported that the conversations with potential clients became easier, which reduced the number of home visits to ineligible women. Nevertheless, FNs reported reservations about the utility of the educational criterion because they thought that in some cases that the young women claimed to have qualifications they did not have, thus leading to an inaccurate decisions of ineligibility.

*“...sometimes you got the idea that some girls maybe they were making up one or two qualifications because they didn’t want it to appear they hadn’t got any...”* (FN)

In other cases young women considered vulnerable and therefore suitable for gFNP met all other criteria for recruitment but were over-qualified educationally.

Whilst the FNs might have encountered some difficulties during the recruitment process for gFNP, the newly appointed MWs reported they definitely found the recruitment process a challenge for a number of reasons. These included the criteria being overly restrictive, lack of time before the sessions started, unsuitable referrals and lack of referrals from their colleagues in community midwifery.

*“Horrific. Very, very stressful.” (MW)*

*“I felt like I was knee deep in mud and I just couldn’t get out, it was so, so difficult. We were supposed to get the referrals from the MWs who had already cherry-picked who they thought would meet the criteria, and then when you rang them and questioned them further, they didn’t meet the criteria. There were just so many obstacles that even getting MWs to refer in the first place was really difficult. There were a lot of barriers there, and as a MW I’m completely ashamed of that...” (MW)*

*“It was a nightmare. The criteria were so tight. If we had more lenient criteria we could have done it in the time we had. Or if we had more time prior to the group starting even with the criteria as it was.” (MW)*

In one site where the FN was absent due to extended leave the newly appointed gFNP midwife had been required to carry out much of the recruitment and this had not been successful. On reflection, the FN felt this had not worked very well because the midwife had not fully understood and consequently not fully explained what gFNP was about or the *commitment* that was required from the client.

*“...the few people we had coming at the beginning thought it was just going to be some ante-natal care and they would just leave afterwards...I think had I done all of it I would have been firmer about what was expected, the commitments, the boundaries...” (FN)*

## **2.2 Taking up the offer of gFNP**

- *What percentage of referred women was enrolled?*
- *What (if known) are the reasons for accepting or declining the offer?*
- *What are the characteristics of enrolled and non-enrolled women?*

### **2.2.1 Percentage enrolled**

After potential group members have been identified and found to be eligible, the next step was for them to accept the offer of gFNP, usually during the first home visit although in some cases more than one visit was made. Acceptance of the offer of gFNP by those definitely eligible for the programme ranged from 11/27 (41%) in site 1 to 9/10 in site 4 (90%) (see Table 2.1). However, there was some confusion in the data making the overall figures difficult to summarise accurately. In site 3, four of the six who were recorded as accepting the programme, enrolled and given an ID number, were also recorded on the UK050 as refusing, the reason being that they then failed to attend any sessions. In other sites clients who accepted and subsequently miscarried were also double coded as enrolled and not eligible. Thus in future delivery of the programme it will be sensible to enrol the maximum number of clients (12) or even slightly more with the expectation that between recruitment and the first group meeting they may change their mind or may experience a miscarriage. It will also be important to develop clearer guidance about when to create ID numbers. While this is also true for home-based FNP it is more straightforward to then open up a space on the FN’s client list whereas the group, once selected, cannot easily be added to without disrupting the group process. No information was available about reasons for refusal.

Table 2.1 Referrals and their dispositions by site, from UK050G (percentages by site are based on eligible + ineligible, excluding those whose eligibility was not known)

Disposition of referral	Site 1 N=52	% for site	Site 2 N=45	% for site	Site 3 N=38	% for site	Site 4 N=103	% for site
<b>Eligible plus ineligible</b>	<b>47</b>		<b>43</b>		<b>30</b>		<b>88</b>	
<b>Definitely eligible</b>	<b>27</b>	<b>57.4</b>	<b>15</b>	<b>34.9</b>	<b>15</b>	<b>50.0</b>	<b>10</b>	<b>11.4</b>
Eligible and Enrolled in programme	11	23.4	10	23.3	9	30.0	9	10.2
Eligible and Refused	16	34.0	5	11.6	6 <sup>1</sup>	20.0	1	1.1
<b>Definitely not eligible</b>	<b>20</b>	<b>42.6</b>	<b>28</b>	<b>65.1</b>	<b>15</b>	<b>50.0</b>	<b>78</b>	<b>88.6</b>
Not eligible, qualifications	13	27.7	17	39.5	10	33.3	18	20.5
Not eligible, >28 weeks pregnant	0	0	3	6.7	0	0	1	1.1
Not eligible, miscarried	0	0	3	7.0	2 <sup>2</sup>	6.6	1 <sup>3</sup>	1.1
Not eligible, not in right area	1	2.1	0	0	0	0	54	61.4
Not eligible other reason	6	12.8	5	11.7	3	10.0	3	3.4
Not eligible, language issues	0	0	0	0	0	0	1	1.1
<b>No eligibility known</b>	<b>5</b>		<b>2</b>		<b>8</b>		<b>15</b>	
Unable to Locate	5		2		8		8	
Not approached, group full	0		0		0		7	

### 2.2.2 Reasons for acceptance

To ensure a good recruitment pathway it is important to understand why women accept the offer of this particular programme. Clients were asked about their reasons for accepting the offer of gFNP during individual interviews and focus groups. It would have perhaps been even more interesting to find out why some refused, but that is beyond the scope of this evaluation. It must be kept in mind that the question of reasons for acceptance of gFNP was posed after clients had been in receipt of the programme for several months. Thus their responses are likely to have been influenced by what they perceived to be the advantages of a group context for support.

Responses were generally positive about the fact that it was a group, preferring the idea of being in a group than to receiving a one-to-one service (though by definition these women were not eligible for 1 to 1 FNP), and it was widely perceived as a 'good idea'. The view generally expressed was that discussion within a group setting would be more beneficial than in a one to one session because there would be a wider pool of experience and opinions to draw on. Other reasons given included the perception that as a 'first time mum' gFNP would provide information about pregnancy and

<sup>1</sup> 4 refusals also listed as enrolled

<sup>2</sup> 1 miscarried also listed as enrolled

<sup>3</sup> 1 miscarried also listed as enrolled

looking after a baby, and there was also the understanding that it would offer more than routine ante-natal care with the approach being more 'personal' rather than 'clinical'. There appeared to be a general understanding that being in a group would offer more support, more information about being pregnant, and more ideas on how to look after the baby; there would also be the opportunity for company and to make friends thus reducing the isolation often felt by new mothers.

*"I think it's better that it's in a group because then we can all chat to each other about our experiences with the babies and when they are a bit older they can all sort of play together..."* (Client, focus group)

*"A lot better (than one to one), being pregnant with other girls and everyone being able to share their experiences, I thought it were real good..."* (Client, focus group)

*"...I wanted to do it, it were good and the fact that I were a first time mum as well, that it would help me learn things I needed to learn especially with me being pregnant."* (C1:2)

### 2.3 Characteristics of enrolled clients

While there were clear criteria for eligibility it is useful to look at the characteristics of women who accepted gFNP, in particular whether they had any additional vulnerabilities, since age and educational qualifications are used as proxies for those clients found to benefit most from one-to-one FNP, women with fewer 'psychological resources' (Olds, 2006).

*Demographic characteristics:* Age was available on the UK050G form for most of the 39 enrolled clients (N=37). The average age was 20.7 ranging from 18 to 24; nine (24%) were under 20. Demographic information was available using the UK010G form for 27 of the 39 enrolled clients. The majority (23, 85%) were white British, with one Asian, one Black and two of mixed ethnic background. Just over half (15, 56%) were cohabiting, one was married (4%) and the remainder (11, 41%) were single. Asked about living arrangements, 11 (41%) lived with their partner, the remainder with partners living with both their partner and extended family or friends (5, 18%). Six (22%) lived alone and 5 (18%) lived with extended family members. The majority (21, 76.9%) saw their expected baby's biological father daily and only 1 did not see the biological father at all. The majority (22/26, 85%) were renting unfurnished, 9 of whom renting from the local authority. Only 4 (15%) were living in accommodation being purchased with a mortgage.

Clients were identified in part on the basis of having fewer than 5 GCSEs at grade C or above. This information was available for 25 clients based on the UK010G form. The average number of any GCSEs was 4.4 (range 0 to 13) and the average number of GCSEs at grade C or higher was 1.3 with a range from 1 to 10; 15 clients (60%) had none and all but one of the remainder (9, 36%) had between 1 and 4. The one client who had more (10) was aged 18 and therefore would not have been required to fulfil this criterion. Thus the recruitment was successful with respect to this aspect of eligibility.

Just under two thirds (17/27, 63%) had been employed at some time but fewer were employed at the time of enrolment, five (19%) full time and two (7%) part-time. Household income was available for 25 clients; six (24%) were completely reliant on benefits, ten (40%) had a weekly income of less than £150, four (16%) had a weekly income between £150 and £249, and five were in households with a weekly income of between £350 and £499.

*Health and well-being:* UK005G forms describing maternal health at intake were available for 24 clients indicating that 18/24 (75%) had been pregnant before, most once (12) or twice (5) with one client reporting four previous pregnancies. No information was recorded about previous live births.

One quarter (6, 25%) reported experiencing asthma, 5 (21%) reported experiencing frequent UTIs, one reported frequent STIs, and five (21%) reported having experienced mental health problems. No client was reported as having heart problems, high blood pressure, diabetes, kidney problems, sickle

cell anaemia or gastric problems. BMI information was only available for 22 women, with a mean of 24.7 (range 16.3 to 44.0). Of the 22 with information, three (14%) were underweight (<18.5) and eight (36%) were overweight (>25), with three of these (14%) in the obese range (>30).

*Health related behaviours:* Details about health related behaviours at intake were available for 28 clients on the UK006G form. A relatively high proportion (23/28, 82.1%) indicated that they had ever smoked but fewer (18/28, 64.3%) had smoked in the previous 48 hours. For the 18 who had smoked in the previous two days the mean number of cigarettes smoked per day was 6.5 with a range from 2 to 15. Only two of the 28 (7%) reported having had any alcohol in the previous 14 days and a different two clients (both smokers) reported using marijuana in the previous 14 days.

*Relationship:* Enrolled clients are asked about experiences of violence in relationships. Only 23 UK007G forms were completed and of those, more than half (12, 52%) indicated that at some time in their life they had been physically or emotionally abused. A smaller number (4, 17%) reported having been physically hurt in the past 12 months; for one it was during the pregnancy. One client reported a forced sexual experience in the previous 12 months and two reported that they were fearful of someone they know, for one a family member and for the other an ex-boyfriend.

## **2.4 Summary of recruitment issues**

As with home-based FNP, the main criterion for enrolment in gFNP is young maternal age, though the age range is extended for gFNP up to 24, with a specific EDD range so that the women will have similar delivery dates. An additional limitation is that clients in the 20 to 24 age range should have few or no educational qualifications. Compared to recruiting for home-based FNP, the FNs at all four sites reported encountering problems during the process of recruitment to gFNP. This was due both to issues concerning the information received (or not in some cases) from community midwifery and to difficulties related to managing the educational criterion, which had not been applied in Phase 1 of gFNP. In some cases there were very few referrals. Referrals received from community midwifery highlighted a lack of clear understanding regarding the criteria for gFNP. It was also evident that in many cases there was insufficient information on the referral slips that were passed onto the gFNP teams.

A more successful approach in one site involved developing a liaison with a particular individual in the hospital midwifery unit who sent records of all new pregnancies to the gFNP supervisor who then sifted through them to narrow the field for potential recruits. Nevertheless, although possibly more efficient this placed a much heavier burden on the FNP team than had been anticipated, in that they were doing what they had hoped community midwifery would do. In all sites FNP teams had to check with referred women about their educational qualifications which involved a substantial number of phone calls and home visits.

FNs reported reservations about the utility of the low educational criterion as a requirement for participation in gFNP. They felt in some cases the young women claimed to have qualifications they did not have thus placing themselves outside the criteria. In other cases some young the women were over-qualified for the programme but appeared to be extremely vulnerable and met the other criteria for recruitment. However, in most of the sites the issues were resolved to a certain extent (by some adjustment to the criteria) and sufficient clients were recruited to form a viable group to enable them to start to deliver the programme. In the future recruitment strategy will probably require more effective communication with the community midwifery unit, manifest by a thorough understanding of the recruitment criteria at all levels. In addition efforts will be necessary to ensure that all the relevant information is included on the referral slips. Taking this approach would maximise opportunities for recruitment within the specified delivery time frame for client due dates and eliminate numerous extra telephone calls and visits to young women who do not meet the programme criteria.

Once found to be eligible a substantial proportion of the women took up the offer of gFNP. The young women who were interviewed individually or expressed their views during the focus groups had accepted the offer of gFNP because they liked the idea of joining a group where they would meet other 'mums' like themselves and make new friends. There would also be the opportunity to learn about pregnancy and how to look after their babies. An added attraction for many was the increased contact with a midwife providing more 'personal' care than that offered by routine antenatal care.

In phase 3 of delivering gFNP the resulting client group has a range of other risk factors making it likely that they will gain from experiencing gFNP. For those with information there was evidence of additional vulnerabilities. For example, half were under or overweight, one in five had at some time had mental health problems, more than half reported emotional or physical abuse experiences in their past, some still on-going, most were not currently employed, and while many were living with their partners this was often in a household with other family members and in rented accommodation, with generally low income or reliance on state benefits. However there is a proviso when interpreting this information; demographic, health related and relationship data were not available for all 39 enrolled clients. For some data forms only just over half that number were completed. In future delivery it would be important to ensure that these background characteristics forms are completed for all clients, so that programme delivery and client progress can be understood in relation to client characteristics.

## Chapter 3 Professionals' Perspectives

The Phase 3 model of gFNP adopted a modified approach to programme delivery compared to previous phases in that a mix of group facilitators was introduced. Rather than two FN's, one of whom also a midwife, for Phase 3 the programme was provided by one FN who acted as the lead facilitator throughout the programme with a local community midwife (MW) as co-facilitator during the pregnancy stage and a local child and family worker (FSW) during the infancy stage. In this chapter professionals' perspectives are discussed in relation to this new model of programme delivery. The following questions were addressed in interviews:

- *What does each of the professionals involved in delivering gFNP in the Phase 3 model think about their own role, and that of other professionals?*
- *What does each of the professionals think about their own preparation for the role, and support received to enable them to be facilitators of change?*
- *What is the time involvement, and associated cost, for each staff member as they prepare, plan and run groups and for their training and supervision? What are the incidental costs, such as for childcare at the venue, other expenses, travel etc.?*
- *What do associated professionals (e.g. FNP supervisors, Children's Centre managers) think about delivering gFNP using the Phase 3 model?*

Interviews were conducted with the family nurses, the community midwives and family support workers who acted as co-facilitators, the FNP supervisors and, in order to place gFNP in wider context, interviews were also carried out with Children's Centre Managers. They were not directly involved in delivering the service, but were in a position to provide a broader professional perspective on its impact and future locally. The chapter focuses on a range of themes that emerged from the semi-structured interviews (see Figure 3.1) covering views about the different roles taken when delivering gFNP, the training and preparation for their roles, how delivering gFNP impacted on work-loads and time management, the supervision issues including the impact on the FNP team and finally thoughts about the future of the Phase 3 model of delivering gFNP



**Figure 3.1 Themes on Professionals' Perspectives**

### 3.1 Role perceptions of self and others

- *What does each of the professionals involved think about their own role, and that of the other professionals?*

#### 3.1.1 Family Nurses (FNs)

Family Nurses saw themselves, not surprisingly given their greater knowledge of the programme, as leading the delivery of gFNP and expected they would be supported in this task by the midwives and family support workers who were their co-facilitators. They envisaged their role as supporting the clients and their infants until the infants reached twelve months and ensuring the delivery of the Health Child Programme. They also considered that they were predominantly responsible for establishing a 'safe container' for the group to operate within i.e. a place of trust and confidence where learning could take place; they followed the FNP methods in that learning would be achieved by eliciting and affirming existing knowledge as well as providing any missing information for the clients.

However, for the most part the FNs reported they did not feel adequately supported by their co-facilitators in delivering the programme. It felt to them as if they were teaching not only the clients but the facilitators as well, thus there was no real sharing of responsibility. They had noticed at training that the MWs in particular were finding it difficult to grasp the idea of motivational interviewing which is a key aspect of delivering the gFNP curriculum. They were not used to working in a strength based, non-directive way and they did not grasp the idea of letting the group come up with the information, nor were they experienced at working in a group context. This placed pressure on the FNs. This was not quite so likely in infancy when the Children's Centre staff took over. In particular two FSWs had substantial experience of delivering to groups and were able to give more support to the FNs in terms of programme delivery, taking a more shared role.

*"I think my role was to lead the project and to train the co-facilitator (MW) to enable her to fulfil her role. I think this role was very difficult to do with somebody who has no real understanding of the approaches and styles required for FNP. Because it was so time consuming this required a lot of time which I needed for my own existing caseload. The co-facilitator did not understand well how to use the group setting and she felt her training was inadequate. Her confidence did improve but at times it felt like she was another group member. She was lovely, kind and helpful but it felt onerous at times and supervision did not address this." (FN)*

*"It was pretty evident when we started. I'm used to the programme, I knew what was coming, I knew how to do it, but the MW wasn't. There was a lot of teaching and facilitating and [MW] wanted more time for preparation, wasn't exactly sure what she was doing and how she was doing it." (FN)*

Comments on the reflective forms (completed after each session) echoed the sentiments expressed in interviews.

*"Aims may need more explaining to MW"*

*"Felt MW not prepared for the session but it did go well"*

*"Encourage MW to develop leadership skills"*

Another aspect of their role that required more input from FNs than the co-facilitators was the record keeping inherent in gFNP, completed following each session:

*"The record keeping has to be done by me. For example two of the infants in group have needed paediatric referrals so that's been time consuming doing those and then following them up and*

*ensuring that they attended the appointments ... I know that in the past it has been run by two FNs; that would share that workload.” (FN)*

A major challenge for the Phase 3 model of working was the transition from the pregnancy to the infancy stage with the attendant change in co-facilitator. During the pregnancy stage of the programme they had worked hard at building up a working relationship with their new and relatively inexperienced MW co-facilitator and overcome some of the difficulties of adjusting to someone who had a different teaching style to them, as well as less knowledge of the programme. When making the transition from pregnancy to the infancy stage, when the MW was replaced by another professional (the FSW) they needed to have to repeat the process and start from the beginning again in terms of matching teaching styles.

*“It felt quite hard at the time the transition itself...you are working with somebody different, you’ve got to get to know their learning and teaching style.” (FN)*

However, if the FSW had previous experience of teaching a group and particular skill in doing so the transition was made easier.

*“The MW required more support than the Children’s Centre worker as she was less experienced in group work and MI style of communication...I found this difficult at the beginning as I felt the whole group responsibility was on my shoulders. The Children’s Centre worker was not only an experienced group leader but also in the MI communication style and I could sit back and relax a little knowing that she could share the responsibility. I only needed to show her the material we had and she could deliver.” (FN)*

In summary, the FNs had reservations about the multi-agency or partnership working for a number of reasons, chiefly because they were likely to feel that they were teaching their co-worker as well as the group and the co-workers had not fully grasped the FNP concept of motivational interviewing which is crucial to FNP. They found it challenging to deliver the service as the only FN and without exception stated the situation would have been greatly improved had they delivered the service alongside another FN. However they realised that, if the service was being delivered locally on a regular basis, these issues would be likely to diminish as long as the co-facilitators remain constant.

### **3.1.2 Midwives (MWs)**

The community midwives who co-facilitated the pregnancy phase of gFNP perceived their role principally as providing the midwifery checks to the young women in the group while supporting the FN to deliver the programme was seen to be secondary. Nevertheless, good relationships did develop and one interviewee stated she felt she bonded with FN and they they worked well as a team. There was recognition of the greater experience of the FN both in delivering FNP and in working within a group context.

*“..it is very FNP led, so it’s very much FN expertise and I was there for the MW side but in the delivery of the programme there is not a lot of MW stuff so I was assisting the FN to deliver her programme” (MW)*

*“I think FN is brilliant...I really admired her. I think that comes with being a family nurse in practice. She’s had a lot more experience than me – I was sometimes in awe of her as she would just take questions and put it back to the group for discussion and then we would be able to move back and cover what we had set out to cover...” (MW)*

Some of the midwives reported anxieties about working in a different way from their usual practice and that initially the motivational interviewing approach was challenging. In addition they were unfamiliar with the gFNP materials. They did not feel fully prepared after training (covered in section 3.2.2). Comments made by midwives on the reflective forms completed after group sessions support the remarks made in their interviews.

*“Unsure of content at times”*

*“Did not feel prepared...”*

*“Unprepared, did not flow well”*

However, over time most midwives gained confidence and their reflective comments appear more positive in the later ante-natal sessions.

*“Felt more confidence with material”*

*“More relaxed this week”*

*“Well paced, all content covered”*

One particular aspect of the midwifery role was to conduct health checks according to NICE guidelines and to facilitate women conducting their own checks. This was not an issue for one midwife as she was already adopting a similar approach with her local midwifery team where active participation amongst the pregnant women is encouraged. However, when applying this approach within gFNP she found there was not enough time within the sessions to wholeheartedly adopt this strategy. A second interviewee thought it was a very good idea but also came up against time constraints when trying to put it into practice.

*“I think it was a brilliant idea...women aren’t stupid, they are capable of testing their urine and actually they loved being involved...(but)because of the time frame it made it very difficult.” (MW)*

The remaining two midwives who were asked this question were more circumspect in their responses. Accountability was the main reason stated for their reservations about clients conducting their own health checks.

*“...very scary for me because it is ultimately my responsibility at the end of the day and I didn’t want anything to be missed—but I did my ante-natal checks as per the NICE guidance- anything they did was extra for themselves...it’s my registration on the line.” (MW)*

*“I think it made me slightly nervous, it probably still does...from the accountability point of view, but I think it’s good.” (MW)*

The Phase 3 model of gFNP involved a change of co-facilitator at the end of the pregnancy phase of the programme and a handover of responsibility from the MW to the FSW but concern was expressed by MWs that clients, having built up a relationship with the midwife, would find it difficult repeating the process with the FSW during the infancy stage of the programme. Midwives also became attached to their clients and found it difficult to leave the group.

*“It was quite hard because you got used to doing it and you got used to seeing all the girls.” (MW)*

*“...I found it hard because I had become so involved with them...” (MW)*

Of the four midwives interviewed, one reported a trouble free handover to the family support worker but the remaining three found this transitional period challenging. In the site where things had gone more smoothly the introduction of the FSW during several ante-natal sessions was effective and she started to get to know the clients before she took over the post of co-facilitator. The clients were then well prepared for the changeover.

Nevertheless in other sites this was not so successful and criticism was expressed about the handover between MW and FSW had been handled and the fact that for some sessions both co-facilitators were present. There was the view that bringing the FSW into ante-natal sessions caused confusion amongst the clients. Since births occurred over several weeks, it was also necessary for

there to be some overlap in the first infancy sessions so that midwifery post-partum checks could be provided for women delivering later. This overlap caused one MW to feel 'disjointed' as she continued to attend the group sessions for longer than expected in the infancy stage instead of finishing at the end of pregnancy.

### 3.1.3 Family Support Workers (FSWs)

The FSWs' understanding of their role was that it was to co-facilitate group FNP, to share the planning and delivery with the family nurse so that they supported each other in the delivery of the service. Perhaps understandably, those who had previously worked with families (including women and their partners) in a group setting felt less daunted by the challenge than others who lacked this experience.

Working in a non-directive way could also be challenging because previously FSWs had been more used to giving advice and trying to 'fix' clients' problems for them. This was referred to as the 'righting reflex' which was in contrast to taking a strength-based approach and using motivational interviewing. Thus a key perception of their role compared to previous work was the move from being a fixer to being a facilitator.

*"...a lot of the clients we work with in the Children's Centre come to us at crisis point and you pretty much want to fix it really, and that righting reflex was quite strong before I started gFNP...you want to pick up a phone and signpost them somewhere that can sort something out straightaway...you want to save time, you want to stop the distress and I realise now through gFNP that we try to encourage them to do it for themselves." (FSW)*

*"I found the way you had to approach the young people quite challenging: you change the way you talk and that's quite challenging to grasp..." (FSW)*

Perceptions of the transition from the ante-natal period to the infancy period and taking over from the MW varied. The FSWs felt it was not a particular problem for the clients as the FSWs had joined them for a few sessions beforehand and they had started to get to know each other. However there was concern that, after the FN had worked hard to build up a 'safe-container' for the group, being introduced as new facilitators they did not want to damage the group's confidence and security.

## 3.2 Training and preparation for their role

- *What does each of the professionals think about their own preparation for the role, and support received to enable them to be facilitators of change?*

### 3.2.1 Family Nurses

On the whole FNs reported that they were reasonably well prepared after their training and did not need much further preparation for delivering the gFNP programme, although one issue not covered in detail in their training was how to include client's partners in the group. The FNs were confident about working in a group context because they had done this previously. Nevertheless, an aspect of the training that was appreciated was learning how to use motivational techniques which they used to deliver one-to-one FNP within the group context:

*"I thought the MI training was very good because that works differently from one to one, having to manage ten people's needs, to get what they want out of it. That was a big challenge." (FN)*

However once the programme was underway it became evident that, although the FNs felt prepared, their co-workers did not and some were experiencing difficulties delivering the sessions at the beginning. Their training did not prepare them adequately for the role of guiding their co-facilitators.

It was also suggested that possibly training should have included how to manage the delivery of all of the content of the sessions. FNs initially thought that their role involved ensuring that the full content of every session was delivered as per the programme which was different to their one-to-one role in FNP where they would 'agenda match' with the client if other issues arose. However at a subsequent mentoring session it became clear that this was not necessarily the case; it was clarified for them that 'agenda matching' was as relevant in group work, though a more complex task with many and possibly contrasting agendas to match.

### 3.2.2 Midwives

After their initial training, one midwife reported she felt well prepared for delivering the programme, another was reasonably confident after the preparation but felt she learnt more once programme delivery had begun and the remaining two felt unprepared, particularly given the difference from their routine practice. The idea was also expressed that having worked in a particular (more directive and 'expert') way within the NHS for a number of years and then being expected to switch to a completely different (motivational) approach was an issue which was not adequately addressed during training.

*"...that first lot of training...it just threw up more questions and it's a completely different way of working. I've been in the NHS for twenty years and that is something I have never done before...so to ask me to change something I had been doing for twenty year was hard." (MW)*

Whilst all had previously delivered information to groups (e.g. ante-natal classes) some specific differences were noted and more training sessions on delivering to groups using a non-directive approach would have been useful. It was thought that this had not been covered adequately during the training. While all had found the training interesting and acknowledged they were being given some background knowledge of FNP, there was the general perception among the midwives that they needed more detailed information about how to perform their specific tasks in the programme, supporting the FN rather than co-presenting all the content.

*"I wanted more about actually delivering to a group" (MW)*

*"...we weren't training to be FNs –I am fundamentally a midwife, I didn't want to do the FN training, I wanted more on my role with supporting the FN to deliver the group" (MW)*

Added to this it appeared that their presence on the training course had not been adequately explained to the trainers, who appeared to be confused about why the midwives were attending a routine one-to-one FNP pregnancy course. The situation improved later in the week when they were grouped together and separately from the trainee FNs, with the focus switched to delivering gFNP.

*"Nobody seemed to know why we were there, including the trainers." (MW)*

*"...we didn't know our role really, and they didn't have a clue why we were there, and it was all very daunting." (MW)*

*"Further on in the week I think they realised, then we were put in a group and we had the group FNP trainers and that was much better, more directed to the groups because we had loads of questions." (MW)*

### 3.2.3 Family Support Workers

In terms of training, three of the four interviewed felt well-prepared for their role as co-facilitators alongside the FN, although two stated that the time-lag of several months between finishing the training and starting the service was too long (they had been trained together with the FNs and midwives, but did not join the groups until several months later, at the start of the infancy sessions).

*"I felt a lot of my learning had been lost..." (FSW)*

As with the MWs, comments were made about the apparent confusion when they arrived for their first week of training which was for FNs delivering one-to-one home-based FNP. There was the impression that the trainers were unsure as to where they fitted in with this particular phase of training. However all found the training they did take part in beneficial and interesting.

*"It took quite a while for the facilitators to know what to do with us...we felt a bit out on a limb...so we got put together in our group (of gFNP facilitator trainees)." (FSW)*

One of the four was a late starter in terms of recruitment and training and missed out on group training altogether which left her lacking in confidence in delivering to a group. Comments on session feedback forms suggested that they continued to think they needed more detailed knowledge of the curriculum and the materials:

*"I need to be more familiar with the PIPE materials."*

*"I will read the material to be more familiar"*

### **3.3 Work load and time allocation**

- *What is the time involvement for each staff member as they prepare for, plan and run groups and for their training and supervision?*

#### **3.3.1 Family Nurses**

When asked about their time involvement in order to deliver gFNP the FNs were unanimous that the time allocated was inadequate. Describing how her diary looked in a week when gFNP was offered, one FN confirmed a whole day was needed for preparation and delivery.

*"...my diary.. I just write that whole day out." (FN)*

In particular there was often insufficient time to plan for and prepare for delivering the sessions. This may have been exacerbated by the fact that, unlike previous phase of gFNP, for Phase 3 the professionals were not necessarily co-located so preparation was the responsibility of the FNs and planning for the meetings took place immediately before the clients arrived. Comments on session feedback forms reflected this:

*"We need more time to prepare."*

*"More planning and preparation time needed for the next session."*

There was a particular problem when FNs were working with the midwife co-facilitators, who needed to carry their 'normal' case-load with no additional support for the time they gave to gFNP. This increased the element of 'time pressure' on the FN. The MW often could not arrive early and usually had to leave soon after the gFNP session finished and thus was unable to assist the FN with paperwork relating to the session. Any time at the end involved MWs with carrying out client health checks and they would invariably have to leave straight away after this.

*"She would come before and have a look at 'what are we doing today' and go through it, then we'd do the group, then we'd fill in all the paperwork we needed to do, the data collection, reflection, all this sort of thing. I would end up having to do the majority of that as she would invariably have to go off..." (FN)*

In addition to the routine forms that are an inherent part of the programme and are usually completed right after the session, further time was spent by FNs in the following days updating

client records on NHS databases (to confirm standard checks and procedures consistent with usual NHS care).

If clients missed a session the FNs usually followed up with a phone call and if absent for three or four sessions, home visits were carried out. In addition to visits for clients who were absent, although home visiting was not part of gFNP some FNs carried out home visits to group members where they felt it was necessary, possibly to follow-up on sensitive issues that could not be fully explored in the group. At one site the FN reported 60% of clients required at least one home visit in addition to attending group sessions and 40% required more (up to a maximum of four home visits for one client).

Transporting and packing away materials was especially time consuming if they were stored away from the Children’s Centre. Although the operational recommendation was to re-fill the boxes containing paperwork and session materials after each session, this was not possible for a couple of reasons. Often the room needed clearing quickly as it was booked for a specific time period and others needed punctual access. Thus some point before the next session the FN needed to review what was in the boxes and see which materials needed copying and which new ones needed to be added for the next part of the programme. On a non-group day this could take between one and a half and two hours. This was less stressful in the infancy phase as the FSWs were usually based at the gFNP venue and could stay and assist the FN with paperwork and clearing away.

In summary, an approximate breakdown of time spent on the different components of delivering gFNP is given in Table 3.1. Preparation of the materials to be used and planning what is going to be covered with the co-facilitator averaged half a day, whether the materials were prepared on a different day to the session or prepared just before the session itself. The sessions themselves take two to two and a half hours and approximately an hour was spent after the group session has finished completing data and nurse reflection forms. The following day the FNs could spend a further hour and a half updating client records on NHS databases.

Table 3.1 Time allocation by Family Nurses for each gFNP session

	Planning and preparation	Session reflection +	Record keeping -	Approximate total for session	Follow up phone calls and visits for non-attenders or those that request one
FN1	One afternoon (with FSW)	4.5 hours	2 hours	11 – 12 hours	yes
FN2	One whole day				yes
FN3	6 hours		1 hour		yes
FN4	1-2 for materials preparation on non-group day	4.5 hours	1 -1.5 hours	Whole day in total	yes

*“On group day we probably leave our office at 11.30 to go over there, the group finishes at 3 p.m., we probably finish doing the paperwork about 4 p.m. so that would be about four and a half hours on the day and another three hours in total, so it is a whole day...” (FN)*

### 3.3.2 The co-facilitators

For the MWs in particular, supervisors reported that the preliminary time to attend training was a challenge:

*“They had a week of pregnancy training, then they had three days down in London and a couple of days in Birmingham and all these odd days, that was all counted in. And they weren’t best pleased [managers] that their MW was going off to training for a week.” (Sup)*

They also had to make time once a month for the supervision and, while in some cases this took place after the group session, in other locations due to practical considerations this was not possible, meaning that the MW needed to make a special journey for the supervision:

*“They had to be out of the building so it was a real challenge trying to find another time when we could get the co-facilitators together which put another pressure onto the MW to come to that supervision session.” (Sup)*

For the MW co-facilitators being short of time was an issue in terms of preparation and carrying out all the health checks that were required as part of the programme. The MWs reported full case-loads in addition to their gFNP work and an allocation of five hours in which to carry out the programme. All spent more time than they had been allocated on gFNP. The MWs reported that any paperwork they did complete was time consuming and repetitive. Hardly any time was spent preparing and getting materials to the group.

One MW reported spending the morning of the session preparing what they were going to teach, but in terms of getting the materials together the FN did all that preparation with some support from the administrative assistant.

*“I didn’t do any of it [getting materials together] because I didn’t have time to do it. We [self and FN] would do the preparation together, but in terms of getting the materials together FN did all that, she had admin support but I wouldn’t have had the time.” (MW)*

On the whole the midwives reported leaving completion of records to the FN after a session:

*“I was allocated I think it was five hours, so I was expected to be doing my midwifery work for the last two and a half hours of the day. So there wasn’t much leeway after we had finished doing the group to help with the paperwork so the family nurse did the majority of it.” (MW)*

Another issue that impacted on the MWs’ workloads, raised in supervision, was their concern that a crisis might be missed through only seeing pregnant women in the group, at which time they might not disclose all of their concerns and through emphasising self-care. To compensate they often made home visits to clients in addition to seeing them in the group:

*“Our MW who did the group did home visits on top of; she increased her workload, but she couldn’t sit easily or comfortably without having done what she clinically felt comfortable that she had to do.” (Sup)*

*“They were really anxious about their governance arrangements.” (Sup)*

Confirming this all the MWs reported carrying out home visits in addition to seeing women in the group sessions to complete health checks and to follow up on problems.

*“I had to do an awful lot outside of group, so if you have got someone with a problem with their pregnancy you have to go and see them at home.” (MW)*

*“We had a couple of girls who were quite demanding midwifery wise, wouldn’t take a huge amount of responsibility with themselves and their antenatal care, you know’ I can’t be bothered to stay for my antenatal checks, can you come and visit me at home’ and that type of thing.” (MW)*

Lack of time was not such an issue for the FSWs because they were usually based at the Children’s Centre where the gFNP sessions took place and appeared to be able to stay and do the paperwork with the FN after each session or attend supervision and be more available for the planning

beforehand. They did not report particular time pressures and were generally not involved in any home visits.

### 3.4 Supervision

Supervision pertaining to gFNP took place monthly and ideally included the FN and whichever professional was the current co-facilitator, or in a few instances both the MW and FSW during the transition from pregnancy to infancy. The supervision role was very similar to the support given during FNP team supervision:

*“We tried to agenda match and sometimes we talked about the clients themselves and we might for one session go through all the clients and what they had noticed, what their challenges were, how they had engaged, what was happening. Another time we might be talking about the group process or which stage they are at.” (Sup)*

One additional aspect to the supervision was that different professionals were involved. This gave the co-facilitators an opportunity to discuss their respective roles in delivering gFNP. One perception emerging from supervision was that the MWs may have been keeping more to their MW role because the clients themselves perceived the MWs predominantly in their medical role rather than as being an integral part of gFNP:

*“We had quite a few discussions about the roles that they both played it was a very interesting because when it was the MW and the FN it was two separate roles, because the MW was there as the midwife and the clients saw her as the MW, they didn’t see her as the group facilitator. We explored this quite a lot, what were the benefits or drawbacks of that and what else could she do to or how else could they both help the clients to understand that she was actually a joint facilitator.” (Sup)*

This was less often the case when the FSW was present, possibly because in infancy the FN was the ‘medical’ expert but both facilitators delivered the gFNP materials:

*“With the FSW, the group members saw them both as group facilitators; she (FSW) didn’t have the specific role that went to the FN who was overseeing the Healthy Child Programme, the weights and the ASQs and so on, but she was a group facilitator.” (Sup)*

MWs and FSWs expressed how they were extending their skills and wanted to be part of the planning for the group sessions:

*“Discussions were around thinking about the skills that they were developing, using the MI skills and the materials that they were using and how they were able to share out the preparation time for group because it generally did fall more to the FN to prepare for the sessions but equally the MW and the FSW wanted to be involved in that preparation and they wanted to know what the session was going to be about.” (Sup)*

Co-facilitators, especially the MWs who generally did not experience this level or frequency of supervision, talked about how taking the gFNP co-facilitator role had enhanced their other [midwifery] work:

*“The MW said she was really pleased to have a chance to be able to talk about issues and actually think about the skills that she had developed in doing the group and thinking about how much she had learned. It was a good way for her to explore that.” (Sup)*

*“Our MW talked about how she had transferred her skills into her other life and how she was doing that.” (Sup)*

While new skills were being developed, the conflict experienced by MWs in managing both their midwifery role and that of gFNP co-facilitator was noted, that the new role led to raised anxiety about whether they could manage the necessary tasks:

*“I think it was the sheer fact that it was so different to her ‘day role’. She usually sees a client one-to-one and goes into midwifery mode and gets everything checked off whereas with group she’s got ten people, or seven or however many sitting there, and because she is not having this one-to-one with them is she going to miss something and she’s very anxious that she will miss something.” (Sup)*

While delivering gFNP allowed the MWs and FSWs to develop their skills, the Phase 3 model of delivery placed extra stress on the FN in their role. Supervisors saw the FNs individually for their FNP supervision and in those conversations the FNs expressed concerns which they had not talked about in front of their co-facilitators about the responsibility for the programme falling principally to them:

*“Some of those statements perhaps came to one-to-one supervision rather than to the shared supervision sessions, you would get a much more analytical thinking of what was going on in the group because you felt that very safe relationship, it’s different when there are three of you.” (Sup)*

Thus while supervision including both facilitators led to useful exchanges, in the future some thought might be given to providing one-to one supervision for all the co-facilitators, thought this would add to the cost of programme delivery in terms of supervisor time.

### **3.5 Perceptions of Children’s Centre Managers**

Children’s Centre managers were interviewed to gain a broader perspective of awareness and impact of gFNP locally. All were aware of FNP and the newer gFNP with the majority being knowledgeable about the integrated health aspects of the service regarding increased midwifery and health visiting support. Combining a local Children’s Centre worker (FSW), local midwife and Family Nurse in delivery of gFNP was considered a success in terms of joint agency working. CCMs saw part of their role as trying to integrate gFNP into the broader public health strategy and gaining support from strategic partners. In addition to facilitating the delivery of the service within individual Children’s Centres, raising awareness of the service amongst those carrying out targeted work with vulnerable families was considered key in order that they would be able to identify those individuals who might meet the criteria for gFNP and could thus be referred into the service. However, referral was also experienced as a two way process with gFNP clients being encouraged to take part in other groups and services offered by Sure Start.

*“...generally we are all aware of the project, if we came into contact with a parent...if we think this person would benefit...we would look at making that referral...” (CCM)*

Children’s Centre Managers commented that they would like to see more integration of the clients into Children’s Centre services at the start of the programme rather than as an exit strategy. They also wanted to see more signposting on to other services within the Centres. Generally they were supportive of an expansion of gFNP in the future as they thought it would lessen pressures on their own services and offer increased support to more vulnerable families.

*“I still don’t think there is enough integration into the existing programme that exists outside the service” (CCM)*

*“I would like to see the FN take the families to other facilities as well” (CCM)*

*“We do have good relationships and I encourage our team and the FNs to link together, I believe it could be done more effectively on the FNP side.” (CCM)*

### **3.6 Role perceptions, summary**

FNs saw their role as leading the delivery of gFNP and expected they would be supported in this task by the MWs and FSWs who were their co-facilitators. However, there was divided opinion about whether this had taken place, especially in the ante-natal phase of programme delivery. This was attributed partly to MWs’ lack of knowledge and confidence regarding gFNP, but also to time

constraints placed on the MWs due to commitments elsewhere and to their focus primarily on the provision of midwifery care. Thus FNs described how they carried the full burden of preparation, session delivery and paperwork afterwards in the ante-natal phase. After transition to the infancy stage the situation eased when working with FSW co-facilitators, who were more experienced in delivering to groups and who were not subject to the same time constraints as the MWs.

In terms of training, the FNs felt reasonably well-prepared. However the time allocated to them for delivering the programme was inadequate. On the whole FNs found it challenging to deliver gFNP using the Phase 3 model and they agreed that they would have preferred to deliver the service alongside another FN. Co-facilitators had, presumably for expedience and to limit costs, been included in the regular training week for one-to-one FNs causing some confusion, both for the trainers and for the co-facilitators. It would be better, if feasible, to organise trainings specifically for gFNP professionals but this may not be cost-effective until gFNP is offered more widely.

MWs perceived the most important aspect of their role being to provide the midwifery checks and support the FN to deliver the programme, possibly because that was within their 'comfort zone' whereas approaching topics from a motivational standpoint, agenda matching or responding to issues raised in the group were relatively new to them. Some reported initial anxieties about lack of knowledge of the FNP programme. Not all MWs felt well-prepared after their training and they lacked the confidence to deliver the teaching side of the programme. They also reported being under time pressure not only because of other commitments and full case-loads but also because they faced difficulties carrying out their midwifery checks for gFNP clients in the time allocated to the gFNP session. There was acknowledgement that due to this time pressure they had to leave many of the duties associated with delivering the programme to the FN. Added to this, two MWs had reservations about encouraging the young women in their groups to carry out their own health checks, which is an inherent element of gFNP.

The FSWs saw their role more collaboratively, sharing in the planning and delivery with the FN. Working in a non-directive way was a new approach for most and a key realisation over time was that the role involved moving away from being a 'fixer', trying and sort their clients problems out for them as quickly as possible, to being a facilitator encouraging women to resolve situations for themselves. On the whole the FSWs felt prepared for their role although the time lag between training and delivery was seen as too long.

Local Children's Centre Managers were aware both of FNP and the newer gFNP and considered it a success in terms of joint-agency working. They saw part of their role as integrating gFNP into the broader public health strategy and gaining support amongst strategic partners. They were optimistic about the impact of gFNP on maternal health because of the increased support given to the young women and in particular about the choices that were available to them. The strategy of trying to engage fathers was viewed as having a positive impact on future parenting; learning about attachment and infant needs were also expected to have a positive impact on the way children would be cared for. By holding the groups in Children's Centres they expected that potentially vulnerable families would become aware of where they could access other support should they need it. As a suggestion for the future they suggested increased integration of gFNP clients into other Children's Centre services at the beginning of the programme rather than as an exit strategy could be beneficial to the families.

## Chapter 4 Client involvement

- What was client participation over the entire course of the programme?
- Can any differences in participation be identified in comparison with Phase 1?
- Can any client characteristics be associated with participation and retention?
- How did clients and professionals rate the sessions, and did this differ from phase 1?
- What factors, according to clients and professionals, impact on maintaining participation through to the programme's conclusion?

### 4.1 Participation in the programme

- What was client participation over the entire course of the programme?
- Can any differences in participation be identified in comparison with Phase 1?

While attendance can be influenced by a range of practical issues, or personal events, it can be assumed that to a certain extent regular attendance is one indicator that the sessions are valued and thought to be beneficial. The presence of each client is recorded on UK001G forms in addition to the extent to which they appeared to be involved in the session, understand the content, and indicate any conflict or disagreement with the materials. According to these forms 43 clients were enrolled with ID numbers and expected to attend but 7 never attended any groups and 6 of these were then recorded as leaving on the UK004G forms, which has been discussed in Chapter 2. The attendance statistics are based only on the 36 clients in the four sites who attended at least one session. Across the 14 pregnancy sessions a total of 413 forms were completed in the four sites and attendance was indicated for 289 of them (70%). Looking at each client, the number of pregnancy sessions attended ranged from 1 to 14, with a mean of 8.3/14 (59%). The average proportion of sessions attended in pregnancy was 57% (range 7% to 100%). One third of clients (12/36) had attended at least 80% of pregnancy sessions (11 sessions, the 1 to 1 recommendation) and nearly two thirds (21, 58%) had attended 9 or more of the 14 sessions (see Figure 4.1).

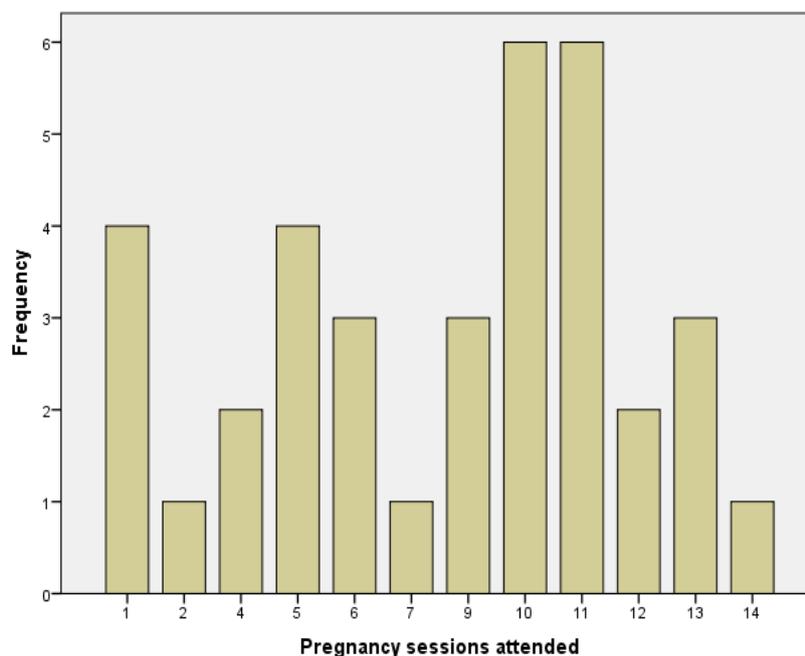


Figure 4.1 Client attendance in pregnancy, from UK001G forms (N=36)

The Phase 3 attendance in pregnancy is slightly lower than that recorded in Phase 1. Information was available for 22 phase 1 clients in two Phase 1 sites. While the range of attendance was similar (1 to 14) their average number of pregnancy sessions attended was 10. 4/14, (74%) and half (11) had attended at least 80% of the sessions (Barnes & Henderson, 2012, p.19).

By the beginning of infancy sessions there were 27 clients remaining in the four Phase 3 groups. Of the 612 forms submitted for infancy sessions for these clients, attendance was indicated for 364 of them (60%). Looking at attendance by client, the mean number of sessions attended was 13.5 with a range from 1 to 29 (see Figure 4.2).

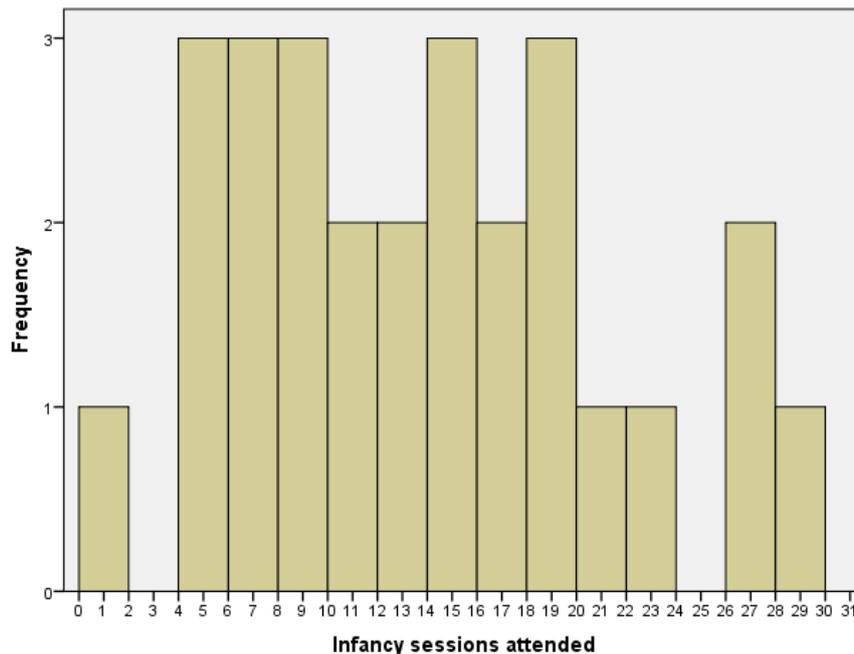


Figure 4.2 Client attendance in infancy sessions, from UK001G forms (N=27, all four sites)

However, one site stopped delivery of the programme after holding 7 infancy sessions, so figure 4.3 shows the same information for the three sites where the programme continued until infants were around one year of age. The number attended for the 24 clients in these sites ranged from 4 to 28 with an average of 14.5. It should be noted that none of these three sites held the maximum of 30 infancy sessions, offering 22, 26 and 29.

The average proportion of infancy sessions attended (with calculations based on the number actually provided in each site, not on the possible number of 30) was 58% (range 14% to 100%) and these 27 clients attended 62% of sessions in total in pregnancy and infancy (range 24% to 96%). There is no specific recommendation for gFNP attendance in infancy but the home-based FNP recommendation is for 65% and this was achieved for nearly half the Phase 3 gFNP clients remaining in infancy (13/27, 48%) with only six (22%) attending fewer than a third of sessions.

More infancy sessions had been attended by 10 clients in one of the Phase 1 sites, with an average of 19.4 (range 2 to 29) but attendance was similar to Phase 3 for the 10 clients in the other Phase 1 site, with an average of 13.7 sessions (range 1 to 23) (Barnes & Henderson, 2012; p. 19). Thus the Phase 3 mode of delivering the programme does not appear to have markedly influenced attendance but there is some indication that the trend is for lower attendance than that documented for the Phase 1 model of delivery, with two Family Nurses.

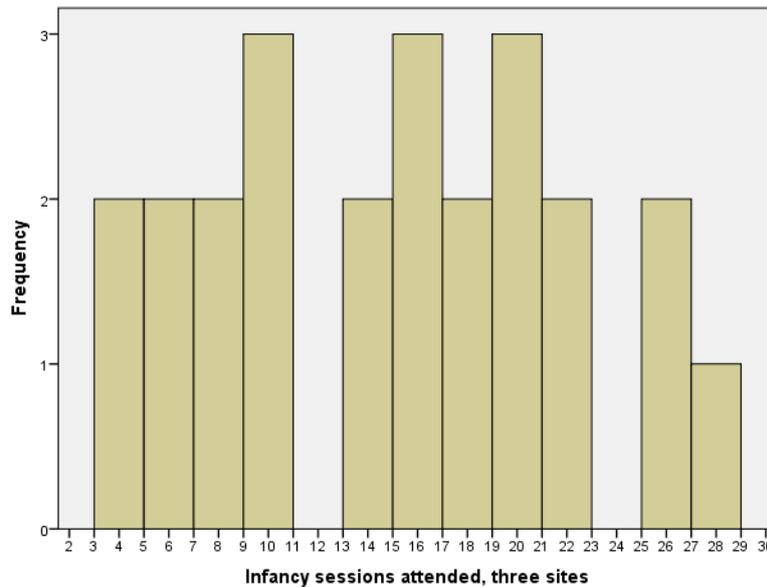


Figure 4.3 Client attendance in infancy sessions, from UK001G forms (N=24, three sites)

Attrition during pregnancy was noted for 7 of the 36 clients who attended at least one session, representing a rate of 19%, but was much less in infancy with only a further 3 clients leaving (8%) making a total attrition rate of 27%. This overall rate is comparable to sites in Phase 1, where overall attrition was 30%, the expected level for home-based FNP by the end of infancy. But in Phase 1 departure was less likely in pregnancy (13%) than in infancy (17%). However there was considerable variation between the four Phase 3 sites. In one there was 45% attrition in pregnancy, the loss of a further client in infancy (55% attrition) leading to the premature conclusion of the programme whereas two of the sites indicated the departure of only one client during the whole delivery of the programme, representing 10% and 11% attrition in total. Thus there may be large variations in the group with this aspect of gFNP delivery which may not be easily predictable based on the demographic characteristics of clients (see section 4.2), but which may have adverse consequences for the programme’s viability.

#### 4.2 Participation in relation to client characteristics

- Can any client characteristics be associated with participation and retention?

Characteristics examined in relation to attendance were marital status, age group, ethnic background, employment status, educational qualifications and income. However, none of the client demographic characteristics could be statistically related to the extent of their attendance. For all categorical characteristics comparisons between the groups in terms of mean attendance did not lead to any significant results (see Table 4.1) although the trend was for clients with lower income to be more likely to attend based on broad income groups, substantiated by correlations (income with: total sessions  $-.33$ , pregnancy  $-.23$ , infancy  $-.33$ ). It is also possible that lower attendance is associated with membership of ethnic groups with groups other than white British, but the numbers are much too small in the current study to make any reliable predictions. The number of GCSE qualifications at any grade and the total number at A\* to C were correlated with the number of sessions attended in total, in pregnancy and infancy and none of these correlations was significant

(Any level: Total sessions -.18, pregnancy sessions -.23, infancy sessions -.14; A\* to C: total sessions .10; pregnancy sessions -.11, infancy sessions .15).

It must also be noted that of the 43 women enrolled demographic information was only available for 27 clients. A small number (7) never attended any group but there should have been information for the remainder (36). However if clients miss the week that the information is completed it is generally not then back-filled. It might be useful in the future to consider ensuring that demographic information is as complete as possible, so that implementation can be monitored effectively. This is likely to involve collecting information at the recruitment home-visit then not only can attendance be evaluated but also characteristics of clients who agree to the programme but never attend, potentially a more important issue when trying to establish groups of a viable size.

Table 4.1 Mean number of sessions attended in relation to client demographic characteristics

Characteristic		Total sessions	Pregnancy sessions	Infancy sessions
Total group (27)		21.8	9.5	12.3
Teen	Under 20 (8)	21.6	9.6	12.0
	20 to 24 (19)	21.9	9.4	12.5
Employed	Full time (5)	21.6	9.4	12.2
	Part time (4)	18.0	8.0	10.0
	Not employed (18)	22.7	9.8	12.9
Marital status	Single/ never married (11)	21.8	9.0	12.8
	Cohabiting/ married (16)	21.8	9.8	12.0
Ethnic background	White British (23)	23.2	9.7	13.5
	Other groups (4)	14.0	8.3	5.8
Weekly income	Benefits (6)	28.5	10.8	17.7
	Up to £150 (10)	21.1	9.4	11.7
	£150 to £250 (4)	24.0	9.8	14.3
	£350 to £450 (5)	17.8	8.6	9.2

### 4.3 Judgements about the sessions

- How did client and professionals rate the sessions, and did this differ from phase 1?

#### 4.3.1 Clients

Details of Phase 1 gFNP clients' ratings (Barnes and Henderson, 2012; p.24) are summarised in Table 4.2 together with the Phase 3 client ratings. In the four sites providing Phase 3 of gFNP there were 236 anonymous client ratings for pregnancy sessions, using 5 point scales (1 low, 5 high) to indicate how involved they had felt in the session. The majority (83%) of ratings were at the maximum point, indicating that they felt involved with all group members, a further 12% reported involvement with most group members, with only a small proportion of clients (5%) reporting involvement at the mid-point and only one client reporting not feeling involved. The mean score was 4.8 (range 1-5). This scale was not used in Phase 1 but a similar question asked how comfortable the client had felt in the group, which had a mean score of 4.9 (range 4-5).

A smaller number of clients (N=127) in Phase 3 completed two additional scales. The first indicated whether the FN had listened to them, which was said to be all of the time for 95% and most of the

time for the remaining 5%. The mean rating was 4.9 (range 4-5), which is close to the equivalent rating that was made by phase 1 clients (N=193, mean 5.0, range 4-5). Clients also reported in Phase 3 on how well they thought the group had got on together. The most common response (87%) was that the group members really enjoyed each other's company or that they got on well most of the time (10%) with 2% (3 clients) indicating that the group or on OK or not that well. This question had not been posed to Phase 1 clients.

Table 4.2 Average ratings made by clients on anonymised feedback forms in Phases 1 and 3 of gFNP using scales from 1 (low) to 5 (high) or 10 (high) (ranges in brackets)

	N	How involved were you with group?	Did FN listen to you?	How well did the group get on?
<i>Pregnancy</i>				
Phase 1	193	4.9 (4-5)	5.0 (4-5)	-
Phase 3	236	4.8 (1-5)	4.9 (4-5) N=127	4.8 (2-5) N=127
<i>Infancy</i>				
Phase 1	295	9.9 (5-10)	9.5 (9-10)	-
Phase 3	253	4.9 (2-5)	5.0 (4-5) N=118	5.0 (4-5) N=118

Involvement was also rated in infancy (N=253) and again the majority (233, 92%) reported that they had felt involved with all group members or most of the group (17,7%) with only 3 clients indicating lower involvement. The mean rating was 4.9 (range 2-5). Phase 1 clients, using a 10 point scale, had a mean score of 9.9 (range 5-10) representing a mean of 4.9 and indicating that involvement was equivalent in the two phases. Judgements of whether the FNs had listened to the clients were very marginally higher for Phase 3 clients compared to Phase 1. All but one of the 118 ratings made in phase 3 were at the maximum (mean 5.0) while the mean for phase 1 was 9.5 on a 10 point scale (range 8-10), which is equivalent to a mean of 4.8 out of 5 (see Table 4.2).

#### 4.3.2 Professionals

For each client, a UK001G form was completed after each session noting not only whether or not she had attended but also the level of involvement and understanding of the materials, plus any observed conflict with the content, on scales ranging from one to five.

In pregnancy the average client understanding and involvement were both high at 4.8 and comparable to those made in Phase 1 of gFNP (see Table 4.3). Minimal conflict with the materials was documented. In infancy there was a similar picture, with high ratings of involvement and understanding, and a low rating for conflict, almost identical to the ratings made in Phase 1

Table 4.3 Average FN ratings of clients' behaviour during group sessions based on UK001G forms using scales from 1 (low) to 5 (high) (ranges in brackets)

	Involvement	Understanding of materials	Conflict with materials
<i>Pregnancy</i>			
Phase 1	4.9 (2-5)	4.9 (1-5)	1.0 (1-2)
Phase 3	4.8 (3-5)	4.8 (2-5)	1.1 (1-5)
<i>Infancy</i>			
Phase 1	4.9 (3-5)	5.0 (2-5)	1.0 (1-3)
Phase 3	4.9 (3-5)	4.9 (3-5)	1.0 (1-3)

The group facilitators also completed feedback forms (not anonymous) after sessions using ratings from one to ten to describe the overall group behaviour. For phase 1 those were all completed by FNP professionals, either the FNs delivering the programme or in a few cases someone taking over to cover illness or other absence (the supervisor, another FN, the gFNP trainer). For phase 3, in some cases the form was signed by the FN, in some cases by the MW or FSW, but in a number of cases the form was a joint report even though the FN's name was used. For the purpose of analysis those with the FN's name, or any other FNP professional (supervisor, gFNP trainer) are considered FNP reports and those specifically identified as being only the opinion of the MW (in pregnancy) or FSW (in infancy) are considered non-FNP opinions.

After making this division the mean ratings for each group were not significantly different (see Table 4.4) and were generally very positive about both interest shown in the content and engagement of the group. Interest was highly rated in infancy, presumably as any group member who had not been very interested was likely by that time to have stopped attending on a regular basis. The only slight difference was that FNP professionals used more of the scale in infancy with ratings for interest as low as 6 on occasion and for engagement as low as 4 whereas FSWs used less of a range of possible ratings.

Table 4.4 Average professional ratings on session feedback forms about the whole group, using scale from 1 (low) to 10 (high)

	N	How interested was the group today?	How engaged was the group? (Phase 1 - listened to you?)
<i>Pregnancy</i>			
Phase 1	40	9.6 (8 – 10)	9.2 (8- 10)
Phase 3 FNP professionals	55	8.6 (6 – 10)	8.3 (6 – 10)
Phase 3 non FNP (MW)	27	8.5 (6 – 10)	8.2 (5 – 10)
<i>Infancy</i>			
Phase 1	98	9.0 (6 – 10)	9.1 (7 – 9)
Phase 3 FNP professionals	54	9.1 (6 – 10)	8.7 (4 – 10)
Phase 3 non FNP (FSW)	24	9.1 (8 – 10)	8.9 (7 – 10)

#### 4.4 Factors relevant to maintaining involvement through to programme conclusion

- What factors, according to clients and professionals, impact on maintaining participation through to the programme's conclusion?

##### 4.4.1 Client reports

In both interviews clients were asked about any reasons for not attending sessions, with additional questions about maintaining attendance right to the end in the second interview. Many comments indicated that the clients made efforts to attend regularly with illness the main reason for non-attendance:

*"I attended every week bar one, before and after [the birth]"* (C1:5)

*"The only time I haven't been is when I was in hospital with him just before I give birth, and a couple of times since he's been born when he's had a bit of a cold...because of other babies"* (C1:1)

*"I think I've missed two or three sessions...one or two were in pregnancy just due illness and then one or two just not being able to make it with [baby] being ill."* (C1:3)

*"We missed last week because the car didn't start, but we try to get to each session."* (C1:8)

Some comments however did indicate that once the baby was born attendance was more of a struggle:

*"I don't attend as regularly now I have the baby. I am either tired or I just leave it."* (C1:7)

Most in their second interviews, conducted with clients who attended until the programme was finished, reported sustained efforts to maintain attendance through to the programme's conclusion.

*"We pretty much went all the way through. Unless he was poorly or we had something else arranged. I moved house halfway through so it was easier to begin with. It was about a 45 minute walk so I just walked there. It helped shift the baby weight."* (C2:5)

Most reasons for non-attendance concerned illness or unavoidable circumstances such as family holidays.

*"I've only missed a couple of times - once when I was heavily pregnant and once when my grandma was ill."* (C2:6)

*"He [baby] was in hospital for the first few weeks after he was born but as soon as he was better I took him. It was nice to share my experience of what I went through compared to other women."* (C2:8)

*"I did attend quite a few of them but I missed a few because of family holidays."* (C2:1)

*"Yes, I attended almost every time, I only missed about three sessions, buggy was broken [had a 15-20 minute walk to group]."* (C2:2)

Poor weather in combination with transport issues was also mentioned as a reason for not attending:

*"Sometimes [had problem getting to group] when it was raining. It's about half an hour's walk away. It wasn't really worth going by bus, it wasn't a direct route".* (C2:4)

Having employment also proved to be a stumbling block in the infancy phase

*"When I was pregnant, they [her employers] let me go to every one. Then after Christmas some months I went to every one and others, just one. I missed the last one."* (C2:9)

*"At the start I was able to attend every one, then I went back to work. I missed about 4 or 5 towards the end and then went back for the last one. Work wasn't very considerate, they wanted me to work extra time if I asked to leave early to attend the group."* (C2:7)

Only occasionally was non-attendance linked to characteristics of the other group members:

*"There was also a problem with one of the girls. There was bad feelings between us. I didn't turn up for one [session] but then she left anyway."* (C2:1)

#### 4.4.2 Facilitators' reports

The family nurses and family support workers were able to comment not only on the clients who remained but on those who did not stay involved throughout. Most reported that they believed their clients wanted to remain involved with the programme:

*"I would say overall they were all very sad when it ended. They all wanted it to go on for another year."* (FN)

*"All of the clients attended at some time in the last three months."* (FN)

*"It did start to drop off towards the end....but even in the last weeks we got all of them suddenly arriving."* (FSW)

*"Most of them came to every session." (FSW)*

One reason for attrition was family circumstances and in particular having to deal with other children, which made attendance more complicated to manage:

*"One had issues about taking her other child to nursery and if life was a bit hectic for her, she was struggling and not in a very good place, so sometimes I think it was just too much effort for her." (FN)*

*"One girl had other children so that affected her attendance." (FN)*

Lack of encouragement from other family members was also described:

*"One girl missed about three or four sessions because she was off on cruises. Her family were quite well off and they didn't prioritise her with things which we thought were more important to her". (FN)*

*"She wasn't very engaging, she lived with in-laws. I think she was the youngest. Her partner didn't come. She was just one of those hard ones to engage." (FSW)*

Many partners could not attend due to employment but a possibly unavoidable reason for non-attendance, especially in a climate of employment shortage and concern about not upsetting employers, was that some clients were employed which could mean that they had other priorities:

*"A number of them had either moved or gone back to work and were involved in other things." (FN)*

*"People started to return to work and things started to change in their family life which possibly affected their commitment." (FSW)*

Organisational factors within the gFNP team, particularly the absence of the FN but also the change over from the MW to the FSW, could also affect attendance:

*"Perhaps there had been too many changes, we had lost the midwife role so they had to get used to having a different facilitator [followed by staff sicknesses which led to more changes]." (FN)*

*"I think that if we were to do it again, we wouldn't have so much of a dependence on the FN by the clients. The functioning wouldn't have depended on my attendance then." (FN)*

#### **4.5 Summary, client involvement**

Clients who attended until the programme was finished reported sustained efforts to maintain attendance through to the programme's conclusion. Most reasons for non-attendance concerned illness or unavoidable circumstances such as family holidays. Poor weather in combination with transport issues was also mentioned and having employment also proved to be a stumbling block in that women were reluctant to make requests for absence to employers when they had contracts that were not permanent or were 'zero hours'. The FNs reflected similar reasons for attrition, highlighting family circumstances and in particular having to deal with other children. They also commented that some women had stopped attending due to pressure from other family members. They also suggested that organisational factors within the gFNP team leading to changes in staffing could precipitate lower attendance.

## Chapter 5. Partner involvement

This chapter addresses the following questions:

- *What was the extent of partner involvement?*
- *What are the partners' views about being involved in the groups?*
- *What are the views of the women participating in the programme about the inclusion of fathers or partners in the groups?*

### 5.1 Participation in the programme

Partner involvement cannot be compared with phase 1 since they were not invited to attend at all for that phase of the programme's delivery. From the UK001G data forms completed by the FNs it could be seen that mothers were accompanied by their partners to 16% of pregnancy sessions which had recorded this across the four sites (68/438) and 19% of the infancy sessions (94/505). Data are reported for 32 partners of the 36 clients attending sessions during the pregnancy phase and the average number of sessions attended was 2.1 (range 0 to 14). Data were available for 25 partners of the 27 clients attending any infancy sessions and their mean attendance was 3.8 sessions (range 0 to 25). The ratings of partner involvement and understanding of made by FNs in pregnancy (rated on a scales from 1 to 5) were predominantly high (means: involvement 4.4, understanding 4.6) though lower than that of the clients whom they accompanied (means 4.7 and 4.8 respectively, t tests 2.172,  $p < .05$  and 2.816,  $p < .01$  respectively). The level of conflict partners expressed with the programme content was reported to be low (mean 1.1) and the same as that of their partners. During the infancy sessions partners' involvement and understanding were said to be slightly higher than in pregnancy (means: involvement 4.8, understanding 4.9) and not significantly different from that of the mothers (mean 4.9 for both).

### 5.2 Partners' views about their involvement

Some anonymous ratings were completed by partners on feedback forms after sessions, although in a number of cases the rating was a joint mother/father response so any separate views of partners cannot be determined. Most partners completed the very brief feedback form with only one question asking how involved they felt in the group. Responses were predominantly very positive, with three quarters (35/46, 76%) reporting being involved with all group members (score of 5), and a further 20% (9/46) felt involved with most of the group (score of 4). No partner gave a rating beyond the mid-point of the scale (3 -involved). All of those who completed the question about whether the FN had listened to them answered affirmatively (5, all the time, 15/15, 100%) and all but one partner (14, 93%) indicated that the group members really enjoyed each other's company (score 5).

A small number of partners were present when clients were interviewed in their homes in early infancy in one site where partners attended regularly. Partners were present at the focus group for that site. It is from this group that most of the quotations for the following discussion have been taken so they may not be representative of all partners experiencing gFNP. Therefore any points raised in this section should be interpreted with the reservation that they may not apply more widely. Partners' quotes are not identified by number to ensure anonymity due to the small number who participated.

Partners were enthusiastic about attending gFNP and looked forward to the sessions. The view was expressed that it was a place where they could socialise and meet new people.

*"I liked the group; you could socialise and meet new people."* (Partner)

*"I was new to it all, so everything was great to me."* (Partner)

*"It is something I look forward to." (Partner)*

*"I think it is good we came to Group, it has helped." (Partner)*

However one father expressed the opinion that it could be problematic if other men were too inclined to talk without letting others state their views:

*"One [partner] did talk over everybody.....he was just talking over everyone and butting in." (Partner)*

Being at work was a problem for some as it meant they sometimes missed a session; one partner stated he would like to attend every session if he could but this was not always possible due to work commitments. This comment made during the focus group led to a discussion around holding the sessions at a time all partners could attend, perhaps over lunchtime for example.

*"Some people work as well, so it is fitting it round that...it would be good to go to every meeting of course." (Partner, Focus group)*

### **5.3 Clients' views about partner involvement**

Clients were asked about the involvement of partners in the focus groups, their early infancy interviews and the telephone interviews after the programmes had concluded. The majority of young women responded positively to this question whether they had a partner or not. Those who were interviewed or took part in the focus groups fell into one of three categories regarding partners: clients who had partners who were actively involved in the gFNP sessions, clients who had partners who were unable to be involved with the group due to work commitments, and clients who did not currently have a partner at the time the evaluation was carried out. At one site it appeared to be the norm that partners attended the sessions whilst at the other three sites it was not such an established routine that partners were present. However, regardless of whether partners did attend sessions regularly, there was the feeling that they were welcome to come if they wanted to. Comments were made about the sessions being especially useful for first time fathers as the young women felt it gave them an insight into what happened during pregnancy and labour.

*"My partner came and he enjoyed it and he put his point when we was discussing topics which he really enjoyed as well because he didn't feel pushed out, which you can be in some groups because it's just for mums, and he felt pretty much part of the group." (C1:5)*

*"Really good because all being first time, the dads as well so they got to learn stuff..." (C1:2)*

*"It's nice to know that your partner can come if they want to, there's the option" (Client, Focus group)*

*"It gives them an insight...as to what we go through" (Client, Focus group)*

*"...three or four people's partners have been here and they've quite enjoyed it." (Client, Focus group)*

*"My partner loved it when he came." (Client, Focus group)*

There were some women who preferred the group to be all female.

*"I think it should be more just for the women, and maybe for the birthing bit...when we did the birthing bit one week partners were invited to come but I think it's better just girls cos a few partners have been before and it's awkward.... I like it just girls." (C1:1)*

One client commented that although she thought it was a good idea involving partners in the group she felt she did not want to bring him along because there were some girls without partners and she felt sorry for them. Another thought it was a good idea and took her partner to the first gFNP session but he was the only male to attend so did not go again; however he continued to provide transport so she could attend the sessions and asks her about what happened in the session

afterwards. Several other clients also mentioned that their partners had attended the odd session but as they tended to be the only male present they felt excluded, although clients not think that they were intentionally excluded by other members and continued to encourage the men to attend.

*"I didn't want to bring my partner because I felt sorry for other women who didn't have partners and who were bringing up baby on their own...I felt it would be disturbing for them." (C1:4)*

*"He drops me off and picks me up so we'll talk like 'what you been doing' and 'how much does she weigh?" (C1:3)*

*"Mine (partner) came to first one and he'll never come again...he was the only bloke that day." (Client, Focus group)*

*"He went to one or two after the baby was born. He thought it was more of my thing really. I didn't think that but he didn't want to keep on going." (C2:3)*

While supporting the idea of partners being involved, a client went on to comment that this placed restrictions on her for some activities during the sessions because she is Muslim. For example her religion does not allow her to show any part of her body to a male other than her partner so she was unable to publicly have her baby's heartbeat checked whilst she was pregnant if there were other males present in the room. Whilst this client's partner did not attend any of the gFNP sessions because he was at work when they took place he did ask her about the groups and help her fill in the various paperwork exercises (homework) that was given out at the sessions.

*"We've got a lot of sheets and every time we get one for us we get one for dads as well, and we [she and her partner] used to go through it and fill it in." (C1:9)*

Although the majority of clients expressed the view that including partners in the group was a positive aspect of gFNP, there were reservations about their presence during some or sessions, or parts of sessions, especially during the ante-natal stage, where specific medical issues were discussed that some clients felt were 'private and personal'. It was also felt that the partners might also be uncomfortable with the nature of some of the discussions, for example around sexuality.

*"Advantages are that father gets to see what's going on, disadvantages are maybe you are carrying on something that is a bit more of the female kind of subject which we don't really want the boys to know." (Client, Focus group)*

*"Some partners don't have that confident side to go right into things with their sexuality and stuff like that." (Client, Focus group)*

*"I think it's better with all girls...there's just certain things you feel uncomfortable about when there's men there..." (Client, Focus group)*

*"I felt it better without him there because some of the girls didn't have partners and when some girls brought theirs, the other girls didn't speak out as much as when it was just women. I preferred for my partner not to be there because there were issues I wanted to discuss that I didn't want him to know about. I felt more open just being with women." (C2:8)*

*"As soon as there wasn't a male figure, it was different you know. So, as a group, we did decide with the FN that if they [partners] wanted to come they were allowed but we [she and her partner] decided against it." (C2:7)*

For several mothers, however, it was their partner's employment that prevented attendance:

*"Yes he was going as well but he didn't come to as many as I did because he works. He did find it a bit boring" (C2:1)*

*"He didn't mind [that the group preferred a women only group], plus he was working so it was quite hard for him getting there anyway." (C2:8)*

*"Yes he went to a lot before he [baby] was born because he wasn't working at the time but once he had a job so he couldn't make it to many."* (C2:2)

*"He went when he could but he worked a lot of hours. He couldn't always make it but when he could, he would."* (C2:5)

*"He came twice. He works so he went once before I joined and once after I had her."* (C2:6)

#### **5.4 Professionals' views about partner involvement**

The group facilitators reported that they had been able to engage fathers, although there was a sense that they were more involved during pregnancy, when there was an opportunity to monitor foetal heart rate and hear details of the labour experience:

*"We had a core of about four dads who came intermittently, that lessened in infancy, in pregnancy they were there because they wanted to be there for the ante-natal checks and foetal heart; they don't come as much now."* (FN)

*"We did engage partners, they don't come to every session, they might be working, they might not want to come to every session, some turn up just for the midwifery check bit and go after that."* (FN)

FNs also had the opportunity to comment on the nature of partner involvement using the pregnancy session feedback forms (the same question was not included in the infancy session forms which focussed on the impact of infant behaviour) and several commented that the men were quiet (in comparison with the mothers) but most comments indicated that the partners were well engaged with the group. Some were slightly slower to contribute than the women, with comments such as *"quiet but participated"*, *"appeared comfortable but quiet"* and *"quiet, interacted eventually"* and *"quiet, answered direct questions"*. Some of the men were actively involved, with comments such as *"always involved, some insightful things to add"* and they particularly engaged with other fathers; *"engaged and worked well with each other"*. Some fathers *"came and went"* during the session which was perceived as less than optimal and it was sometimes thought to be awkward when there was only one father present but only one comment indicated that the presence of the partners possibly made some of the mothers quieter. The attendance of fathers was not as consistent as that of the women and in some cases a father would appear who had not attended before but generally this was managed well (e.g. *"a new dad, integrated seamlessly"*).

There were some comments to indicate that a female only group was preferred in that the women were more confident about taking part in discussions when men were not present, possibly because some men tended to talk quite a lot:

*"Girls who had partners and the partners came occasionally, said they preferred it without their partner"* (FN)

*"We did get them [partners] to come, it was a bit hit and miss really, and then the group gelled and they didn't want their partners in. It was as if this was their time. We did notice when partners come in at odd times that the girls were different and they didn't share as much, they just didn't seem as confident as they were when the partners weren't there."* (MW)

*"They are probably chattier than the mums sometimes, one in particular."* (FSW)

However men could be very involved, particularly if there were separate 'break-out' groups for the men and women:

*"We did something about sleeping and the change in the relationship when baby arrives and the Mums went together and the Dads went together and that was quite good. The camaraderie between them. I took the dads and [FN] took the mums and I heard one of the dads saying 'I absolutely adore the Mum and I am going to get up and do all the feeds. This was really lovely to hear.'" (MW)*

Nevertheless this strategy was not universal. Some sites did see the need to separate out the men from the women:

*“There are partners in the group so we looked [in training] at how we could split the groups with dads having group discussion on certain things like domestic violence. We do have dads, they don’t come every week, we’ve never had to split them up because it’s never been anything that they couldn’t take part in.” (FSW)*

Supervisors discussed how a different strategy might emerge in different groups with respect to fathers and their participation in gFNP, which could depend on the particular fathers for that group:

*“There weren’t any fathers that came, they were invited but they just chose not to.” (Sup)*

*“In our site there were one or two fathers who dipped in and out initially but the mothers in the group had an opportunity to talk about it and they said they preferred men not to be there.” (Sup)*

*“They actively invited partners and they had a good cohort that came and that was really beneficial.” (Sup)*

*“Whatever gets set up at the beginning, than becomes the norm and that becomes safe so they don’t want to change.” (Sup)*

*“If we did it again I might suggest that we would have specific sessions where we would actively invite partners... I am mindful that it felt as though we hadn’t really engaged the fathers very well.” (Sup)*

## **5.5 Summary of partner involvement in gFNP**

The young women participating in the programme thought that it was a good idea that partners were invited to be included in the groups, whether or not they had a partner who attended with them. They thought it was especially useful for first-time fathers as it gave them an insight into what they experienced during pregnancy and labour. However there were reservations about partners being present during some sessions or parts of sessions where specific medical issues were being discussed which it was felt were ‘private and personal’ to the young women themselves. The concern was also expressed that there might be issues being discussed that partners might feel uncomfortable with, for example those concerned with sexuality.

Of the four sites under investigation one had a regular group of partner attendees, with the other sites experiencing more sporadic attendance; just one partner attending from time to time. Where irregular attendance was the case the young men reported feeling excluded and that they had not enjoyed being the only male present at the sessions, this had deterred them in some cases from going to future sessions.

The professionals involved in the delivery of gFNP were generally positive about the inclusion of fathers, which was a change from Phase 1, but it emerged that each site in Phase 3 had taken a slightly different approach to their inclusion, something that emerged based on the characteristics of the group (e.g. the proportion of women with partners, the proportion of partner’s who attended, partners’ high or low involvement). It may be confusing in a wider roll-out of the programme if it is left to the group to decide whether or not to include men in all meetings, to include them for only some specific meetings, or not at all and whether if men were present if it was preferable to have separate discussions for men and women. From a policy perspective it is likely that providing a service that encourages men to be involved would be welcomed, so more development work is necessary on how to achieve this as successfully as possible.

## Chapter 6 Programme content and impact

### 6.1 Perception of the impact of gFNP on parenting, maternal and infant health

Interviews with clients, partners and professionals asked about their perceptions of potential impacts of receiving gFNP. The following questions are addressed:

- *What are client's views about receiving midwifery care as an integral part of gFNP and about its contribution to their knowledge of pregnancy and their confidence as mothers-to-be and then mothers?*
- *How do the specific gFNP approach, the materials and resources contribute to parents' confidence and enjoyment of their infants?*
- *What do clients perceive to be the likely impacts of participation in gFNP for maternal and child health, child development and parenting?*
- *What are the partners' views about the contribution of group involvement to their role supporting their partners during pregnancy and in caring for their new infants?*
- *What are practitioners' views about the likely impacts of gFNP for maternal and child health and parenting?*
- *Are there other impacts that clients, partners or professionals perceive in relation to participation in gFNP?*

#### 6.1 Clients views about midwifery care in the group

The availability of midwifery care was one of the key factors for some young women in deciding to take part in gFNP and maintain attendance. They liked the idea of consistent and more frequent contact with the same person throughout their pregnancy, rather than the possibility they would see a different midwife at each check-up under standard care. Those who already had a child appreciated learning more and increasing their understanding of pregnancy and childbirth despite already having been through the experience.

*"...we had the opportunity to do everything ourselves, like the heartbeat and all sorts of things, which I thought was nice, and they involved the father a lot more as well" (C1:10)*

*"I like the fact that we got to know our midwife and health visitor on a more personal basis...I think it's more support" (C1:6)*

*"With the [community] midwife you'd only see them once every so often, you don't really see one midwife, and I liked the fact that I was reassured through my pregnancy there was always somebody there that I could call." (C1:4).*

*"More frequent...I had not been getting in to see my MW that often, not getting any co-operation with the MW I got whenever I rang her...they offered for me to join every week so I could get to see a MW." (C1:12)*

*"...being the second time I still learnt a lot this time that I didn't know, the warning signs and what to look out for...I knew of pre-eclampsia but I didn't know what the warning symptoms were, I didn't know what it actually is, and I had all that information, I enjoyed that and I enjoyed understanding." (C1:5)*

There were, however, mixed responses from clients when asked how they felt about carrying out their own health checks. The majority of the women interviewed expressed the view that carrying out their own health checks gave them a sense of independence and control over their own pregnancies.

*"It was absolutely fine because I felt like I could do something for myself we could all just do it as and when and we could write it all down. We knew what we were doing. I could check my own urine and write it all down." (C1:12)*

*"You felt independent, you've got more control over your own pregnancy" (Client, Focus group)*

*"I understand it, the dip test, I understand the sugars, the protein and what they mean, and I understand my blood pressure and what's normal for me and what's not, and I enjoy that." (C1:5)*

*"[partner] did my blood pressure most of the time .. She [MW] said to do it three times and make an average, she would check it and if you weren't sure she would do it for you. We were quite happy to do that." (C1:6)*

*"When you go into hospital they just say your blood pressure is such and such and you don't know whether or not that's high, and when we came here we knew." (Client, Focus group)*

*"It gave me the opportunity to do it [urine test] it made me feel confident in doing it, at the doctor they just said go and do that in the toilet... it's the same when we're listening to the babies' heartbeat's." (C1:3)*

*"We learnt a lot about how to do things...we used to find the heartbeats on each other's stomachs, so we learnt where to look for it, and things like that, it were really good" (Client, Focus group)*

Nevertheless there were some women who voiced the opinion that they would prefer a nurse to do the tests for them in case they made mistakes while others did not have strong feelings either way.

*"I didn't really do it by myself, [MW] used to do it all the time for me especially the heartbeat, because none of us could ever find it, but when we did do urine tests it was our responsibility so it made us feel a bit better knowing what we were doing." (C1:2)*

*"I would rather them do it...because you could do it wrong" (Client, Focus group)*

*"I didn't really do the blood pressure, and I just used to wee on a stick and show it to [MW]." (C1:10)*

*"I'm not fussed either way really but I didn't see it as a bad thing" (Client, Focus group)*

The more detailed session feedback forms used intermittently allowed clients to report whether they had received the appropriate level of assistance with managing their own health checks, on a scale with five possible responses ranging from 'much too much' to 'much too little'. All those who responded (only 35 forms were submitted) said that the amount of help was 'about right'. Using the same response scale they were also asked if there was sufficient privacy for antenatal checks and all but one responded 'about right' with one response of 'too little'.

## **6.2 Clients' views about specific materials and their impact**

- How do the gFNP approach, the materials and resources contribute to women's confidence and enjoyment of their infants?
- What do women perceive to be the likely impacts of participation in gFNP for maternal and child health and development?

### **6.2.1 Specific materials**

During their interviews most of the women were unable to specify many specific materials they had found particularly useful but they were able to remember topics they had enjoyed learning about, or activities they liked. During the pregnancy phase of the programme the session on labour and birth was one of the more popular sessions and mentioned most frequently. Many of the women also stated that they enjoyed 'scrap-booking' because it would help them remember being in the group and they could show their babies when they were older. They generally preferred more practical activities and especially those that they could do with their babies.

*"Not a particular topic but when we've done hands-on activities, not just sat talking about it – you can imagine two hours of just sat talking about it, I know you are pregnant and you need to know this stuff but ...." (C1:1)*

*"I've enjoyed most of it, I can't really think of anything I've not really enjoyed" (Client, Focus group)*

*"We enjoyed learning about labour...so when we went into hospital... we had more of an idea what we could ask for." (Client and Partner, Focus group)*

*"I enjoy doing scrap-booking, and all the facilities we had to make our scrap-books, it was really good" (Client, Focus group)*

*"Most of the sessions where we've done the babies footprints, and the feet and us hands, little sessions like that where we get to...you wouldn't think of those things at home to do, they are memorable... I go and get me milk out to make a cup of tea and they are there stuck on my fridge, and you can see the difference." (C1:3)*

*"...I tend to like the more creative things, the more hands-on stuff." (C1:6)*

In infancy there was widespread praise for baby massage and the musical activities such as singing nursery rhymes were also said to be successful with the babies sharing the experience together.

*"I enjoyed it all. Baby massage, that was good I think we all really enjoyed that. Some weeks we did singing, everybody did it together." (C2:6)*

*"He wasn't into singing but when we did it as a group, he really enjoyed it. Everyone was singing at the same time and learning the actions." (C2:5)*

*"We all sat and sang and we all agreed that the babies enjoyed it." (C2:4)*

However not all sessions were received positively. Several women mentioned they had not enjoyed the session where they learnt about cot death which included being shown a video which aroused a high level of anxiety, although they agreed that it was a necessary and useful issue. Similarly attention to domestic violence was not always received positively.

*"I didn't like it when we did about cot-death video thing, not at all... I'm a smoker myself they were showing smoking.. I knew it could happen but I don't think it were appropriate to show it to young pregnant girls who were worried anyway." (C1:1)*

*"The only thing I would say sometimes I think sometimes it is a bit over the top, quite regularly more so before the baby is born they have brought up abusive relationships and stuff..... it is something you need to cover obviously, because it does happen but I think sometimes they are a bit way over with it." (C1:6)*

It was also suggested that talking about depression might not help women who actually were depressed:

*"When we were talking about depression and stuff like that, some people might not have felt comfortable in talking about it in a big group, because you know...we do feel sometimes they push for answers...some things should be talked about one on one...a girl that had already had a baby, it really upset her and we felt uncomfortable, that she felt uncomfortable." (C1:8)*

### 6.2.1 Confidence as parents

A key impact of participating in Group FNP was a general improvement in confidence amongst the young women that they would be able to look after their babies. This came from the learning that took place and information received during the sessions as well as the reassurance and support provided by the facilitators. Confidence was also gained by joining a group of people they did not

know but who were going through a similar experience and gradually being able to speak out and express their own opinions.

*"It gives people a lot more confidence...before I had x I were so scared, thinking how am I going to do this, how am I going to do that? But going to a group like this has made me feel confident that I can do it..." (C1:3)*

*"...I know a lot more, I always thought that when I got pregnant I'd be right scared of, but Group really helped me, it made me feel secure about things..." (C1:4)*

*"I felt really comfortable doing it [talking in the group] because everybody were just having their own piece to say, not like just one person said something, it were a group discussion" (C1:3)*

*"I took everything in and it made me a better person myself and also a better mother because I was learning stuff I never knew before." (C2:6)*

Hearing that other parents were experiencing similar issues helped with confidence, enabling the mothers to understand that the problem was not uniquely theirs, and hearing other mothers' solutions or viewpoints could lead to a change in their own behaviour:

*"Yes definitely [more confident with her baby]. If you mentioned something at the group, you noticed that pretty much all the mums had the same problems, so you felt that you were not alone." (C2:5)*

*"Sharing a problem with the others. If you discussed it with the other women, it was just nice to have people there you could rely on." (C2:8)*

*"Yes I was more confident with him. You get to ask more questions. It's quite nice that if you have any worries you can get to ask questions every week. Mainly when he was born and when he was going on to solids. I wouldn't have had a clue otherwise." (C2:9)*

*"I think when you have a baby you lose a lot of friends and confidence and I think a lot of girls tend to just stay at home. It encouraged me to get out of the house really and I think I will always be encouraged to go and join a baby group... it has given me confidence to know that I am going somewhere with other girls who are in the same situation as me. I have got somewhere to go just to have a chat t...you can feel isolated especially if you don't have a car...It is nice to get out and sit with another couple of mums because all you want to do is talk about your baby when you have got one." (C1:12)*

Some of the group members found that taking part in the group programme had helped them to gain confidence through discussing their experiences, they were aware that they had expertise that could be shared:

*"Yes, she's had all of them [immunisations]. That's why I liked the group. It was nice because my baby was the first to be born, she was the first to have everything, first needle, it was nice to be able to share it with the group, also give them advice." (C2:7)*

## 6.2.2 Maternal health and well-being

Evidence of impact on maternal mental health was provided by a young woman who reported suffering from depression in a previous pregnancy and felt there was no support for her, whereas it was a different situation after receiving gFNP during her second pregnancy:

*"...because last time I was alone I shut myself off...pretty much to do with depression, it's better to have people to talk to and to get the help you need...they (FNs) always ask if you need any help and so it's out there for you" (C1:7)*

Other clients also suggested that gFNP might be particularly appropriate or helpful for mothers who were likely to be socially isolated and consequently prone to depression or who had babies with challenging behaviour:

*“A lot of first time mothers and single mother who don’t get to go out. If you stay indoors all the time you will get postnatal depression.” (C1:6)*

*“Since I had my son I’ve had post-natal depression. I got really down and was crying all the time. I think it was because my son had very bad colic and he was crying all the time. The FN and helper both got me through that and got me a Counsellor.” (C2:5)*

Despite their increased knowledge of the effects of smoking on the developing foetus most of the clients and their partners who smoked were not able to stop smoking during pregnancy but did manage to cut down and then change their ‘smoking behaviour’ after the baby was born.

*“We both tried but we couldn’t do it so we changed the way we smoked which was...he changed jackets, because we smoke outside so it’s put a different jacket on, wash our hands, brush our teeth, which we do, and still do now” (C1:5)*

Women also report behaviour changes around trying to eat more healthily as a family which they hoped would ensure that their child will be a healthy eater, even if they themselves might revert to less healthy eating practices.

*“I’d say eating [was a behaviour change] because I don’t eat fruit and veg, I don’t really eat anything healthy. Then when we did about 5 a day and what’s good for baby it made me think I need to start having a bit of fruit and stuff but for his sake more than anything.” (C1:1)*

One client reported that whereas previously she would not sit and eat a table her intention was to do that because it would improve her child’s behaviour and also she would ‘eat better’; added to this and because of the introduction of the healthy eating plate during the programme there would be vegetables and meat in the meals.

Relationships could also be enhanced through being part of the group by gaining confirmation that they were doing well. For example one mother remarked:

*“It helped with me and my partner. We got to see what all the other couples were like and I think that it made us stronger. We both feel like we were the strongest couple there. It was really nice to feel like that.” (C2:1)*

### 6.2.3 Specific parenting knowledge and practice

Much of the reported impact, not surprisingly, was described as increased knowledge about being a parent and about babies.

*“I’ve learnt a bit more than what I would have done if I were just going to a midwife...” (C1:2)*

*“I think I’ve learnt a lot from the group. When I look at my nieces and nephews, I look at them and think what I’ve done is so different to what their mums have done with them. My baby is the youngest and she’s the one that’s into the most routine. I need routine in my life because I’m working.” (C2:7)*

Discussion about breast feeding during Group clearly had an effect on some clients encouraging them to breastfeed:

*“They showed us the DVD on breast-feeding and I really enjoyed that one session. It encouraged me a lot more. I knew I wanted to but it encouraged me to do it.” (C1:12)*

*"Because of the group I started breast feeding, I didn't even think about it at all until they said how are you going to feed, so I really liked that. (C1:11)*

*"We discussed it at Group...I'm definitely breastfeeding from discussing it at Group." (C1:4)*

*"I was totally against breastfeeding but going to the group changed my perception and I did give it a go." (C2:8)*

However other group members were not persuaded to change their plans to bottle feed:

*"I didn't breast-feed I didn't feel comfortable doing that. I can remember in one group session we had like a boob we tried with, I was sat there, it felt right weird." (C1:3)*

*"They tried to change my mind every time I went to group, it just weren't for me." (C1:1)*

Weaning was another popular topic that effected change in the way many of the young women intended to feed their infants. It made a particular impact when they tasted different foods in the group meeting.

*"We tasted...processed food (in jars) and you could taste the difference...I would never have compared it so I do try to make x more homemade meals..." (C1:3)*

*"The weaning topic, where that was the best one for me by far as it encouraged me to make all my own foods as best I could" (C1:12)*

In terms of impact on other parenting skills there was the view that attending the programme was preparation for when the babies were older and especially around how to communicate with toddlers.

*"...the worst stage is when they are toddling, and you have to learn how to speak to them and things like that, it got me more prepared for it..." (C1:7)*

*"I just thought it were a really, really satisfying process altogether, you felt like one big family altogether with your babies and bumps, it were definitely great" (C1:4)*

#### 6.2.4 Child health and development

Many mothers commented that coming to group helped with child health in terms of being up to date with immunisations, but for one the group context was not optimal, providing little privacy for expressing concerns.

*"He's just had his MMR a couple of weeks ago. The thing with his check-ups - we had to do them in the group so if there were any personal things you wanted to talk about, you couldn't because obviously its personal and you just want to talk one-to-one and not in front of everyone." (C2:2)*

Regular contact with the FNs however did help with guidance of when it was important to contact the GP and with referrals to other medical professionals, and when it was not necessary to be anxious:

*"It's hard to get into the Doctors now. When you ring up, it's like you're going to have to ring back in the morning. Because [FN] knew my baby, she knew if something was out of character, she would advise about what to go to the Doctors with, which is what you need. She got me referred to a paediatrician because he had a nut allergy" (C2:4)*

*"For a while he was putting quite a lot of weight on so it was nice to get him weighed and get an opinion and being told the weight was fine." (C2:9)*

The activities that took place later in the infancy phase were perceived to be important in encouraging both physical development and infant exploration and cognitive development:

*“Yes, he wasn't sitting up and crawling on his own but when he saw what the other children were doing at the group, it boosted him with his crawling and stuff.” (C2:8)*

*“When he got a bit older we made these little boxes and put lots of things in like feathers and other things you wouldn't think of and he really enjoyed seeing what was inside. He got really excited with that.” (C2:5)*

*“We all sat and sang and we all agreed that the babies enjoyed it.” (C2:4)*

Mothers also reported that the interactions with other infants and with other adults had helped their babies to be sociable and confident.

*“He's really confident playing with the other babies and likes playing with the older kids. I think they don't become confident if you don't take them out.” (C2:4)*

*“I think she's better with other children because we've been there every week so she's good around other children.” (C2:6)*

*“He was quite shy and it brought him out of his shell being around other children.” (C2:8)*

*“He's quite a sociable baby. He loves being around people. All the babies are quite good around each other.” (C2:9)*

*“I think it's been really good for him, bonding with other babies.” (C2:1)*

It was also suggested that the combination of an expert presence in addition to socialising with other babies had been beneficial:

*“He's had some problems with his behaviour that the FN pointed out a baby shouldn't be doing, he punches and is quite unsocial. So being with the FN and the group in the last few months, he has come out of his shell.” (C2:5)*

### **6.3 Partner perceptions of impact**

- What are the partners' views about the contribution of group involvement to their role supporting their partners during pregnancy and in caring for their new infants?

Partners particularly mentioned that during the ante-natal stage they appreciated the opportunity to learn about what to do when their partner was in labour so they could support her. They also claimed 'joint ownership' of the pregnancy and labour and were able to use appropriate terminology when describing the process, demonstrating that Group was not only a social occasion for them but also that they retained information that would be useful to them.

*“... the fact that we have learnt about how to handle our partners being in labour, I think that helped as well” (Partner)*

*“...we rang the midwife, this is on our labour, (and) waters broke at 12...X was 8 centimetres dilated at five o'clock...” (Partner)*

*“...if I hadn't gone to the group I wouldn't have coped so well in the labour.” (Partner)*

There were some reservations about being involved in weighing their babies during the infancy stage, although the observation was made that it was nice to be involved in the health checks it was the responsibility of the health professional, not them as they might get it wrong. Some of the more practical aspects of the group sessions were appreciated as something the baby would enjoy when older such as creating a keepsake box with items such as hospital bracelets from when they were born.

*“It would be better for when they are older...” (Partner)*

Another session which was perceived to be of benefit was that in which 'cot death' and safe sleeping are discussed. One partner commented that it was only those who were unaware of the risks encountered the problem, indicating an appreciation of learning about that type of risk.

*"People who tend to have these problems with cot death and stuff tend to be people who don't know about it."* (Partner, Focus group)

There were other comments about learning to recognise what their babies' crying meant so that they could respond appropriately, for example:

*"...you get to learn what cries which, what it's for and stuff."* (Partner)

The session on emotions and relationships was also mentioned as useful, one partner commented that he had found out that if he was stressed the baby would pick up this and become angry as well. This comment was made during the focus group session at one particular site and there followed a general discussion about this topic amongst the group demonstrating to the researcher that partners 'took on board' what was discussed during Group.

When asked about the impact of Group sessions on their future parenting one partner stated: "...they give us an insight into what the future holds." (Partner)

Final comments come from one father who stated:

*"I like learning about the psychology of babies and how they think and feel...all in all I think the group is very beneficial to the (service) user...I am very grateful for having the opportunity to do it."* (Partner)

#### **6.4 gFNP Practitioners' views about possible impacts**

- What are practitioners' views about the likely impacts of gFNP for maternal and child health and parenting?

##### **6.4.1 Confidence as a parent**

During the course of the programme changes were observed in clients' attitudes as the importance of their role as a parent became clear to them. It became apparent from group discussions that the young women were gaining insight into the issues round becoming a parent. Being part of a group and having a positive experience within that group was building on self-efficacy and the confidence gained would allow them to access other children's services in the future.

*"They were all very confident, they were very mindful about how they spoke to them because you were giving them all the right information they felt very confident to make the right choices and confident in the ability to parent."* (FN)

*"To see the mothers contributing their knowledge and others picking up on that and testing things out and discussing it the following week, it was just wonderful."* (FN)

*"They quickly fell into the role of being experts on their own child. They realised that when you've had your baby, no-one knows your baby better than you do and that really empowered them."* (FSW)

*"They came there, learnt something new, asked questions. The dads learnt a lot too."* (FSW)

*"Knowledge is power...and I think for lots of these young women it's about them seeing there are services out there who are willing to invest in them and actually value them."* (FSW)

#### 6.4.2 Maternal health and well-being

In terms of impact on pre-natal maternal health, the view was expressed that the quality of care given by the midwife and the family nurse was excellent, and added to this the clients were learning from each other. Giving them the opportunity to carry out their own health checks was empowering and led to them feeling valued.

Data collected by the nurses during pregnancy (at intake and when 36 weeks pregnant) indicated that, while nurses (and clients) may hope for positive health benefits following participation in gFNP, health related habits are a challenge to alter, particularly in a group when efforts are made not to let any group member feel as though they are making less progress than others. For instance, many of the clients had at some time been a smoker (23/28, 82%) although fewer (18/28, 64%) were smoking at the time they enrolled in gFNP. By 36 weeks pregnant records indicate that 16/22 (73%) were smoking and only one smoker has completely given up. Of the 16 still smoking, 6 were smoking less, 3 the same amount and 7 were smoking more than at intake.

There was acceptance by the professionals that this kind of health related behavior was not easy to change, but that they had at least helped in the understanding of the potential impact on infant health.

*“At the beginning, some of them did smoke but now at least they do go outside and don't smoke around their babies” (FSW)*

*“We talked about smoking and alcohol consumption, healthy living generally. Discussions promoting thoughts about that made a big difference. We did see some women starting to make changes just through that vehicle.” (FSW)*

The social aspect of gFNP was emphasized with the view that the social interaction reduced isolation, and there was recognition of commonalities with other women in the group. Improved mental health was mentioned as part of the benefit of being less isolated, alongside the positive aspect of strength based development that takes place within gFNP. One FN mentioned that in the period since the beginning of her particular gFNP programme 50% of the group had become employed or re-entered education. An often cited positive outcome of taking part in gFNP was that of improved child health and development from being appropriately cared for. Interaction with babies of similar age was mentioned as a positive impact by one FN as well as developing healthy interactive relationships with their parents.

There was the general view that taking part in gFNP would have a positive influence on the clients and they had grown together as a group. Clients had forged strong bonds and were making plans for forming their own baby group after gFNP. The view was expressed that there had been much professional input to the group and therefore future parenting ought to be positive.

*“I would hope it is positive on parenting because they have had an awful lot of input, I can't believe how much they do get actually on the programme. There's no excuse not to be a decent parent when you've done FNP...I thought there were lots of positives there.” (MW)*

#### 6.4.3 Parenting and other behaviour

Coverage of concepts such as attachment was seen as particularly beneficial as they not only strengthened mother-child relationships but helped mothers to understand infant behaviour that could otherwise be distressing.

*“They really loved doing a lot of the practical stuff, like about their babies and the love and attachment. When their babies were crying after them we looked at it as a positive, that their babies wanted them, so that gave them confidence.” (FSW)*

In one case a MW observed a behaviour change in parenting during the time she was facilitating the sessions. A client had previously shouted at her toddler [her first child] and was observed to handle him in a negative way. After the gFNP session covering relationships and abuse the client was paying more attention to her child and not shouting at him, thus a positive behaviour change was observed in a relatively short period of time. The client also indicated that she had changed the way she and her partner communicated due to her increased knowledge of the impact that arguments might have on the baby she was expecting.

*“She came back a couple of weeks later and said of the back of that session instead of arguing with the partner face to face they had started texting each other their arguments and that meant she started thinking more about what she was saying to him.” (MW)*

The social aspect of the group, learning from other parents, was highlighted as a route to behaviour change.

*“I think the group almost appeared to monitor each other's ways. There was one mum who didn't bond well with her first child and actually there was quite a lot of difficulty around that and the group. So we talked about that and helped that mother's confidence grow.” (FN)*

The professionals were able to use different viewpoints or different stages in infant development to bring about learning.

*“One of the babies wasn't sitting up properly and we had a discussion about encouraging floor play and a mother whose child was extremely mobile was encouraging the mother to let the baby try to sit up by itself.” (FN)*

Overall there was the view from the gFNP professionals that having taken part in gFNP would continue to benefit the young women in the long term, in parenting as their children develop and also in other aspects of their life.

*“From group discussions it is very clear that they increasingly realize their role as parents is a vital one. They have so much more insight into issues and concerns over their parenting role and this appears to offer safeguarding for their children and I believe the wider family. They have developed social skills and empathy and understanding of other parents and learnt the value of support. I observe children who are cared for in an appropriate way and have healthy interactive relationships with their parents. I think long term they will continue to benefit from this learning this learning” (FN)*

## **6.5 Other professionals**

The Children's Centre Managers did not have direct experience of the programme but talked with the members of their staff who were working in the role of co-facilitators. They believed that taking part in gFNP would be likely to improve pre-natal maternal health because the women feel more supported, have more information about what will happen to them (for example during labour) and are thus increasingly aware of choices that might be available to them.

*“...as far as things like taking care of themselves, speaking openly about many things they may not have done it they had been at home...the group has certainly opened lots of avenues for them to talk about issues that were cropping up...and identifying any problems at an early stage and discussing lots of health matters.” (CCM)*

*“...I think they feel more supported and think they are much more aware of choice...what is available to them...” (CCM)*

The engagement of fathers with gFNP was particularly mentioned as an aspect that would have potential impact on future parenting. The CCMs also felt that receiving intensive support within gFNP and especially learning about attachment and infant needs would have positive impact on the

way the children would be cared for. The impact on potentially vulnerable families would also be positive because those families taking part in gFNP would know where to access support should they need it and be able to be quite proactive in doing that. The view was also held that by coming into the centre on a regular basis and developing relationships both inside and outside the group would provide support for any additional parenting needs such as facilitated access to other services and advice.

*"..impact is good from a family perspective...peer support that has made a difference for them (dads)"* (CCM)

*"it should do, and having that intensive support...being able to look at the attachment and bonding and then perhaps take it back to the young person's experience of their own...that they had with their own parents" (CCM) "...the understanding of the child's needs is probably greater...a more realistic expectation of what to expect as a parent..." (CCM)*

*"the hope is that these families would then know where to access support should they need it and be quite pro-active in doing that...and know what their support networks are..." (CCM)*

## **6.6 Summary of perceptions of impact**

There was a mixed response when asked how they felt about carrying out their own health checks with some feeling it gave them a sense of independence and control over their own pregnancies and others voicing the opinion they would rather a health professional carry out the tests.

When asked which of the resources or materials had added to their confidence or enjoyment of their babies most were unable to specify any particular materials but they were able to talk about specific sessions they had enjoyed or found useful. Finding out about the experience of being in labour and the choices that were available to them was cited as one of the most useful topics during the pregnancy phase and practical activities they could do with their babies were most popular during the infancy phase of the programme.

A direct impact of taking part in gFNP for the women was an increase in personal confidence and in their ability to look after their babies. There was also an improvement in mental health from being less isolated and receiving more support from the health professionals and the other members of the group. Many had changed their behaviour in terms of cutting down smoking whilst pregnant and taking a new approach to eating more healthily as a family including preparing home-made food for their infants at the weaning stage. In instances where they young women reverted to their former less healthy eating habits they still intended that their children would eat more healthily. The majority felt that they had learned a lot more about parenting than if they had taken part in gFNP and that the programme had changed their lives and as a consequence their children's lives for the better.

At the site where partner attendance was usual practice the young men reported the sessions were something they looked forward to, it was a social occasion for them as well as being helpful in giving them information that would allow them to support their partners during pregnancy and with their new baby. They particularly mentioned they appreciated the opportunity to learn what they could do to support their partner whilst she was in labour. This particular ante-natal session appeared to be the best attended by partners across all four sites; this was the session they attended even if they did not attend any others. Some partners reported benefiting from all the session and others highlighted specific sessions such as those focusing on emotions and relationships. They talked about enjoying learning about the psychology of babies and felt that attending gFNP gave them an insight into future parenting.

## Chapter 7 Conclusions and recommendations

### 7.1 Recruitment

The recruitment criteria were workable in that the clients recruited had the expected demographic characteristics, but proved challenging to implement with the addition of the educational qualification limit of 4 GCSEs at grade C or above. Thus, while this requirement was introduced so that women offered gFNP would have fewer psychological resources, it will continue to restrict eligibility and may prove problematic in locations with lower birth rates for the relevant age group (20 to 24 at LMP) so may need to be re-considered at some time in the future.

- One alternative would be to amend it slightly so that clients without both Maths and English GCSE at grade C or higher would be eligible. These are the qualifications most relevant to the possibility of moving into higher levels of education and are gained by a smaller proportion of the school population that gain 5 or more GCSEs at grade C or higher.

Communication with midwifery was highlighted with respect to the age and parity criteria and any other criterion is likely to reduce further the possibility of identifying a large enough group of women for any round of delivering gFNP. This is somewhat surprising since the change in phase 3 from phases 1 and 2 of gFNP was that a local community midwife was the second facilitator for the pregnancy phase. However the on/off nature of recruitment to gFNP makes it more of a challenge than recruiting for FNP and will remain a difficulty if it is only offered infrequently.

- Sites with large teams may want to consider more of a rolling provision, maybe with two or three FNs trained to deliver gFNP, each of whom devotes more of their week to gFNP rather than FNP so that a new group can be started up more often. This is more viable with the Phase 3 model of delivery than the previous model on Phases 1 and 2, which required the programme to be delivered by two FNs one of who was also able to provide the midwifery care.

Acceptance rates varied and this may have been related to who was recruiting and how comfortable they felt in using the educational qualification limitation. Scripts could be developed and shared with all future sites so that this can be dealt with more easily.

- Recruitment would be facilitated by requiring only that clients did not have both English and Maths GCSE. Then only one question is needed and it will enable referred women to report possibly with some exaggeration (as was thought in some cases) a large number of other GCSEs but to also indicate that these did not include those specific subjects.

Being clear about the commitment that would be involved on the part of the client is crucial, in addition to a clear understanding of the programme itself, which was not always the case for the newly appointed midwifery colleagues who had joined in with FNP to delivery gFNP.

- Again scripts could be developed so that the expectation of involvement until infants are one year old is set out clearly while still promoting the potential benefits of the reassurance to be gained from midwifery care in the group, and then checks on the new-borns' progress in the early weeks after the birth.

### 7.2 The roles of the different professionals

Phase 3 has been unique compared to previous delivery of gFNP in that only one of the group facilitators was a fully trained Family Nurse. They were accompanied in pregnancy by a community midwife and in infancy by a Family Support Worker from the Children's Centre. A particular strength of this approach is that it integrates FNP with other services in the community. The link with

midwifery could be important in widening awareness of FNP and FNP with other midwives, which should lead to stronger and more effective referral pathways. The link with the Children's Centres may mean that gFNP clients are helped to be more aware of other services available to them once gFNP is completed, and the Children's Centre staff will learn more about young parents, their particular needs, and may think about improved strategies to involve them in services.

However there were also substantial disadvantages to this method of programme delivery. The training experienced by the non-FNP professionals was not sufficient for them to be fully cognisant of all the details of the FNP approach and the content of the materials. This meant that planning and preparation fell primarily to the FNs. It could also mean, especially for midwifery colleagues, that they focussed most on their role as a midwife, conducting the antenatal checks, seeing the rest of the programme delivery as less relevant. Some were less experienced in conducting group support so this aspect of programme delivery was likely to become the responsibility of the FN. Having to shoulder not only the responsibility for understanding and delivering the curriculum, and delivering using Motivational Interviewing strategies and a strength-based approach but also for keeping the group on track and engaged less to a higher level of stress for FNs that had been experienced in Phase 2, even though at that time the programme was newly developed. This reflects the kind of issue that was identified in an investigation of delivering the home-based FNP with an interpreter to non-English speaking clients. Those FNs also reported more stress and found that managing all the relationships (client and interpreter, client and FN, interpreter and FN) took away from successful delivery of the programme itself (Barnes, Ball & Niven, 2011).

- Being aware of all the relationships within a group and being able to ensure that they are predominantly positive is key to successful delivery and one aspect of training for non FNP professionals if this model of delivery is used in the future will need to focus on that.
- If using the Phase 3 model, the amount of time that it takes to provide gFNP may need to be revisited. Planning and preparation is more complex when working with a colleague from outside the FNP team, and the paperwork required after the session (such as the attendance forms and reflections) may fall solely on the FN whereas if two FNs are delivering the programme they are both familiar with all the data forms and can share the workload. So while it may seem a cost effective option and one that take less time away from the delivery of FNP, this may not be true in actuality given the additional workload of the FNS with this model.

Nevertheless, as with the previous model of delivery gFNP, all professionals were struck by the progress that they saw in clients and this provided them with evidence that the programme was important. They could be discouraged when few clients attended but also some of the best session reflections were given when only a small number of clients were present, allowing more detailed discussion of their particular views and issues.

### **7.3 Client involvement**

The attendance of clients was slightly lower than that found in Phase 1 evaluation which had been 71% in one site and 78% per client in the second for the pregnancy sessions, whereas the average across the four phase 3 sites was 59%. It is not possible to say whether this was related to the different modes of delivery but that is one possibility. It may also be related to the slightly different eligibility criteria used, compared to phased 1, with more focus on women who have low educational qualifications. From the distribution of attendance it can be seen that 5 clients attended only one session and this will have reduced the overall attendance rate. This may have been related to hasty recruitment or to the clients not fully understanding what gFNP would entail.

- If the non-FNP professionals are involved in recruitment they may need more preparation, and it may be preferable to recruit a slightly smaller group rather than recruiting 10 to 12 clients only to find that some never attend or attend only once or twice.

Client attendance in infancy was good, and comparable to Phase 1 but with less attrition, except in the site where the programme had to close prematurely. Possibly the greater amount of sharing of responsibilities between FNs and FSWs contributed to well-functioning and cohesive groups.

Clients who were interviewed or took part in the focus groups were very positive about the group context and made it clear that a key factor in their joining was the consistent and frequent midwifery care. Once in the group, many commented on feedback forms that being able to hear their baby's heartbeat regularly relieved anxieties. This strength of gFNP should not be underestimated, and continues as they are able to regularly check new-born infants' weights. However if this is focussed upon too much as a benefit it is then not so easy to maintain attendance in the later stages of infancy.

- Recruitment, while highlighting the benefits of regular midwifery care from one familiar midwife, could also highlight the learning in infancy related to managing infant behaviour, coping with feeding and weaning, and developing close relationships with infants.

The comments from others include many remarks about increased confidence and appreciation of the learning opportunities, including those who were not first-time mothers. The extra advantage of gFNP is the opportunity to discuss parenting issues with other parents in addition to the professionals. Many clients commented on this and in similar ways to the clients interviewed in the earlier, Phase 1 evaluation, and they had developed their social support network as a consequence.

#### **7.4 Inclusion of partners**

Overall this aspect of Phase 3 was successful although the differences between partner involvement across the four sites indicate that there needs to be some attention to encouraging partner attendance in the early meetings. If it is erratic then those men who do attend may soon feel less involved and stop coming to the group altogether or attend only occasionally such as when they are given detailed information about labour and delivery. While some women will not have partners, and the partners of some will not want or be able to come regularly, when men do attend they are able to contribute in a meaningful way to the discussion, are seen to be involved, and they appreciate both the time talking to other fathers and learning more about the details of their child's birth and later development, and what to be aware of so that they could be fully involved in their care.

- If attendance by partners is sporadic and infrequent then it may be useful to plan some special topics (such as the very successful session on labour) that may draw in a larger number of men, which might then improve their regular attendance.

#### **7.5 Potential for impact**

Impact during pregnancy was noted by many clients, who valued finding out about the experience of being in labour and the choices that were available to them. This is not exclusive to the Phase 3 model, but may be particularly useful in terms of links with community midwifery. Hearing from clients how much they value the 'self-care' side of gFNP may lead any community midwives involved in delivering gFNP to share these ideas with their colleagues. However it was also perceived by some midwives as a factor about the programme that they were unsure about.

- Presentations for local community midwifery groups where gFNP clients are able to talk about their experiences of the programme may help to clarify the 'self-care' aspect of gFNP which could encourage more referrals to be made if the programme is rolled out.

A direct impact of taking part in gFNP for the women was an increase in personal confidence, in mental health, in health related behaviours and in their ability to look after their babies. They also reported less isolation and receiving support from other members of the group. The social support gains have been noted in earlier phases of gFNP delivery and should be highlighted when describing the programme to professionals who might become involved and to potential clients.

## 7.6 Conclusions

The Phase 3 model of delivery potentially would allow a larger number of FNP teams to offer gFNP by involving local community midwives when there is not a midwife among the FNP family nurses. However there were a number of challenges for delivery of this model. In common with earlier phases a stumbling block was communication with community midwifery about the particular eligibility requirements for gFNP and the need to receive a number of names in a short space of time. The inclusion of the educational requirements also led to difficulties in recruiting. Theoretically the involvement of a local community midwife could lead to greater awareness amongst other midwives about the eligibility criteria, thus boosting recruitment. However this would require more groundwork and joint presentations to be successful.

Involving non-FNP practitioners, new to Phase 3, provided the opportunity to strengthen links with Children's Centres. However the newness of the programme and the relatively brief time available for training meant that the FNP nurses took the major responsibility for planning and delivering programme content, especially in pregnancy and this placed additional stress on them. The non-FNP professionals involved, if this model is used in the future, would benefit from more training, but also more training close to the time of their involvement. The small number of sites involved meant that FSWs were prepared with the community midwives (which has the benefit that they meet) but well ahead of the time that they joined the groups, which was problematic. It was also confusing to have training sessions for the non-FNP gFNP professionals with home-based FNP nurses. While the programme content is similar the issues of delivery are very different.

Future professionals using this model for delivering gFNP (or the Phase 1 model) should have specific training and not be included in the training for home-based FNP nurses. If future gFNP training includes community midwives and FSWs, then the FSWs will also need some refresher sessions close to the time that they join the gFNP delivery.

Some recruited clients never attended any sessions and this issue is of concern, given that groups are of limited size. While this may not be specifically a Phase 3 model issue, there are some suggestions that if the midwives who are not also part of FNP are involved in recruitment they may not convey the details of the programme as successfully as FNP personnel. This again indicates the need to more detailed preparation of non-FNP professionals before offering gFNP using this model.

There is no indication that the change-over of professionals from pregnancy to infancy (a particular feature of Phase 3) or the characteristics of the clients in terms of demographic factors, led to lower attendance, resulting in the programme concluding prematurely in one location. It is more likely that each group brings together a unique mix of individuals, sometimes they consolidate into a cohesive a group and at other times this fails to take place. This will require more investigation in order to determine the processes that are most relevant to a group's ongoing successful functioning.

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