This specification must be read along with the overarching specification which applies to all services

1. **Population Needs**

1.1 **National context and evidence base**

1.1.1. This Service Specification is based upon the Family Nurse Partnership teams contribution to the delivery of the Healthy Child Programme (DH 2009) for expectant parents and children aged 0 to 2 years and their families. It should be read in conjunction with the Health Visiting 0-5 service specification and considered a continuum of comprehensive family support.

1.1.2. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities through assessment and intervention as and when need is identified and on an ongoing basis for more complex or vulnerable children and families. Successive reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years.

1.1.3. The Family Nurse Partnership programme (FNP) is a licenced, evidence-based, preventive programme for vulnerable first time young mothers. Central to the model are structured home visits, delivered by specially trained family nurses, offered from early pregnancy until the child is two. FNP is an integral part of the progressive universalism approach recommended in the Healthy Child Programme and the Partnership Plus element of a Call to Action. When a mother joins the FNP programme, the HCP is delivered by the family nurse instead of by health visitors.

1.1.4. FNP has a strong body of research evidence developed over 30 years in the USA with evidence reviews consistently identifying it as the most effective preventive early childhood programme for improving the health and development of vulnerable young mothers and their children.

1.1.5. FNP is the UK replication of the Nurse Family Partnership Programme, developed by Professor David Olds and colleagues in the USA. At the University of Colorado, three large-scale randomised control trials of the programme have shown a range of benefits for children and mothers over the short, medium and long-term. The programme effects are greatest among those most vulnerable. An economic evaluation in the US showed that for low-income and unmarried mothers the cost of the programme was recovered by the child’s fourth birthday.
1.1.6. Benefits of the programme include:

- Improvements in women’s antenatal health
- Reductions in children’s injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increases in fathers’ involvement
- Increases in employment
- Reductions in welfare dependency
- Reduced substance use initiation and later problems
- Improvements in school readiness

1.1.7. FNP has been tested in England since 2007; an independent evaluation of the first 10 pilot sites showed FNP could be implemented well in England, in accordance with the programme model and in the context of the NHS and that the potential for positive outcomes was good.

1.1.8. A large-scale randomised control trial to assess the programme’s effectiveness in an English context has recently concluded and is due to report shortly. In the interim, The Parenting Programme Commissioning Toolkit has recently evaluated FNP and rated it as having the highest quality of evidence, one of only a few programmes rated at this level. In addition, an international review of programmes that prevent child maltreatment found that the Nurse Family Partnership programme was one of only 2 programmes known to prevent child abuse and neglect.

1.1.9. Detailed references for the evidence base that supports this specification are set out in Appendix 1.

1.2. Local context

Please see overarching specification

2. Outcomes

2.1 Research evidence from the US suggests that through the implementation of FNP we should see the following outcomes for mothers with the lowest psychological resources.

- Reduction in smoking in pregnancy
• Increased initiation in breast feeding

• Increase immunisation rates which reduce vaccine preventable communicable diseases in the whole community.

• Improved emotional and social well-being through strong parent child attachment, and positive parenting and family relationships

• Greater intervals between and fewer subsequent births

• Fewer accidents

• Reduction in child abuse and neglect

• Better language development

• Increases in employment and training

• Greater involvement of fathers

• Reduction in the health, social and educational costs of supporting the child and family.

2.1.1 Specific deliverables for Bristol include:

• Up to 100 families recruited to programme based upon 25 cases per Family Nurse (minimum tolerance 93).

• Delivery of FNP to the agreed population in line with the delivery manual

• An expert team of 4 WTE qualified band 7 FNP nurses, 1wte band 8a supervisor plus 1WTE administrative support

• Fidelity goals of the programme and dosage achieved in line with FNP manual

• FNP model integrated seamlessly with Health Visiting sharing of the learning and tools as appropriate.

• Full engagement with other primary care and early years services providers to ensure a whole systems approach to family health and wellbeing.

• Identified improvements in pregnancy outcomes, child health and development (including school readiness and achievement) and economic self-sufficiency for vulnerable first-time young mothers and their children and families.
2.2. Family focused provision

2.2.1. The Health visitor implementation plan 2011-15: A call to action states: “The government believes that strong and stable families are the bedrock of a strong and stable society” (DH, 2011). It sets out what all families can expect from their local health services under the following service levels:

**Level 1 Communities Offer:** To empower all families within the local community with children up to school entry age, through maximising family resources and development of community resources via involvement of local agencies and community groups as appropriate. ‘Health visitors will signpost and support access to a range of services already available in the community and work with partners to develop services including services communities can provide for themselves and they will make sure families know about them.’

**Level 2 Universal Offer:** Working in partnership with parents and carers to lead and deliver the full HCP from ante-natal care through to school entry. ‘A universal service from health visitors and their teams, providing the full HCP to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.’

**Level 3 Universal Plus Offer:** To identify vulnerable families, provide, deliver and co-ordinate evidence based packages of additional care, including maternal mental health & wellbeing, parenting issues, families at risk of poor outcomes and children with additional health needs. ‘Rapid responses from the health visitor team when parents need specific expert help, for example with postnatal depression, a sleepless baby, feeding or answering any concerns about parenting.’

**Level 4 Universal Partnership Plus Offer:** To work in partnership with parents and agencies in the provision of intensive multi-agency targeted packages where there are identified complex health needs or safeguarding needs. ‘On-going support from the health visiting team, plus a range of local services working together and with families, to deal with more complex issues over a period of time. These include services provided by Sure Start Children’s Centres, other community providers including charities and, where appropriate, the Family Nurse Partnership (FNP).’

2.2.2 Whilst specifically noted within Universal partnership plus offer, FNP should deliver to all levels of a Call to action for the families enrolled in the programme i.e. Family Nurses are responsible for ensuring core checks are undertaken, families are signposted to additional help as required and that they are supported to engage in their local community.

3. Scope

3.1. Aims and Objectives of the Service

3.1.1 FNP shares the over-arching aims of the HCP to reduce inequalities in
outcomes and to ensure a strong focus on prevention, health promotion and early identification of needs. It however has additional specific aims, which are to:

- Improve the outcomes of pregnancy by helping young women improve their ante-natal health and the health of their unborn baby
- Improve children’s subsequent health and development by helping parents to provide more consistent competent care for their children; and
- Improve women’s life course by planning subsequent pregnancies, finishing their education and finding employment.

3.1.2. The key objectives of the Family Nurse Partnership service are to:

- To deliver the Family Nurse partnership programme in accordance with the FNP manual and licence agreement, delivering an agreed full service offer in line with National FNP protocols which includes universal access to the Healthy Child Programme (HCP) and early identification of complex need with timely access to specialist services.
- To maximise engagement of vulnerable clients and offer evidence based preventive interventions and reduce inequalities in health and well being
- To improve pregnancy outcomes for young first time mothers
- To improve child health and development by helping parents to provide a secure, nurturing and stimulating environment for their children
- Promote secure attachment, positive maternal mental health and parenting skills using evidence based assessments and effective interventions
- To ensure that the service takes positive, timely, action and focuses services so that the outcomes of the disadvantaged or at risk children and families are not compromised by poor early experiences and environment, and to reduce problems and services costs in the long and short term.
- To ensure a seamless, timely, high quality, accessible, efficient and comprehensive service that engages Young first time parents and their children from conception to two years and which promotes social inclusion, equality and respects diversity.
- To improve economic self-sufficiency of the family by helping parents to develop a vision for their own future with their baby.
3.1.3 Responding to the new vision for nursing and the “Six C’s”, Family Nurse Partnership nurses will:

1. Show care and compassion in how they look after families

2. Find the courage to do the right thing, even if it means standing up to senior people to act for the child or parent's best interests, in a complex and pressured environment

3. Communicate well at all times and finally

4. Demonstrate competence.

3.2. Service Description

3.2.1 The FNP programme is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to. The purpose of the licence is to ensure that the programme is implemented as in the original research conditions so as to maximise the likelihood that similar outcomes will be achieved.

3.2.2 FNP is a voluntary programme, targeted to first time mothers aged 19 and under (at last menstrual period) with the aim to enrol women on the programme as early as possible in pregnancy, ideally before 16 weeks and no later than 28 weeks gestation.

3.2.3 The FNP programme consists of structured home visits from early in pregnancy until the child is two, delivered by family nurses. The visits cover the six domains of: personal health, environmental health, life course development, maternal role, family and friends, and health and human services. The nurses use licensed programme guidelines, materials, methods and practical activities to work with the mother as well as the father and wider family, on understanding their baby, making changes to their behaviour, increasing their parenting capacity, developing emotionally and building positive relationships. FNP is based on the theories of human ecology, attachment and self-efficacy.

3.2.4 Home visits are planned in advance; young parents will be given details of each visit and examples of areas that could be covered in advance of the visit. Young parents accepting the programme will have a named family nurse who will continue to work in partnership with the family until the child is aged 2 years.

3.2.5 FNP must be delivered in an integrated way with maternity, general practice, community health services, health visiting, children’s centres, Job Centres and third sector providers within the context of integrated children’s services and the HCP.

3.2.6 The service will be flexible and responsive, adapting to the individual needs of children and families whilst ensuring fidelity to the licensed FNP.
3.2.7 Programme requirements include:

- Systems should be in place for the early recruitment of eligible clients as set out in the Implementation and Delivery Manual
- Young mothers interested in becoming involved in the programme will be referred to the FNP team who will contact them to confirm that they meet the eligibility criteria
- Young mothers recruited onto the FNP programme should wherever possible be visited by the same family nurse until the completion of the programme when the child is 2 years of age.
- The programme will be delivered to young mothers within the context of the immediate and extended families involving fathers and grandparents.
- Where professional concerns exist for the potential safety of practitioners a risk assessment will be completed before a home visit is undertaken and appropriate multi-agency procedures followed.
- Young mothers who accept the programme will receive structured visits from the family nurse in line with the FNP guidelines
- The family nurse will work closely with the midwives who will be responsible for the young mothers midwifery care.
- Babies born into the programme will receive universal elements of the healthy Child Programme and A call to Action as part of the FNP. The Family Nurse is responsible for ensuring access to the physical examination new-born hearing screening, blood spot screening and immunisations.
- When children reach the age of two years the family nurse will notify the health visitor lead for that locality, and agree future service delivery. Families will be supported to access wider children’s services to meet their individual needs
- The Family Nurse Supervisor will have systems in place for effective communication, audit and information sharing for all aspects of the FNP with Midwives, Social Care, Health visitors, GPs and Children’s Centres.
- Young mothers who choose not to enrol on the FNP will be notified back to the midwife who will continue to coordinate care for the family until 14 - 28 days after the birth of the baby ensuring the young mother has access to all aspects of midwifery and health visiting care.
3.3 **Expectation of providers**

3.3.1 The provider will deliver the implementation and delivery requirements for the FNP programme as set out in the FNP Sub-licensing Agreement for Providers and the FNP Management Manual. These documents are made available to prospective local sites.

3.3.2 Providers will be expected to have systems in place which ensure early recruitment of young women (before 16 weeks gestation) to maximise the enrolment of eligible clients in early pregnancy, enabling them to get maximum benefit from the programme.

3.3.3 Providers will be expected to have clear operational standards in place, in relation to how the FNP interfaces with, and relates to, all of the agencies supporting the delivery of the HCP and safeguarding the welfare of children. Providers will also be expected to have robust pathways in place for families moving from FNP back into Health Visiting and children’s services. Providers will be expected to provide strong organisational leadership and support so the FNP programme can be delivered well in their area.

3.3.4 Family nurses will work in partnership with parents using the FNP guidelines, other programme materials and methods to enable mothers and fathers to increase their knowledge and understanding, set goals, make behaviour changes and develop their reflective capacity. This will enable them to build strong attachments with their baby, enhance their self-efficacy, develop effective strategies for good infant and toddler care-giving, strengthen and adapt to their parenting role.

3.3.5 Each site is required to recruit an FNP supervisor to lead the clinical implementation of the FNP programme with families. The FNP supervisor is responsible for the quality of programme delivery, using the FNP information system to support their assessment and improvement of implementation quality.

3.3.6 Family Partnership Nurses will identify children and families who require additional services or support from a number of agencies to overcome entrenched problems known to contribute to poor health, social and educational outcomes, intergenerational worklessness and poverty in line with the Equality Act 2010 and Supporting Families Strategy.

3.3.7 Family Nurses will ensure that there are links with specialist services and the common assessment framework is utilised for families where there are the most complex health or social care needs (e.g. disabled children, children with major health difficulties, or children likely to be “in need”. Where there are safeguarding concerns as in the Children Act 1989, safeguarding referrals should be made. The Common Assessment Framework should be implemented in line with local policy.

3.4 **Service model**

3.4.1 FNP will be delivered by a team of trained family nurses, led by the FNP supervisor and accountable to the local FNP Advisory Board. The FNP
Advisory Board consists of senior decision makers for children and young people’s services from the NHS, Local Authority and appropriate partner services. FNP will be delivered with fidelity to the FNP model, and meeting the programme’s core model elements and fidelity goals as set out in the license agreement.

3.4.2 The programme of FNP visits includes:
- 1 per week first month
- Every other week during pregnancy
- 1 per week first 6 weeks after delivery
- Every other week until 21 months
- Once a month until age 2

3.4.3 Visits last approximately one hour and cover the following domains:
- Personal health – women’s health practices and mental health
- Environmental health – adequacy of home and neighbourhood
- Life course development – women’s future goals
- Maternal role – skills and knowledge to promote health and development of their child
- Family and friends – helping to deal with relationship issues and enhance social support
- Health and human services – linking to other services

3.4.4 The programme will include the following:
- Pregnancy guidelines
- Infancy guidelines
- Toddlerhood guidelines
- Six domains covered at every visit
- Dyadic Assessment of Naturalistic Caregiver-Child experiences (DANCE)
- Ages and Stages Questionnaire (ASQ)
- Partners in Parenting Education (PIPE)
At each contact with the Family Nurse the mother is encouraged to look at her goals and needs, using a process of agenda matching which is outlined in the FNP schedules for pregnancy, infancy and toddlerhood. Clients are encouraged to develop their hearts desire in partnership with the family nurse.

3.4.5 The provider will implement the programme in accordance with the FNP Sub-licensing agreements and the expectations set out in the latest FNP Management Manual, provided by the FNP National Unit. This includes ensuring services are delivered in line with local safeguarding arrangements.

3.4.6 Every effort will be made by the family nurse to ensure continued engagement of the client in FNP. Clients who leave the programme before their child is 2 years old will be notified to the health visitor who is responsible for universal services, ensuring access to preventive services and to others providing the HCP (e.g. GPs).

3.4.7 FNP teams will follow the FNP National Unit’s guidance and local guidance regarding clients who cannot be traced and will act to safeguard the child or other family members where risks are identified requiring further actions.

3.4.8 Family nurses and supervisors will use the FNP Information System to record data about their clients and use this to inform how they deliver the programme.

3.4.9 Where the FNP client has a second child during the time of her involvement with FNP, the family nurse will be responsible for delivery of the HCP to the family for the second child, in addition to the first, until the first child reaches the age of 2 years.

3.5 Recruitment Pathway

3.5.1 Those eligible will be identified by maternity services and notified to the FNP supervisor at 12 weeks gestation or earlier as far as possible. Clients must be enrolled on the programme no later than 28 weeks gestation with a specific fidelity goal to enrol at least 60% by 16 weeks gestation. Other services (e.g. GPs, education, children’s centres) are able to identify and refer potential clients to FNP according to local criteria. Offer of the programme and recruitment will be carried out by the FNP team. FNP teams are expected to enrol clients onto the programme using a staged approach. Appointments will be generated for attendance at immunisations, screening tests and health reviews. Children/families who do not attend will be actively followed up by the family nurse.

3.6 Discharge Criteria and Planning

3.6.1 Discharge from FNP is age related. A client graduates from the programme when the child reaches 2 years of age and responsibility for HCP delivery is transferred back to core Health Visiting services at this point. The programme includes materials and activities to prepare the client for the end of the programme and the family nurse will have introduced the client
and her child to local services before this time.

3.6.2 Before children reach the age of two years the family nurse will notify the health visitor lead for the HCP team and discuss the handover process with the client.

3.6.3 Families will be supported to access children’s centres and the HCP will match services and interventions to their individual needs.

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

3.6.5 Family nurses will continue to make all efforts to locate clients who cannot be found and persist in their efforts to re-engage clients who indicate that they no longer wish to receive the programme, either directly or by repeated missed visits.

3.6.6 Once 6 months has passed with no client contact, the client will be classified as being an ‘inactive’ case on the nurse’s caseload and the nurse can re-recruit to that vacancy. Inactive clients can subsequently return to the programme if they wish and if there is capacity in the FNP team.

3.6.7 If a client with significant risk or safeguarding factors is not receiving programme visits for any reason, local safeguarding processes should be implemented.

3.6.8 Young mothers who choose not to accept FNP will be notified to the midwife who will continue to coordinate care for the family until 14-28 days after the birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP.

4. Applicable Service Standards

4.1. Applicable national standards - please see Appendix 1

4.2. Record keeping, data collection systems and information sharing

   a) In line with contractual arrangements, providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data at all times. Providers should also refer to ‘Record Keeping: Guidance for Nurses and Midwives’, NMC, 2009.

   b) In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies including other health care providers, children’s social care and the police to enable effective services to be provided to children and their families. Providers will ensure that all staff have access to information sharing
4.3.3 The Personal Child Health Record (PCHR) will be provided and completed routinely by professionals supporting parents and carers to use proactively. Appropriate records will be submitted to the Child Health Information System (CHIS) or similar system to enable high – quality data collection to support the delivery, review and performance management of services.

4.3 Workforce model

4.3.1 Each FNP team has a FNP Supervisor responsible for clinical and safeguarding supervision, management of the Family Nurses, meeting their learning needs and team functioning. Providers will ensure that all family nurses attend FNP training arranged by the central FNP team and that the supervisor attends the monthly learning sets provided by the central team. Family nurses will be supported to achieve the Family Nurse competencies. The face-to-face training elements of the programme for family nurses amount to 19 days spread over 15 months.

4.3.2 Family Nurses will be recruited from professional nursing backgrounds, meeting the person specifications provided in the Implementation and Delivery Manual and with young parents involved in the recruitment panel. The role of family nurse is both demanding and challenging therefore providers will ensure the FNP supervisor is central to the recruitment process for family nurses to ensure their suitability to undertake the role.

4.3.3 Family nurses can deliver the programme to a maximum caseload of 25 eligible families per full time equivalent, in accordance with the licence requirements.

4.3.4 The FNP is known to be effective in preventing abuse however the intensity of the programme may expose additional challenges in relation to safeguarding and therefore providers will be expected to have in place clear policies that demonstrate the interface between the FNP and local safeguarding arrangements. The Common Assessment Framework should be considered for use in the majority of cases owing to the level of need of the families engaged in the programme.

4.3.5 The Provider will develop and maintain a supervision policy in line with the FNP manual and licence agreement including:

- Weekly 1:1 supervision
- Fortnightly team case discussions
- Quarterly joint home visits with the supervisor

Providers will need to ensure that supervisors meet the competencies to undertake safeguarding supervision within the framework of FNP supervision. Providers will be required to have in place clear policies for Staff appraisal & Individual professional development plans.
4.3.6 This supervision should be provided by Supervisors with the ability to;

a) Create a learning environment within which the team can develop clinical skills and strategies to support vulnerable families. This will include experiential and active learning methods.

b) Use strengths based, solution focused strategies and motivational interviewing skills to enable nurses to work in a consistently safe way utilising the full scope of their authority.

c) Provide constructive feedback to health visitors using advanced communication skills to facilitate reflective supervision.

d) Manage strong emotions, sensitive issues and undertake courageous conversations, particularly in circumstances where FNP support is not able to fully address concerns for vulnerable families.

e) Provide guidance on the interpretation of principles and policies to FNP nurses.

4.3.7 Providers are responsible for ensuring that they appoint practitioners who meet the expectations of the standard job description and person specifications for the programme. They are also responsible for ensuring that family nurses and supervisors access their FNP learning and training programmes and any additional HCP learning they require. The FNP supervisor will manage the FN’s team based learning and achievement of FNP competencies and the provider lead will ensure that the supervisor achieves the FNP supervisor competencies.

4.4 Safeguarding

4.4.1 Safeguarding is at the heart of children’s public health. NHS England and providers are required to ensure that services are embedded into local safeguarding arrangements with health and local authorities.

4.4.2 The service has a key and explicit role to play in relation to safeguarding and promoting the welfare of children and young people and this needs to underpin all service delivery. There needs to be clear policies and procedures in place relating to safeguarding in line with national guidance and locally agreed procedures. The service, as a partner of the Local Safeguarding Children’s Board are accountable to be compliant with duties and responsibilities laid down in Section 11 Children Act 1989 (revised 2004).

4.4.3 Good parenting involves caring for children’s basic needs, keeping them safe and protected, being attentive and showing them warmth and love, encouraging them to express their views and consistently taking these views into account and providing the stimulation needed for their development and to help them achieve their potential within a stable environment where they experience consistent guidance and boundaries’
Service Specification: Bristol North Somerset and South Gloucestershire Family Nurse Partnership May 2015

(HM Government, 2010).

4.4.4 The service will ensure that the FNP service forms part of the high intensity multi agency services for families where there are safeguarding and child protection concerns in line with ‘A child- centred system. The Government’s response to the Munro review of child protection’ (DfE 2011). Access to risk and resilience tools where these are developed will support the workforce to identify complex need but should not replace professional judgement.

4.4.5 Effective inter-agency arrangements and shared care pathways are crucial to protecting children and promoting their welfare. All agencies working with children, young people and their families should take all reasonable measures to ensure that the risks of harm to children’s welfare are minimised; and where there are concerns about children and young people’s welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies as described in Working Together to Safeguard Children (2010). Services delivered through this service specification are required to follow this guidance and locally agreed safeguarding procedures.

4.4.6 The learning from Child Death Overview and Perinatal Networks will be shared to inform commissioning intentions, practice and public health interventions.

4.5 General

- All individuals will be treated with courtesy, respect and an understanding of their needs.
- Parents / carers will have adequate information on the benefits and risks of individual elements of children’s public health services to allow them to make informed decisions.
- A flexible approach should be taken to ensure equality of access to services and target specific vulnerable groups / families and working parents.

5. Applicable quality requirements and CQUIN goals

5.1 The provider must deliver a comprehensive high quality Family Nurse Partnership Service which meets the standards, pathways and guidance set out in this service specification. The service must be safe, effective and customer focussed.

5.2 The provider service must be quality assured against CQC and all applicable quality standards, key performance indicators and service delivery metrics.

5.3 Providers will be expected to have in place mechanisms for the systematic
collection of high quality data to meet the core fidelity requirements of data collection for the FNP programme. Use of FNP data forms and the FNP information system (FNP IS) are central to this requirement and can be accessed via a web-based interface using the N3 network and NHS Open Exeter Portal;

- Family nurses and supervisors will be required to collect high quality data as set out in the programme guidelines and input this into the FNP IS. They will use this to monitor fidelity to the programme and inform continuous quality improvement of programme delivery
- The supervisor will monitor the collection of the data and ensure its use as a clinical tool
- The supervisor will generate reports on programme delivery that are used with the team and the FNP Advisory Board to improve and maintain the quality of the programme
- The Provider must submit data onto the Open Exeter system and report data to commissioners at minimum on a quarterly basis for analysis
- The FNP team will use local CHIS to record information about each child including immunisation status
- The FNP team will use local provider information systems to maintain clinical records

5.4 Providers must complete a full and detailed annual report in line with national requirements.

5.5 The provider should highlight to commissioners where there is an absence of local services to refer families onto so that future commissioning plans can include mitigation for/provision of these; this is particularly urgent where need is identified but NICE guidance pathways are truncated at the onwards referral stage because local services do not currently exist.

6. Location of Provider Premises

6.1 Provider’s Premises

6.1.1 FNP is a home based visiting programme, however family nurses will be expected to be able to offer parents a choice of location where this is most appropriate e.g. GP surgeries, children’s centres, community health services, extended schools, health centres, café etc.

6.1.2 It is expected that family nurses will follow their clients across organisational boundaries, when feasible, to maintain engagement in the programme.

6.1.3 Hours of operation need to fit around the needs of mothers and fathers, and
providers are expected to support nurses to work ‘out of hours’.

6.1.4 The team will need access to an N3 connection (an NHS secure broadband network, through which NHS information systems are delivered and accessed) in order to access the FNP Information System and consideration should be given to hot-desking, mobile, and working requirements.

6.2 Days / Hours of operation

The core service will operate standard hours of 9am – 5pm but will offer flexibility from 8am – 8pm to meet the needs of local families.

The Provider’s Premises are located at:
Appendix 1: Evidence Base, Applicable National Service Standards and Suite of Evidence Based Interventions/Pathways

Evidence Base

- **Healthy Child Programme – Pregnancy and the first five years of life** (DH, 2009 – amended August 2010)
- **Better health outcomes for children and young people** Pledge
- **The Children and Young People’s Health Outcomes Strategy (DH, 2012)**
- **Health visitor implementation plan 2011-15: A call to action** (DH, 2011)
- **The National Health Visitor Plan: progress to date and implementation 2013 onwards** (DH, 2013)
- **The Operating Framework for the NHS in England 2012/13** (DH, 2011)
- **The NHS Outcomes Framework 2012/13** (DH, 2011)
- **Improving outcomes and supporting transparency, Part 2: Summary technical specifications of public health indicators**, (DH, 2012)
- **Service vision for health visiting in England (CPHVA conference 20-22 October 2010)**
- **Securing Excellence in Commissioning for the Healthy Child Programme 0**
Service Specification: Bristol North Somerset and South Gloucestershire Family Nurse Partnership May 2015

to 5 Years 2013 – 2015

- **Equity and excellence: Liberating the NHS (DH, 2010)** and **Liberating the NHS: Legislative framework and next steps DH, 2011**

- **Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people (DH, 2010)**

- **Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs (DH, 2010)**

- **Healthy lives, healthy people: our strategy for public health in England (DH, 2010) and Healthy lives, healthy people: update and way forward (DH, 2011)**

- **Healthy lives, healthy people: a call to action on obesity in England (DH, 2011)**

- **UK physical activity guidelines (DH, 2011)**

- **Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children (HM Government 2013)**


- **The 1001 Critical Days: The importance of the conception to age two period.Wave Trust, 2013**

- **Conception to Age two: The Age of Opportunity. WAVE Trust and DfE**


- **UNICEF UK Baby Friendly Initiative**

The evidence base and key policy documents specific to FNP include:


Service Specification: Bristol North Somerset and South Gloucestershire Family Nurse Partnership May 2015


Applicable National Standards

Key NICE public health guidance includes, but is not limited to:(Please note: For all reference see the NICE website).

- PH3 - Prevention of sexually transmitted infections and under 18 conceptions
- PH6 - Behaviour change at population, community and individual level
- PH8 - Physical activity and the environment
- PH9 - Community engagement
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH21 - Differences in uptake in immunisations
- PH24 Alcohol-use disorders: preventing harmful drinking
• PH26 - Quitting in smoking in pregnancy and following childbirth
• PH27 - Weight management before, during and after pregnancy
• PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people
• PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued
• PH30 Preventing unintentional injuries among the under-15s in the home
• PH31 Preventing unintentional road injuries among under-15s
• PH40 Social and emotional wellbeing – early years
• PH42- Obesity working with local communities
• PH44 Physical activity: brief advice for adults in primary care
• PH46 Assessing body mass index and waist circumference thresholds for intervening to prevent ill health a premature death among adults from black, Asian and other minority ethnic groups in the UK.
• PH49 Behaviour change: individual approaches
• CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
  CG45 - Antenatal and postnatal mental health: clinical management and service guidance
• CG62 - Antenatal care: routine care for the healthy pregnant woman
• CG89 - When to Suspect Child Maltreatment
• CG93- Donor milk banks: the operation of donor milk bank services
• CG110- Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors
• QS22 Quality standards for antenatal care
• QS31 Quality standard for the health and wellbeing of looked-after children and young people
• QS37 Postnatal Care
• QS43 Smoking cessation: supporting people to stop smoking
• QS46 Multiple pregnancies
• QS48 Depression in children and young people