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Anschutz Medical Campus

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International Nurse-Family Partnership® (NFP)

Phase Four Annual Report

Phase Four - Continued Refinement and Expansion
This phase includes; building capacity and establishing sustainable systems for funding; embedding clinical leadership; selecting and developing new sites; recruiting and educating new NFP nurses and supervisors; and continuously improving program implementation, including refinement and use of the NFP information system. It is expected that countries will move to a higher level of self-sufficiency during this phase while continuing to meet licensing requirements through the annual review process, including completing this annual report. Any substantive change in the way NFP is implemented will continue to require approval of the PRC.

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data are reported, analysed and reviewed, to guide discussion of the country's implementation successes and challenges, as well as emergent outcome variations. The annual report forms the basis of the Prevention Research Centre, University of Colorado's (UCD) annual review of NFP implementation and fidelity in licensed partner countries and for discussing quality improvement plans. By using quantitative and qualitative data, the annual report creates an opportunity for each country's leadership team to reflect on progress and develop quality Improvement plans for the following year.

Completing the report:
The country license holder is requested to coordinate the completion of this report, with contributions from the national implementing body, and others, as required.

Please note: If you are unable to complete any items in the report template, please indicate whether these data are not collected in your country or is not able to be analysed at this time. Where terms used in the report template are generic, please specify how items are measured in your country. Where you have adapted your data collection schedule/timings or approach to accommodate local systems, please adapt the document as necessary to take account of this.

The report should be sent to Dr David Olds, Ben Jutson and the country's International Consultant at least three weeks prior to the Annual Review meeting. Further guidance on the conduct of the annual review meeting can be found on the 'International NFP Resources' page of the international website.

If you have any questions regarding the content of this document, please do not hesitate to get in touch with your NFP International Consultant.

PART ONE: PROGRAM OVERVIEW

Name of country: Northern Ireland

Dates report covers (reporting period): FNP Analysis of data to 31st December 2021

Report completed by: Shona Johnston

Date submitted:

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	**31**	**31**
Part time NFP Nurses	**5**	**5**
Fulltime NFP Supervisors	**4**	**4**
Part time NFP Supervisors	**2**	**2**
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	**0**	
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	**0**	
Total		**42**

- We have 5 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:7

- Current number of implementing agencies/sites delivering NFP: 5
- Current number of NFP teams: 5

- Number of new sites over reporting period: 0
- Number of new teams over the reporting period: 0

- Number of sites that have decommissioned NFP over the reporting period: 0

- Successes/challenges with delivery of NFP through our implementing agencies/sites:

We have successfully moved to DANCE by Distance and set up our own DANCE NI Studio. All teams have now successfully gained re-proficiency and new nurses will complete DANCE training in due course.

Integration and partnership working continues to be integral to the success of local implementation of FNP in Northern Ireland. Through the development and maintenance of an on-going Communication Strategy, the key messages of FNP continue to be reinforced amongst our colleagues in each of the 5 Health and Social Care Trusts. This has helped FNP integrate and work effectively with other services and has strengthened and developed the desired partnership working approach.

Our main challenge continues to be the work on our Information System. A functioning FNP information system is in place that currently enables client management and data input, however we have been informed by our Supplier (DXC) that due to some Microsoft changes, they are unable to support our current system in the long term. This information has now made the funding of a new system or the upgrading of the existing system an immediate priority. A support

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contract is in place at present to ensure functionality for as long as possible and a request submitted to Digital Health and Care NI (DHCNI) to look at our options in relation to an alternative system which would meet our business needs. This work remains ongoing.

Description of our national/ implementation / leadership team capacity and functions
License holder name: Rodney Morton, Director of Nursing, Public Health Agency Role and Organisation: Public Health Agency, Northern Ireland

Description of our National implementing capacity and roles:
Clinical Leadership: The Central team includes a Clinical Lead, Nurse Consultant, Research and Information Manager and a Research and Information Officer.
The Family Nurse Partnership programme has been supported by the Chief Nurse at the Department of Health and Mr Rodney Morton, Director of Nursing at the Public Health Agency.

Data analysis, reporting and evaluation:
A functioning Information System is in place. Analysis is provided by the Central Team.

Service development/site support:
The FNP Research and Information Team, consisting of Dr Emma Larkin and Shauna Conway, have considerable research, training and experience of conducting both quantitative and qualitative research related to, and gained through, previous research focused on early parenting research and evaluation of outcomes for evidence based interventions. The FNP Research and Information Team are embedded within Health Intelligence at the PHA which provides further access to specialist expertise in quantitative and qualitative evaluation in addition to access to comparative data for the purposes of comparative analysis

Quality improvement:
The focus of our quality improvement programme has been to complete the introduction of the Intimate Partner Violence Programme Augmentation. The preliminary analysis has been completed by Dr Emma Larkin and Emma presented preliminary findings at the 4th European Conference on Domestic Violence, online from Slovenia. The session presented findings from a service evaluation of the implementation of IPV innovation into practice in FNP Northern Ireland, alongside findings from the parallel implementation of this innovation in FNP in Norway, England and Canada.

NFP Educators:
FNP Education and training has been provided by NES Scotland.
IPV Training will be provided by two of our Supervisors and sessions have been planned to support new Nurses in this area of work.
Communication Trainers were appointed in 2018 to provide ongoing Communication Training and Development for the Family Nurse teams in Northern Ireland. They have worked closely with FNP Scotland to develop the required skills and have provided Communication Skills training for the Family Nurses. Further training will be planned.
An additional PIPE trainer has been selected. She will work closely with FNP Scotland and FNP England to provide updates for the family nurses on PIPE activities.

Other (please describe)
Family Nurses from each team are undertaking the M9 Infant Mental Health Diploma. This focuses on social and emotional development during the first three years for an infant and their family,

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including a child's ability to form relationships with other children and adults; to recognise and express emotions; and to explore and learn about their environment in a safe and happy way.

Description of our local and national NFP funding arrangements:

The funding for 10 new Family Nurses was secured from the Department of Health's Transformational Fund in 2019. Funding has now been secured on an assumed recurrent basis.

The Delivering Care process, has secured funding for an additional Family Nurse in each team. Recruitment has been successful allowing us to expand the service regionally.

Funding for the remaining posts is secured on a permanent basis via Programme for Government Funding.

Current policy/government support for NFP: The current policy is the Transformation Plan 'Health and Wellbeing 2026: Delivering Together'. This sets out a clear road map, which is an ambitious plan based on early intervention and prevention. One of the key ambitions in the draft Programme for Government and, therefore, Delivering Together is to give every child the best start in life

How our NFP supervisor and nurse education is organised: At present, education for Nurses and Supervisors is provided by NES FNP Scotland and the English National Unit. The core FNP nurse education has been delivered using face to face residential learning, online preparation and consolidation modules as well as materials to support team learning at site level.
Our new Nurses have recently returned to face to face training, which has helped embed new learning through peer support.
DANCE training is now being delivered via our own DANCE NI studio by the team in Denver. This is delivered online and all Nurses have recently completed their re-proficiency.

Description of any partner agencies and their role in support of the NFP program: Project ECHO has provided a virtual platform for FNP regional learning. ECHO brings together clinical specialist teams and educators to provide opportunities for teaching through case presentations. The FNP model is similar in that it involves weekly team meetings and case based meetings to identify client challenges and solutions and provide peer support and learning.

Other relevant/important information regarding our NFP program:

This past year FNP Teams have continued to complete ECHO sessions to ensure collaborative reflective learning. Some of the topics covered included:

- Practical tips for Speech and Language development
- Preparing clients for Labour/Pain relief/Delivery
- Importance of Play and Child development
- Perinatal Mental Health
- Addictions / Mental Health pathways and services
- Home safety and Accident Prevention/Pre-Mobile Bruising - up to date guidance and support
- Tips for Weaning/Feeding/Diet and Nutrition

Midpoint evaluation results of how ECHO has enabled us to achieve our objectives are included below:

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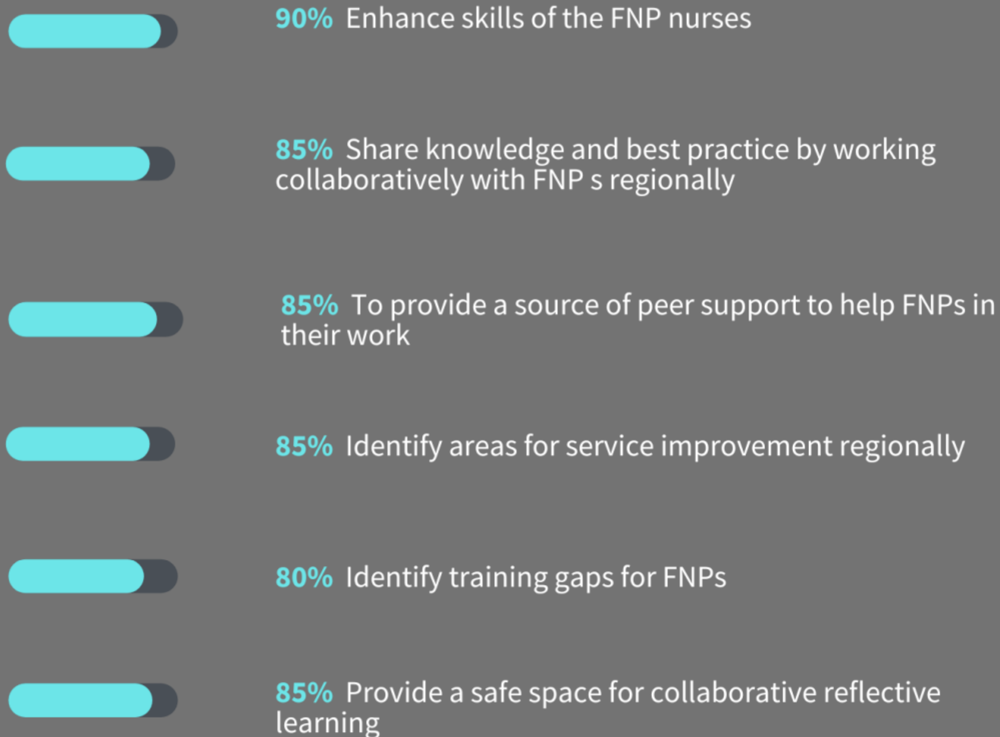
Family Nursing Partnership ECHO Network

Objectives/Benchmarks Progress

Is Project ECHO helping you to achieve your Objectives:



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PART TWO: PROGRAM IMPLEMENTATION

Clients

- NFP clients participating in the program over the last year: In 2021, 72.4% (N=168) of definitely eligible clients offered the programme were enrolled.
- A total of 1605 clients were enrolled on the programme and received a valid visit by the end of December 2021.
- To date, 1517 active clients have completed the pregnancy stage, 1238 active clients have completed the infancy stage and 947 active clients have completed the toddlerhood stage
- Overall, 74.2% (N=1620) of definitely eligible clients offered the programme prior to the end of December 2021 (referred by 31.12.2021) were enrolled on the programme (75.3% BHSCT (N=327), 64.5% NHSCT (N=253), 90.7% SEHSCT (N=292), 72.7% SHSCT (N=343) and 71.8% WHSCT (N=405).
- Our national benchmark for % of eligible women referred/ notified who are successfully enrolled onto the program is 75%

Our reflections on this figure: The programme continues to be offered to eligible clients in a positive, strengths-based way. Some young people remain challenging to engage as they are reluctant to seek guidance and support from professionals. Family Nurses remain tenacious in their approach to enrolling young women as early as possible so that clients gain maximum benefit. The NIMATS midwifery administrative system – which identifies eligible clients to FNP Supervisor at booking - is a more efficient and effective way of accessing new referrals than an individual referral system.

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: Overall, father engagement was 14.5% for pregnancy completers, 13.4% for infancy completers and 10.3% for toddlerhood completers.
- % of home visits, where other family members are present: Overall, client parent engagement was 17.6% for pregnancy completers, 15.5% for infancy completers and 10.3% for toddlerhood completers.
- How we engage fathers/partners/other family members in our program: Family Nurses develop strong therapeutic relationships with their clients, including where possible with fathers or partners. The client decides whether the father/partner is present for visits, with the Nurse recognising that these are often new relationships, and may be quite transient. Programme goals, domains and materials generally apply to fathers as well as mothers and include understanding and developing positive relationships and what this means for their child.
- Our reflections on father/partners/other family member’s engagement: Involving Fathers/partners and other family members who are important in a client’s life is integral to

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the FNP programme in Northern Ireland. Some young fathers often have additional barriers to engagement such as being excluded by the maternal family, lacking resources and having a history of risk taking behaviours. Family Nurses are skilled in matching agendas and in judging where a father/partner poses any risks to the child, exploring this with the client and taking action without clients disengaging from the programme.

Nursing Workforce

NFP Information System

- Current number of implementing agencies/sites delivering NFP: 5
- Current number of NFP teams: 5

- Number of new sites over reporting period: 0
- Number of new teams over the reporting period: 0

- Number of sites that have decommissioned NFP over the reporting period: 0

- Successes/challenges with delivery of NFP through our implementing agencies/sites:

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Continuous Quality Improvement (CQI) Program

Brief description of CQI processes: Through our Quality Improvement process we aim to provide a consistently safe and high quality programme across Northern Ireland replicating and delivering FNP according to the research, thereby maximising the potential benefits for children and families.

- How we use qualitative and quantitative information as part of our CQI program: Every year each FNP Team identifies areas for service improvement.

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This year we plan to continue to use ECHO to contribute to this process by bringing staff together remotely for learning and service development through regional collaborative education sessions.

- Successes/challenges with our CQI approach: Challenges with our Information System have prevented us from moving on with the reporting function of the system. Supervisors having the capacity to run reports would strengthen our quality improvement process through supervision, enabling them to assess and guide programme implementation, inform supervision, enhance programme quality and demonstrate programme fidelity. Work on our Information system remains ongoing to improve its functionality, usefulness and quality.

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PART TWO: PROGRAM IMPLEMENTATION - NFP CORE MODEL ELEMENTS (CMEs)

Please complete the table below to identify how the CMEs are being monitored/assured, progress against benchmarks, and actions planned or undertaken to address any challenges. Where there is a need to add more content than space allows, please add appendices as necessary.

NB: Where any temporary variances to the CMEs have been agreed, please indicate these in the text box below as well as completing Appendix 2 of this document

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: by signed informed consent	100% voluntary participation	
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Supervisor allocates eligible referrals which meet this criteria.	100% first time mothers	
3. Client meets socioeconomic disadvantage criteria at intake	The socioeconomic disadvantage inclusion criteria for our country are: In NI, socioeconomic disadvantage is not part of the referral criteria to the programme. However there is consideration given to the statistics in areas of deprivation and how this equates with teenage pregnancy rates. Application of these criteria are assured and monitored by: Supervisor in each site and Nurse Consultant in PHA	• % clients enrolled who meet the country's socioeconomic disadvantage criteria The youngest, most vulnerable, pregnant teenagers meet the eligibility criteria and should get a place on the programme.	The programme is targeted at areas most in need, either by density statistics, or areas of social deprivation

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	99.9% of NFP clients receive their first home visit no later than the 28th week of pregnancy In 2021, 72.4% (N=168) of definitely eligible clients offered the programme were enrolled. Overall, 36.3% (N=582) of clients were enrolled by the end of 16 weeks gestation or earlier.	Many of our young clients are hard to reach and are reluctant to engage with professionals. Family Nurses continue to be tenacious, persistent and resilient in their approach to recruitment. They are skilled in knowing that recruitment for some clients be challenging especially at the early stage of pregnancy. **Action:** we may look at our Benchmark in relation to enrollment by 16 weeks gestation
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100% clients are assigned a single NFP nurse	
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.	National/ Country benchmark set is: % visits take place in the home	**Pregnancy:** 83.4% visits take place in the home **Infancy:** 81.7% in the home **Toddlerhood:** 82.3% in the home **% breakdown of where visits are being conducted other than in the client's home:** **Pregnancy**: Overall (N=14043 valid visits), the visits took place in 0.2% (N=35) children's centres, 83.4%	We plan to set Benchmarks moving forward.

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		(N=11710) in the client's home, 2.4% (N=343) in a community location, 1.1% (N=152) in a doctors or clinic, 5.6% (N=780) in a family or friend's home, 0.4% (N=55) in school or college, 6.7% (N=937) stated other **Infancy:** Overall (N=24549 valid visits), the visits took place in 0.3% (N=71) children's centres, 81.7% (N=20050) in the client's home, 3.0% (N=731) in a community location, 0.7% (N=183) in a doctors or clinic, 4.8% (N=1179) in a family or friend's home, 0.1% (N=21) in school or college, 9.3% (N=2285) stated other and 0.1% (N=29) were left blank. **Toddlerhood:** Overall (N=13167 valid visits), the visits took place in 0.2% (N=32) children's centres, 82.3% (N=10835) in the client's home, 4.2% (N=553) in a community location, 0.6% (N=76) in a doctors or clinic, 3.3% (N=428) in a family or friend's home, 0.1% (N=15) in school or college, 9.3% (N=1218) stated other	
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with	National/Country benchmarks for : a) Program visit dosage patterns in relation to client strengths and risks benchmarks are:	• 100% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is:	

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	Pregnancy: 14 visits Infancy: 28 visits Toddlerhood: 22 visits b) Length of visits by phase benchmarks: • Pregnancy phase: 60 mins • Infancy phase: 60 mins • Toddler phase: 60mins c) Client attrition by program phase benchmarks: 10% attrition in Pregnancy phase 20% attrition in Infancy phase 10% attrition in Toddler phase	**Pregnancy**: Overall, clients were scheduled to have an average of 11.9 visits and they completed an average of 9.3 valid visits in pregnancy. For clients who enrolled in 2021, 79.0% of expected visits (based on gestational age) were achieved by the end of 2021. **Infancy:** Overall, clients were scheduled to have an average of 28 visits and they completed an average of 19.9 valid visits in infancy For clients who enrolled in 2020, 70.6% of expected infancy visits were achieved by the end of 2021. **Toddlerhood:** Overall, clients were scheduled to have an average of 22 visits and they completed an average of 14 valid visits in toddlerhood. For clients who enrolled in 2019, 68.1% of expected toddlerhood visits were achieved by the end of 2021. **Length of visits by phase (average and range):** • **Pregnancy phase:** Overall, the average visit duration for valid	

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		pregnancy visits (N=14043 visits) for pregnancy completers (N=1517) was 1 hour and seven minutes. This ranged from 15 minutes to five hours and 33 minutes. • **Infancy phase**: Overall, the average visit duration for valid infancy visits (N= 24549 visits) for infancy completers (N= 1238) was one hour and two minutes. This ranged from 15 minutes to seven and half hours. • **Toddler phase**: Overall, the average visit duration for valid toddlerhood visits (N= 13167 visits) for toddlerhood completers (N=947) was one hour and two minutes. This ranged from 15 minutes to eight hours. Client attrition by phase and reasons: 1.7% attrition in Pregnancy phase 8.3% attrition in Infancy phase 6.7% attrition in Toddler phase	
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by: Standardised Job	100% NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
minimum of a baccalaureate /bachelor's degree. 9.	Description		
10. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula 100% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	100% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities 100% completion of team meetings, 100% completion of case conference and 100% completion of education sessions	
11. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table.
12. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and	100% 1:1 supervision and home visit observations undertaken against expected (calculated by time – working weeks- and number of nurse)	95% 1:1 supervision and home visit observations undertaken against expected	All supervisors reported booking weekly 1:1 with all nurses. Completing 1:1 every week was challenging when schedules changed or due to FN Leave.

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
attachment theories) to guide their clinical work and achievement of the three NFP goals.			However the attempt to reschedule within the week or make use of Telehealth/Phone check-ins were always considered.
13. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurse). 100% of 4-monthly Accompanied Home Visits completed (against expected).	100% of NFP teams have an assigned NFP Supervisor 90% of reflective supervision sessions conducted See comment box	Supervisors have reported that accompanied home visits had largely been suspended during the pandemic. These are now being reintroduced and the Central Team has advised teams that while supervisors should undertake an accompanied home visit if there are clear clinical practice reasons for doing so, it has not been possible to meet the 4 monthly target this year. Virtual joint visits were attempted in some cases but the appropriateness of this was difficult to assess.
14. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and	No benchmark. Monitored/assured by: Central Team	Progress: Information System currently under review	Work on our Information system remains ongoing.

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Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
guide clinical practice/reflective supervision.			
15. High quality NFP implementation is developed and sustained through national and local organized support	100% of Advisory Boards or equivalents held in relation to expected 100% attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation): Supervisors/ Central Team	100% of Advisory Boards or equivalents % attendance at Advisory Boards	Systems will be established to monitor attendance at Advisory Boards. The teams have revised the Terms of Reference and Membership of the Board in each Trust.

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Domain coverage*
Please complete with your National /Country benchmarks and average (for proportion of time spent within each domain during visits)

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35-40%	35.3%	14-20%	22.2%	10-15%	19.6%
Maternal Role (My Child and Me)	23-25%	27.8%	45-50%	41.6%	40-45%	39.6%
Environmental Health (My Home)	5-7%	9.7%	7-10%	11.2%	7-10%	12.1%
My Family & Friends (Family & Friends)	10-15%	15.1%	10-15%	13.6%	10-15%	14.2%
Life Course Development (My Life)	10-15%	12.1%	10-15%	11.3%	18-20%	14.5%

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
Overall teams do work within normal limits for programme dosage. It is recognised by most teams that Environmental Health reports slightly higher than normal thresholds. This is mainly due to housing issues

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PART THREE: PROGRAM IMPACTS

Countries report on data indicative of program outcomes to demonstrate continuing achievement of the three NFP program goals:

1. Improve pregnancy outcomes 2. Improve child health and development 3. Improve parents' economic self-sufficiency

Please complete the tables below and add any additional text or diagrams in Appendix 1.

Where terms used in the report template are generic, please specify how items are measured as necessary.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Age at LMP (range and mean)	Average Age at LMP: 17.8 Range: 12.8 to 20.8	Average Age at LMP: 17.9 Range: 13.2 - 20.2
Race/ethnicity distribution	47.9% (N=546)(White British 45.3% (N=516)White Irish 4% (N=46)White Other 2.8% (N=32) Other Ethnic Group	49.3% (N= 752) reported that they were White British 43.4% (N=661) reported that they were White Irish 4.3% (N=66) reported that they were White Other 3.0% (N=45) reported that they were Other ethnic group.
Father involvement	16% for Pregnancy completers, 15.5% for Infancy completers and 12.5% for Toddlerhood completers	14.5% for Pregnancy, 13.4% for Infancy and 10.3% for Toddlerhood
Income (please state how this is defined)	74.8% (N=853) of clients had an annual income of less than £13,000. Annual income in N.I, before housing costs, was £24,960 per year in 2017/2018 and 60% of this is £14,976. Approximately 16% of the population in Northern Ireland were living in relative poverty before housing costs in 2017/2018 (Northern Ireland Poverty Bulletin 2017/2018 [NISRA, 2019]).	74.8% (N=1140) of clients had an annual income of less than £15,600. Relative poverty can be defined as living in a household with an income below 60% of the average income. Annual income in N.I, before housing costs, was £26,312 per year in 2017/2018 and 60% of this is £14,976. Approximately 16% of the population in Northern Ireland were living in relative poverty before housing costs in 2019/2020

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		(Northern Ireland Poverty Bulletin 2019/2020 [NISRA, 2021]). We have presented comparison data for clients with income under £15,600 due to this most closely matching the £15,787 poverty cut off.
Employment/Educational Achievement	43% (N=491) were not in education or employment (NEET) 23.2% (N=265)were in employment 43% (N=491) were in education 9.4% (N=107) were in both education and employment 56.9% (N=649) were in education or employment.	Education and employment status was recorded for 95.0% (N=1524) of clients at intake. 43.6% (N=664) clients were not in education or employment (NEET). 24.1% (N=368) of clients were in employment 41.1% (N=627) clients were in education, 8.9% (N=135) of clients were in both education and employment. 56.4% (N=860) clients were either in education or employment (EET)
Food Insecurity (please define)	Data not collected	Data not collected
In care of the State as a child	Data not collected	Data not collected
Obesity (BMI of 30 or more)	Not able to be analysed at this time	Not able to be analysed at this time
Severe Obesity (BMI of 40 or more)	Not able to be analysed at this time	Not able to be analysed at this time
Underweight (BMI of 18.5 or less)	Not able to be analysed at this time	Not able to be analysed at this time
Heart Disease	2.1% (N=24)	2.5% (N=38) had heart problems
Hypertension	0.9% (N=10)	0.9% (N=14) had high blood pressure
Diabetes – T1 &T2	1.4% (N=16)	1.2% (N=18) had diabetes
Kidney disease	0.9% (N=11)	0.9% (N=13) had kidney disease
Epilepsy	1.6% (N=19)	1.6% (N=24) had epilepsy
Sickle cell Disease	0	0.1% (N=1) had sickle cell disease
Chronic Gastrointestinal disease	0.9% (N=11)	1.0% (N=15) stated they had chronic gastrointestinal disease.

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Asthma/other chronic pulmonary Disease	12.4% (N= 144)	12.2% (N=185) clients stated that they had asthma
Chronic Urinary Tract Infections	5.4% (N=63)	6.0% (N=91) had chronic UTI
Chronic Vaginal Infections (e.g., yeast infections	1.7% (N=20)	1.4% (N=22) had chronic vaginal infections
Sexually Transmitted Infections	Data not analysed separately from Chronic Vaginal Infections	Data not analysed separately from Chronic Vaginal Infections
Mental Illness (eg Depression, eating disorder, substance abuse)	22.5% (N=261)	24.4% (N=371) had mental health condition.
Genetic disease or congenital anomalies		0.7% (N=11) had genetic disease or congenital anomalies

Please comment below on the vulnerability of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time.
Caseloads have varying degrees of vulnerability – some meeting threshold for either Family Support Planning or Child Protection. Safeguarding children and young people and ensuring the unborn child and infant has the best and safest start in life is at the heart of the programme and FNP clinical practice in Northern Ireland. A number of young parents receiving the programme have had poor parenting experiences and this has the potential to impact on their own parenting capacity. Some children are "children looking after children" making them vulnerable. The Family Nurses work with high levels of risk and intensity. Understanding the Needs of Children in Northern Ireland (UNOCINI) is the assessment and referral tool used to produce full and accurate holistic assessments of need, considering strengths and resilience factors in families alongside needs and risks. It is a universal tool and ensures collaborative working and good communication with other agencies. Family Nurse Partnership teams continue to build on client and family strengths, whilst continuing to assess and identify any risks to the child.

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Alterable Maternal Behaviour/ program impacts for clients (please complete for all the time periods where the data is collected)

Hospital Anxiety and Depression Scale (HADs)

HADS at Intake

Overall

Anxiety

- Overall, anxiety (HADs) scores were recorded for 86.5% (N=1234) clients in pregnancy.
- Of these, 80.0% (N=987) were found to have an unlikely presence of anxiety, 11.6% (N=143) were found to have borderline presence of anxiety, 6.6% (N=81) were found to have probable presence of anxiety and 1.8% (N=22) were found to have a high likelihood of anxiety in pregnancy.

Depression

- Overall, depression (HADs) scores were recorded for 86.5% (N=1234) clients in pregnancy.
- Of these, 90.8% (N=1121) were found to have an unlikely presence of depression, 6.0% (N=74) were found to have borderline presence of depression, 2.4% (N=30) were found to have probable presence of depression and 0.4% (N=5) clients were found to have a high likelihood of depression in pregnancy.

HADS at 6 weeks infancy

Overall

Anxiety

- Overall, anxiety (HADs) scores were recorded for 93.9% (N=1313) clients in infancy.
- Of these, 76.8% (N=1009) were found to have an unlikely presence of anxiety, 11.8% (N=155) were found to have borderline presence of anxiety, 7.4% (N=97) were found to have probable presence of anxiety and 3.3% (N=43) were found to have a high likelihood of anxiety in infancy.

Depression

- Overall, anxiety (HADs) scores were recorded for 93.8% (N=1311) clients in infancy.

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- Of these, 87.0% (N=1141) were found to have an unlikely presence of depression, 7.7% (N=101) were found to have borderline presence of depression, 3.7% (N=48) were found to have probable presence of depression and 0.8% (N=11) clients were found to have a high likelihood of depression in infancy.

We have recently introduced GAD7 and EPDS into FNP practice in Northern Ireland - in line with the Peri-natal Mental Health Pathway. Data is currently being collected at local level and will be analysed at a later date.

Cigarette Smoking

All sites

Intake and 36 weeks

- 1249 clients had information on smoking status recorded at both intake and 36 weeks pregnancy. For these clients:
    - a -4.2% change in smoking in the last 48 hours was achieved between intake and 36 weeks.
    - a -16.8% change in the proportion of clients smoking in in the last 48 hours was achieved between intake and 36 weeks.
    - 16.4% (N=205) of clients smoked fewer cigarettes in the last 48 hours between intake and 36 weeks.
    - 77.0%(N=114) of clients smoked fewer cigarettes in the last 48 hours between intake and 36 weeks for clients who smoked more than 5 cigarettes per day at intake.
    - 7.4% (N=92) clients smoked more at 36 weeks than at intake.
    - 2.1% (N=26) clients smoked at 36 weeks who denied smoking at intake.
- The mean number of cigarettes smoked was 14.9 for those who smoked more than 5 cigarettes per day during the last 48 hours at 36 weeks pregnancy.

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6 weeks infancy

- Information on smoking during pregnancy was recorded for 94.1% (N= 1351) of clients at 6 weeks infancy. Of these, 36.1% (N=488) reported that they had smoked at some time during pregnancy at 6 weeks infancy.
- Information on smoking during the last 48 hours was recorded for 94.1% (N= 1351) of clients at 6 weeks infancy. Of these, 27.9% (N=377) reported that they had smoked during the last 48 hours at 6 weeks infancy.
- The mean number of cigarettes smoked was 10.1 for those who smoked during the last 48 hours at 6 weeks infancy.
- The mean number of cigarettes smoked was 14.8 for those who smoked more than 5 cigarettes per day during the last 48 hours at 6 weeks infancy.

12 months infancy

- Information on smoking during pregnancy was recorded for 88.2% (N=1079) of clients at 12 months infancy. Of these, 36.1% (N=390) reported that they had smoked at some time during the pregnancy at 12 months infancy.
- Information on smoking during the last 48 hours was recorded for 88.2% (N= 1079) of clients at 12 months infancy. Of these, 30.7% (N=331) reported that they had smoked during the last 48 hours at 12 months infancy.
- The mean number of cigarettes smoked was 12.4 for those who smoked during the last 48 hours at 12 months infancy.
- The mean number of cigarettes smoked was 16.6 for those who smoked more than 5 cigarettes per day during the last 48 hours at 12 months infancy.

	Intake	**36 Weeks of Pregnancy**	**Postpartum -6 weeks**	**12 months**	**18 months**
Alcohol, (n, % during pregnancy, units/last 14 days)	Drank alcohol in last 14 days: **0.9% (N=13)** Excessive: **0.3% (N=4)**	Drank alcohol in last 14 days: **0.5% (N=6)** Excessive: **0.2% (N=2)**		Drank alcohol in last 14 days: **17.5% (N=189)** Excessive: **13.9% (N=150)**	
Illegal Drug Use is recorded at Intake and 36 weeks	Illegal drug use in last 14 days:	Illegal drug use in last 14 days:		Illegal drug use in last 14 days:	

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	0.2% (N=3) client reported illegal drug use during pregnancy or the last 14 days at intake	**0.1% (N=1) client reported illegal drug use in last 14 days at 36 weeks.**		**0.8% (N=9) clients reported illegal drug use in the last 14 days at 12 months infancy.**	
Excessive Weight Gain from baseline BMI during pregnancy (n, %)					
Mastery, (n, mean)	**Intake** Low mastery: **14.3% clients (N=213)** Not low mastery: **85.7% (N=1280)** Mean: **22.3 (Range= 9 - 28).**	**24 Months** Low mastery: **12.8% clients (N=101)** Not low mastery: **87.2% (N=691)** Mean: **22.6 (Range= 8 - 28).**			
IPV disclosure, (n, %) – **Data not collected at present**.					
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %)	81.0% (N=997) clients reported ever using contraception in the last 6 months and 8.0% (N=98) clients reported not	80.5% (N=888) clients reported ever using contraception in the last 6 months and 8.5% (N=94) clients reported not	77.7% (N=733) clients reported ever using contraception in the last 6 months and 11.2% (N=106) clients reported	75.8% (N=644) clients reported ever using contraception in the last 6 months and 7.2% (N=39) clients reported not	

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	requiring contraception in the last 6 months. 70.3% (N=865) clients reported using contraception every time or most of the time in the last 6 months, 29.5% (N=365) clients used the contraceptive pill, 28.7% (N=353) clients used a male condom and 32.7% (N=402) reported using LARCs in the last 6 months.	requiring contraception in the last 6 months. 68.7% (N=758) clients reported using contraception every time or most of the time in the last 6 months, 27.5% (N=303) clients used the contraceptive pill, 22.5% (N=248) clients used a male condom and 37.4% (N=413) reported using LARCs in the last 6 months.	not requiring contraception in the last 6 months. 67.2% (N=634) clients reported using contraception every time or most of the time in the last 6 months, 23.8% (N=224) clients used the contraceptive pill, 22.3% (N=210) clients used a male condom and 38.4% (N=362) reported using LARCs in the last 6 months.	requiring contraception in the last 6 months. 66.6% (N=566) clients reported using contraception every time or most of the time in the last 6 months, 23.6% (N=201) clients used the contraceptive pill, 21.1% (N=179) clients used a male condom and 39.6% (N=337) reported using LARCs in the last 6 months.	
Subsequent pregnancies, (n, %)	97.9% (N=1205) clients were not pregnant since the birth of their infant. 2.1% (N=26) clients were pregnant since the birth of their infant.	91.4% (N=1008) clients were not pregnant since the birth of their infant. 8.6% (N=95) clients were pregnant since the birth of their infant.	83.4% (N=786) clients were not pregnant since the birth of their infant. 16.6% (N=157) clients were pregnant since the birth of their infant.	76.0% (N=646) clients were not pregnant since the birth of their infant. 24.0% (N=204) clients were pregnant since the birth of their infant.	

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		1.3% (N=14) clients had a subsequent birth at 12 months infancy.	5.5% (N=52) clients had a subsequent birth at 18 months infancy.	22.8% (N=194) clients had 1 pregnancy since birth of infant 1.2% (N=10) clients had 2 or more pregnancies since birth of infant 12.6% (N=107) clients had a subsequent birth at 24 months infancy. The average time to second birth was 17.1 months.	
Breast Feeding, (n, %)	**Initiation** Breastfeeding initiation was recorded for 95.9% (N=1411) of clients with infants. Of these **44.2% (N=623) reported initiating breastfeeding.**	**6 weeks** Breastfeeding status was recorded for 94.1% (N=1352) of clients who had reached 6 weeks infancy. Of these, **10% (N=135) reported that they were still**	**6 months** Breastfeeding status was recorded for 88.5% (N=1197) of clients who had reached 6 months infancy. Of these, **5.1% (N=61) reported that they were still**	**Average** duration for exclusive Breastfeeding: **5.7 weeks.**	

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		breastfeeding at 6 weeks	**breastfeeding at 6 months.**		
Involvement in Education, (n, %)	**Intake** In Education**:** **41.1% (N=627)** In both education and employment: **8.9% (N=135**			**24 months** In Education: **26.7% (N=227**) In both education and employment: **6.7% (N=57**	
Employed, (n, %)	Employment: In both education and employment: **8.9% (N=135)** Not in education or employment (NEET): **56.4% (N=860)**			Employment: **24.6% (N=209)** In both education and employment: **6.7% (N=57)** In education or employment (EET) **44.6% (N=379)** Not in education or employment **(NEET):** **55.4% (N=471)**	
Housing needs, (n, %)	Data not collected.				
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	**Monitored at Supervision**				
Father's involvement in care of child, (n, %)	Overall, 1365 infants reached 6	Overall, 1230 infants reached	Overall, 1125 infants reached	Overall, 971 infants reached	

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	months infancy and frequency of biological fathers contact with baby was recorded for 90.2% (N=1231) of these clients. 52.0% (N= 640) had daily contact, 17.8% (N=219) had contact at least once a week but not daily, 4.7% (N=58) had contact less than once a week, 21.7% (N=267) had no contact at all with the baby in the last three months and data was missing for 3.8% (N=47 clients).	12 months infancy and frequency of biological fathers contact with baby was recorded for 89.7% (N=1103) of these clients. 49.2% (N=543) had daily contact, 18.9% (N=208) had contact at least once a week but not daily, 6.3% (N=70) had contact less than once a week, 23.0% (N=254) had no contact at all with the baby in the last three months and data was missing for 2.5% (N=28 clients).	18 months infancy and frequency of biological fathers contact with baby was recorded for 83.8% (N=943) of these clients. 47.9% (N= 452) had daily contact, 17.4% (N=164) had contact at least once a week but not daily, 5.6% (N=53) had contact less than once a week, 27.0% (N=255) had no contact at all with the baby in the last three months and data was missing for 2.0% (N=19 clients).	24 months infancy and frequency of biological fathers contact with baby was recorded for 87.5% (N=850) of these clients. 44.8% (N= 381) had daily contact, 21.3% (N=181) had contact at least once a week but not daily, 4.7% (N=40) had contact less than once a week, 27.8% (N=236) had no contact at all with the baby in the last three months and data was missing for 1.4% (N=12 clients).	
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g. to previous years, to rates achieved in RCT, to equivalent populations etc)**:** Over the reporting period considerable focus has been on maintaining a safe, high quality service.

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In which areas is the program having greatest impact on maternal behaviors?
Which are the areas of challenge?

Birth data		
	Number	**% of total births for year**

- Overall, weeks' gestation at birth was recorded for 95.9% (N=1411) of clients. 0.3% (N=4) of infants were born extremely preterm, 0.9% (N=12) of infants were born very preterm, 6.5% (N=92) of infants were born moderate to late preterm and 92.3% (N=1303) of infants were born full term.

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	Overall, 1362 infants reached 6 months infancy and immunisation status was recorded for 88.6% (N=1207) of these clients. **94.4% (N= 1140) had up-to-date immunisations**	Overall, 1245 infants reached 12 months infancy and immunisation status was recorded for 88.4% (N=1101) of these clients. **92.7% (N=1021) had up-to-date immunisations**	Overall, 1118 infants reached 18 months toddlerhood and immunisation status was recorded for 82.3% (N=920) of these clients. **95.3% (N=877) had up-to-date immunisations**	Overall, 980 infants reached 24 months toddlerhood and immunisation status was recorded for 85.3% (N=836) of these clients. **97.1% (N=812) had up-to-date immunisations**
Hospitalization for Injuries	Six infants (0.5%) had 1 hospital admission due to injury/ingestion between birth and 6 months. No infants recorded 2 or more hospital admissions	Ten infants (0.9%) had 1 hospital admission due to injury or ingestion between birth and 12 months No infants recorded 2 or more hospital admission	Nine infants (1.0%) were recorded with having 1 hospital admission due to injury or ingestion between 12 and 18 months One infant (0.1%) was recorded with having 2 or	11 infants (1.3%) were recorded as having 1 hospital admission due to injury or ingestion between 12 and 24 months. No infants recorded 2 or more hospital admissions

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	due to injury or ingestion between birth and 6 months.	due to injury or ingestion between birth and 12 months.	more hospital admissions due to injury or ingestion between 12 and 18 months.	due to injury or ingestion between 12 and 24 months.
ASQ scores requiring monitoring (grey zone)	**4 months:** **Communication**: 2.7% (N=32) Mean: 55.6 **Gross Motor**: 4.7 % (N=57) Mean 55.1 **Fine Motor**: 2.6% (N=31) Mean 54.5 **Problem Solving**: 2.6% (N=31) Mean 56 **Personal Social**: 2.5% (N=30) Mean 55.5	**10 months:** **Communication:** 2.0% (N=22) Mean 55.7 **Gross Motor:** 15.3% (N=168) Mean 53.6 **Fine Motor:** 3.8% (N=42) Mean 55.6 **Problem Solving:** 3.5% (N=38) Mean 54.3 **Personal Social:** 2.9% (N=32) Mean 53.6	**14 months:** **Communication:** **3.2**% (N=29) Mean 52.7 **Gross Motor:** 6.5% (N=60) Mean 53.9 **Fine Motor:** 3.2% (N=29) Mean 53.1 **Problem Solving:** 3.4% (N=31) Mean 52 **Personal Social:** 2.3% (N=21) Mean 55.1	**20 months:** **Communication:** 8.6% (N=72) Mean 49.5 **Gross Motor:** 2.9% (N=24) Mean 56.3 **Fine Motor:** 3.7% (N=31) Mean 54.9 **Problem Solving:** 2.5% (N=21) Mean 52.7 **Personal Social:** 3.8% (N=32) Mean 54.9
ASQ-SE scores requiring monitoring (grey zone)	**6 months:** 1.8% (N=21)	**12 months:** 1.3% (N=14)	**18 months:** 3.3% (N=30)	**24 months:** 4.3% (N=35)
ASQ-SE scores requiring further assessment/referral				
Other (please define)				

Please comment below on your child health/development data:

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Our data continues to show benefits in the five main areas of child development and in Social and Emotional behaviours. The low numbers of infants hospitalised due to injury or ingestion are also indicative of how improved, safe and supported parenting closes the inequality gap in child development, improves outcomes and is a protective factor.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts: The Central Team plan to expand the data collected to demonstrate impact and outcomes in the area of safeguarding. The family nurses are working with high levels of risk and intensity and it is important to capture information highlighting this. Data on IPV disclosure will also be collected to demonstrate identify and address Domestic Violence within our young client group. Families at risk of IPV share many characteristics with families at risk of poor child health outcomes. Analysis of data could show comparisons on this.
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program. The picture below shows three current FNP clients, alongside their Family Nurses in the South Eastern Trust (SET), who are all amazing mums and are passionate about Breast Feeding (BF). The girls completed Solihull training, facilitated by the Family Nurse Partnership Team in SET along with the Health Development Team, and are now providing breast feeding peer support to other young mothers on the FNP programme. Going forward the Family nurses in SET, will offer all antenatal clients the opportunity to engage with one of our BF peer support volunteer clients. They will then be referred when their baby is born. We are really proud of our client achievements and are looking forward to seeing a positive impact in sustained breast feeding. This service will be evaluated and results shared in due course

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In the Northern Trust the FNP team completed a celebratory and awareness session to recognise breastfeeding week. The screenshot below shows some of the Family Nurses and young mums who took part.
We had one mum who is tandem feeding a 3 and 2 year old
A second mum who is breastfeeding her second child (first breastfeeding journey for her)
A young mum enjoying her breastfeeding journey after a difficult start
Also other antenatal mums on the zoom - but preferred not to be captured on camera.

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Meaningful client engagement is now an established part of FNP best pracrice in Northern Ireland. Hearing the client voice and encouraging them to share their view on what helped support them is so important to us. The photographs and quotes below are from clients in the Southern Trust who have shared their experiences of the FNP Programme. The Southern Trust also celebrated their 10year anniversary and had a celebratory event to include those clients who have recently graduated from the programme. The link below shows a video clip of the day:

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-a043-ab96da4df32

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Mia Rose Massey.

Mia's mum Jodie, 18years, said "The Family Nurse Partnership is a good support to me. Olivia, my Family Nurse, is a great help and support. She is always just a phone call away. I enjoy the programme as it is filled with different resources on what I need to know about being a mother and helps me out in many ways. It is brilliant for first time mothers like myself as you learn so much."

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J E A N S

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Quote from client Aimee Bradley, above, who has recently graduated and has now commenced a pre-nursing OU programme within Trust.
" I will miss you so much! Brodie and me always looked forward to seeing you! You have helped me, Jamie and Brodie so much and I wouldn't be where I am without you! Not only did you help me as a young mum, but you also encouraged and supported me to pursue my nursing career and I am so thankful. I am so looking forward to seeing you and Lisa (SAMS) on 27th at the 10-year event.
Thank you so much for all the opportunities you have given me. FNP will always have a big place in my heart. I am really enjoying my nursing course and hope to perhaps meet you in my future career!!
Love Aimee, Jamie and Brodie xx

We are so proud of all of them 😊

Understanding the impact of the pandemic continues to be a priority and teams have reflected with their clients looking at both client and practitioner experiences. FNP teams have remained resilient and creative in embracing new ways of programme delivery and thinking of new ideas to make things easier for clients. Supervisors from each team have shared some of the client feedback below.

Feedback from a young client in Northern Trust:
"My daughter and I have just finished the FNP after being in the programme for the past 2 years. Our FN, Barbara has done so much for both me and my child. I was always made to feel like I could contact her for anything and no matter how silly the question, I never felt judged. I count myself so lucky to have been a part of the FNP programme and it has helped both me and my child immensely. I learnt so much from Barbara and the programme, and it definitely made being a new parent that little bit easier."

Video (below – consent to share given by mum)) of a client and child in Northern Trust: Child is 21 months old – (the scenery of the beautiful North Coast in Northern Ireland is also gorgeous)

VID-20220801-WA0
004.mp4

The Belfast Trust FNP team were asked to take part in a local radio show – Radio Ulster – to talk about talk about FNP, teenage pregnancy and working with young teenage mothers. Sinead McCavana, Supervisor, took part in the Lynette Faye show and used this as a fantastic opportunity to promote our service across Northern Ireland.

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Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	**0**	
Maternal death	**0**	
Other		

Any other relevant information or other events to report:

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PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program
Briefly describe your system for monitoring implementation quality; The QI process in Northern Ireland brings together those aspects of the programme that are required for safe, high-quality replication of FNP: • **The core model elements** – ensure replication of the original research conditions. • **Fidelity goals and measures** – evidence that the programme is being delivered to a high standard. • **Clinical, Reflective, Safeguarding Supervision** - ensures safe delivery of a high quality service to clients and their families Goals and Objectives for CQI program during the reporting period: • Continue to use ECHO NI to bring together FNP Nurses and Supervisors and provide opportunities for teaching through case presentations and training. The FNP model fits well with ECHO in that it involves weekly team meetings and case-based meetings to identify client challenges and solutions and provide peer support and learning. • To use continuous quality improvement to monitor the ongoing implementation of the EPDNS and GAD7 Screening Tool and strengthen the Perinatal Care Pathway • Continue to progress work on Information system to improve the quality of the programme and maximise programme outcomes for clients Outcomes of CQI program for the reporting period: • ECHO methodology has been used to support FNP programme delivery and service improvement, enhance the knowledge and skills of staff and provide an environment for collaborative reflective learning. • EPDNS and GAD7 Screening tool have been implemented into FNP Visiting schedule in line with local and regional guidance. Data is being collected at local level at present. • Work on the Information system continues to keep it functioning. Work is being progressed to look at an alternative system which will meet our business needs in the long term. Goals for CQI in next year: • Continue to use ECHO NI to bring together FNP Nurses and Supervisors and provide opportunities for teaching through case presentations and training. The FNP model fits well with ECHO in that it involves weekly team meetings and case based meetings to identify client challenges and solutions and provide peer support and learning. • To gather and analyse data collected at local level on EPDNS and GAD7 Screening Tool and strengthen the Perinatal Care Pathway. • Continue to progress work on Information system to sustain functionality of existing system and progress work on alternative system to meet our business needs.

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Program innovations tested and/or implemented this year (this includes both international and local innovations)
• Program innovations tested[1]: • Program innovations implemented: IPV has been implemented and incorporated into FNP visiting schedule. Reflective practice is used within reflective supervision which guides exploration, reflection and analysis of the content brought to supervision with plans developed and agreed as a result. It allows Supervisors to give attention to the emotional needs of the Family Nurse, how they have been affected by the emotional intensity of their work, and how to deal with these feelings constructively. The Formative/Educational function of Supervision within FNP focuses on developing skills, understanding and ability, by reflecting on and exploring the work of the person being supervised. This includes supporting the integration of different elements of the programme model. • Findings and next steps: The central team to develop Data monitoring for fidelity in relation to Supervision.
Temporary Variances to CMEs
For each variance agreed please attach a report of the variance evaluation methods and findings to date in Appendix 2 to this document - **N/A**
Research and evaluation
Please tell us about any NFP related research and evaluation efforts currently being undertaken or planned in your country In order to demonstrate the value and impact of FNP in Northern Ireland further, we plan to discuss our revaluation findings with The Queens Nursing Institute. This was delayed due to the Pandemic; however, we plan to progress this work next year. Measuring outcomes and improving impact is an essential part of service delivery in FNP. It is important that the work and study already completed is communicated effectively to strengthen the service, share FNP theoretical approaches and demonstrate the value of our evidence among strategic partners and the wider system in Northern Ireland.

[1] Please attach the materials used for the innovations .

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PART FIVE: ACTION PLANS

LAST YEAR:

Our planned priorities and objectives for last year:

1. Implementation of the Learning from the intimate Partner Violence (IPV) Clinical Study
2. Implementation of EPDS and GADS7
3. Explore the options on the way forward with Information System

Progress against those objectives:

1. IPV innovation and implementation into practice has been completed. Preliminary findings have been shared at the Domestic Violence Conference.
2. Further training is planned using ECHO as a virtual platform. This model works well with FNP concepts. The aim is to use ECHO methodology to support FNP programme delivery and service improvement, enhance the knowledge and skills of staff and provide an environment for collaborative reflective learning.
3. The central team have secured a support contract to ensure continued functionality of our existing system and submitted a request to DHCNI to progress work on an alternative Information System.

Reflections on our progress: Our progress in relation to our Information system has been hindered by changes in workforce dealing with our queries. This has resulted in a list of outstanding issues and actions. Dr Emma Larkin has spent a considerable amount of time on this work and it is hoped that this can be better progressed this year to achieve a system fit for purpose.

NEXT YEAR:

Our planned priorities and objectives for next year:

1. Further explore the options for development of the information system and make data improvements to reflect the revised Annual Report template. This will also include a scoping exercise looking at costs of migration to a new system.
2. Use ECHO NI to progress Quality Improvement Training using a virtual platform to bring together FNP teams for collaborative learning to enhance practice and service delivery.
3. Continue with Implementation of GAD7 and EPDS into FNP practice in Northern Ireland and analysis of data collected at local level.
4. Further exploration of the characteristics of clients declining the program and an understanding of their reasons for doing so.
5. Further clarification of client eligibility criteria in situations of limited capacity and exploration of the potential to offer the program more widely to women over 20 years leaving the care system

Measures planned for evaluating our success:

- Connections have been made with both DHCNI and DXC to progress plans for an alternative Information system. The essential fix/update of the system to ensure it is fit for purpose will be the success.
- Evaluation is part of the ECHO model and will be completed at the end of each session. Results will be collated and a paper prepared evaluating the process.
- A new strengthened Perinatal Mental Health pathway will be developed using GAD7 and EPDS.

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• Review client recruitment pathway and eligibility criteria to ensure those families who would most benefit from the programme are enrolled.
Any plans/requests for program expansion? Expansion of the programme was enabled last year through funding secured via the Delivering Care process. Trusts have now recruited an additional Family Nurse into each of the five FNP teams.
FEEDBACK FOR UCD INTERNATIONAL TEAM:
The most helpful things we have received from the International team over the last year have been: • Support and responses to ad hoc questions and requests for information, clarification, documents etc. • Regular meetings and updates on new innovations • Information and support to Clinical lead • Mentoring and guidance to Nurse consultant • Facilitating the sharing of good practice between countries on particular topics. • Sharing new NFP international research outputs from all countries via the website and through the international research seminars. • Regular Clinical Advisory Meetings • Access to NFP International website and resources, Clinical Advisory Group, research and analytical leads forum and other International collaborations.
Our suggestions for how NFP could be developed and improved internationally are: None
This what we would like from UCD through our Support Services Agreement for next year: As above

Please note: with permission, all completed annual reports are uploaded to the restricted pages of the international website so that every implementing country can mutually benefit in sharing their progress and achievements.

Please indicate your country's willingness to share this report in this way by checking one of the boxes below:

I agree to this report being uploaded onto the restricted pages of the international website [X]

I do not agree to this report being uploaded onto the international website [ ]

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PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

<table>
<tr><td>Brief summary of services/support provided by UCD over the last year:
• Information and support to Clinical lead and Nurse consultant
• Responses to ad hoc questions and requests for information, clarification, documents etc
• Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
• Provision of a range of international themed meetings including the international Clinical Leads’ Advisory Group, the data analytic and research-leads forum, the PIPE education group (now the education group) and the strategic leads group.
• Sharing new program innovations developed and researched by PRC and all implementing countries
• Facilitating the sharing of good practice between countries on particular topics.
• Sharing new NFP international research outputs from all countries via the website and through the international research seminars.
• Promoting NFP internationally as an example of a program that ensures high quality replication in all contexts and maintains its international reputation for effectiveness and quality</td></tr>
<tr><td>Identified strengths of program:
• Northern Ireland implementation of FNP is at a very mature stage, with continued committed and collaborative leadership, at all levels.
• The quality of the FNP workforce, whose work is highlighted by the findings presented in this report and the commitment to their continued development through use of the ECHO model
• The quality of program delivery, as evidenced by the implementation and indicative outcomes data analysis findings of this report
• The impressive quality of program data analysis – both for sites and for the annual report
• The strong partnership structures and working practices between services serving the FNP population
• The continued commitment to evaluate adaptations to the program
• The collaborative approach being taken to quality improvement</td></tr>
<tr><td>Areas for further work:
• Further analysis of the reasons for clients leaving the program before completion to understand the extent to which these can be addressed.
• Exploration of father involvement and whether this can be additionally supported.</td></tr>
<tr><td>Agreed upon priorities for country to focus on during the coming year:
• As set out in part 5, with the addition of the areas for further work above, when capacity allows</td></tr>
<tr><td>Any approved Core Model Element Variances:
N/A</td></tr>
<tr><td>Agreed upon activities that UCD will provide through Support Services Agreement:
• The support services agreement is awaiting final agreement</td></tr>
</table>

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Appendix 1: Additional data analyses and /or graphic representations of the data

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Appendix 2: Evaluation of temporary CME variances

Please complete the table below for each variance agreed for your country.

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

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