University of Colorado
Anschutz Medical Campus

Department of Pediatrics
Prevention Research Center for Family and Child Health
Mail Stop 8410
13121 East 17th Avenue
Aurora, Colorado 80045

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): 2019

Report completed by: Deirdre Webb/Shona Johnston

Date submitted: 02/09/20

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	**26**	**26**
Part time NFP Nurses	**5**	**5**
Fulltime NFP Supervisors	**5**	**5**
Part time NFP Supervisors	**0**	
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	**0**	
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	**0**	
Total		**36**

- We have 5 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:6

- 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:

Integration and partnership working is 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 have been reinforced amongst our colleagues in each of the 5 Health and Social Care Trusts. This has helped FNP to integrate and work effectively with other services and to strengthen and develop the desired partnership working approach.

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 is supported by Mrs Charlotte McArdle, the Chief Nurse at the Department of Health and Mr Rodney Morton, who has recently taken up the post as the Director of Nursing at the Public Health Agency.

- Data analysis, reporting and evaluation: An 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 feasibility and implementation study has progressed to include completion of Focus Groups and individual interviews with Supervisors. Focus Groups with clients still need to be completed.

- NFP Educators: 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) A Family Nurse and a Supervisor are enrolled in the Florence Nightingale Leadership Scholarship and both will decide on a quality improvement project to enhance FNP work. 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, 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 the 10 new Family Nurses was secured from the Department of Health's Transformational Fund. This was initially for 18 months but has been extended for another year. Applications for further funding will be required at the end of this period. 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. It is our intention to consider how we can provide our foundation training and education locally. This expansion would require expansion of our central unit function to develop a foundation training programme.

Description of any partner agencies and their role in support of the NFP program: Dr Susan Jack, Associate Professor of Nursing at McMaster University, Canada is supporting the Northern Ireland Team with a feasibility study looking at the implementation of the Intimate Partner Violence (IPV) pathway. Project ECHO will provide a virtual platform for FNP regional learning. ECHO brings together clinical specialist teams and primary care clinicians and provides 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:
FNP Teams have completed training on Child Sexual Exploitation, Signs of Safety and Trauma Informed Care to enhance their safeguarding knowledge in these areas.

PART TWO: PROGRAM IMPLEMENTATION

Clients

Of NFP clients participating in the program over the last year: 303 of definitely eligible clients were enrolled on the programme in 2019.

•Current clients: Pregnancy phase (%): 98.5% clients completed the pregnancy stage.

•Infancy Stage: 90.3% clients completed the infancy stage.

•Toddlerhood Stage: 83.6% clients completed the toddlerhood stage.

% of those eligible clients offered the program who have enrolled to date: 72.6%

- Our national benchmark for % of eligible women referred/ notified who are successfully enrolled onto the program is 75%
- Within 2019 the % of eligible women referred/ notified who were successfully enrolled onto the program was 68.1%
    - Our reflections on this figure: FNP 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: 16% for Pregnancy completers, 15.5% for Infancy completers and 12.5% for Toddlerhood completers.
- % of home visits, where other family members are present: 19.3% for Pregnancy completers, 17.7% for Infancy completers and 11.2% 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

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

- High level description of our NFP Information System, including how data are entered: The FNP Information system (IS) is used to store and manage FNP data. Family Nurses and Supervisors use the IS routinely as part of delivering the programme, in order to improve the quality of the programme and maximise programme outcomes for clients The data collected has a clinical utility, is collected and used by nurses as part of the programme and is integrated within the guidelines for each visit they conduct.

- Commentary on data completeness and/ or accuracy: Along with the Central Team, Supervisors, supported by Data Quality Support Officers, monitor the quality of data completeness and accuracy.

- Reports that are generated, how often, and for whom: We are unable to automatically generate reports from the information system at present. These are manually generated. The reporting function of our system is currently under review.

Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality: DXC Technology, formerly HP, were commissioned to produce an Information System that supported data input and also the ability for each key user group to generate reports for their data within their site. A functioning FNP information system has been developed that currently enables client management and data input. However, the reporting function remains under development and is on hold pending the submission of a DXC proposal to complete this work. The central team, along with a working group within BSO and DXC, have plans to move this work forward over the next year. It is our plan this year to improve the completion of the data forms. It is intended to organise a regional training event for the Quality and Data Improvement Officers. In addition, a half days workshop will be held for all team members to explore any data issues.

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.
  This year we plan 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.

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.	• % 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

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	Application of these criteria are assured and monitored by: Supervisor in each site and Nurse Consultant in PHA		
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 72.6% are intended to be recruited to NFP are enrolled in the program 41.2%% of pregnant women are enrolled by 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	National/ Country benchmark set is: ____% visits take place in the home	**Pregnancy:** 85.8% visits take place in the home **Infancy:** 86.5% in the home	We plan to set Benchmarks moving forward.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
setting (mutually determined by the NFP nurse and client), when this is not possible.		**Toddlerhood:** 87.6% in the home **% breakdown of where visits are being conducted other than in the client's home:** **Pregnancy**: 0.3% in Children's Centre, 2.8% in community location, 1.1% in a doctors or clinic, 6.8% in a family or friends home, 0.5% in school or college, 0.3% other. **Infancy:** 0.3% Children's Centre, 4.0% in a community location, 0.8% in a doctors or clinic, 5.9% in a family or friend's home, 0.1% in school or college, 2.2% stated other. **Toddlerhood:** 0.3% children's Centre, 5.3% in a community location, 0.7% in a doctors or clinic, 3.7% in a family or friend's home, 0.2% in school or college, 2.1% stated other.	
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit	National/Country benchmarks for : a) Program visit dosage patterns in relation to client strengths and risks benchmarks are: Pregnancy: 14 visits Infancy: 28 visits	• 100% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is: Pregnancy: • Scheduled visits: 12.1	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
schedule agreed upon between the client and nurse.	Toddlerhood: 22 visits b) Length of visits by phase benchmarks: • Pregnancy phase: 60 mins • Infancy phase: 60 mins • Toddler phase: 60 c) Client attrition by program phase benchmarks: 10% attrition in Pregnancy phase 20% attrition in Infancy phase 10% attrition in Toddler phase	• Actual visits: 9.5 • Dosage: 78.4% Infancy: • Scheduled: 28 • Actual: 19.8 • Dosage: 70.8 Toddlerhood: • Scheduled: 22 • Actual: 13.6 • Dosage: 62% • Length of visits by phase (average and range): • Pregnancy phase: 70.1 mins • Infancy phase: 66.6 mins • Toddler phase: 65.3 mins Client attrition by phase and reasons: 1.4% attrition in Pregnancy phase 8.4% attrition in Infancy phase 6.9% attrition in Toddler phase	
8. NFP nurses and supervisors are registered nurses or	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree.	100% NFP nurses are registered nurses or registered midwives with a	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	Monitored/assured by: Standardised Job Description	minimum of a baccalaureate /bachelor's degree	
9. 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 _____% completion of team meetings, 100% completion of case conference and _____% completion of education sessions	We plan to put systems in place to collect this data moving forward.
10. 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.
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy,	100% 1:1 supervision and home visit observations undertaken against expected (calculated by time – working weeks- and number of nurse)	90% 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.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
human ecology, and 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.
12. 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 85% of 4-monthly Accompanied Home Visits completed	
13. 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 guide clinical practice/reflective supervision.	No benchmark. Monitored/assured by: Central Team	Progress: Information System currently under review	After very limited progress with the IS developers over the past two years , DXC have re-entered into discussions with the Central Team to resolve the issues and work on the outstanding improvements.hlp improve the reporting system The updating of the System will We look forward to reviewing our data forms and looking at how the IS system can improve the client's outcomes

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
14. 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	_____% of Advisory Boards or equivalents _____% attendance at Advisory Boards	Systems will be established to put Monitoring Systems in place The teams have revised the Terms of Reference and Membership of each Board

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%	35.7%	14-20%	22%	10-15%	19.2%
Maternal Role (My Child and Me)	23-25%	27.8%	45-50%	42.5%	40-45%	40%
Environmental Health (My Home)	5-7%	9.4%	7-10%	11%	7-10%	12%
My Family & Friends (Family & Friends)	10-15%	15.1%	10-15%	13.5%	10-15%	14.3%
Life Course Development (My Life)	10-15%	12%	10-15%	11.1%	18-20%	14.6%

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

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: 17.2 Range: 12.8 to 20.5	Average Age at LMP: 17.8 Range: 12.8 to 20.8
Race/ethnicity distribution	46% (N= 394) reported that they were White British, 47.4% (N=406) reported that they were White Irish, 3.7% (N=32) reported that they were White Other, 2.9% (N=25) reported that they were Other ethnic group.	47.9% (N=546)(White British 45.3% (N=516)White Irish 4% (N=46)White Other 2.8% (N=32) Other Ethnic Group
Father involvement	16.6% for pregnancy completers, 16.5% for infancy completers and 12.7% for toddlerhood completers.	16% for Pregnancy completers, 15.5% for Infancy completers and 12.5% for Toddlerhood completers.
Income (please state how this is defined)	79.8% (N=684) 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=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]).
Inadequate Housing (please define)	Data not collected	Data not collected
Educational Achievement	NA	Not able to be analysed at this time
Employment	43.4% (N=372) clients were not in education or employment (NEET).	43% (N=491) were not in education or employment (NEET)

	56.6% (N=485) clients were either in education or employment (EET) 9.6% (N=82) of clients were in both education and employment. 19.6% (N=168) of clients were in employment 46.6% (N=399) of clients were in education	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
Food Insecurity (please define)	NA	Data not collected
In care of the State as a child	NA	Data not collected
Obesity (BMI of 30 or more)	NA	Not able to be analysed at this time
Severe Obesity (BMI of 40 or more)	NA	Not able to be analysed at this time
Underweight (BMI of 18.5 or less)	NA	Not able to be analysed at this time
Heart Disease	NA	2.1% (N=24)
Hypertension	NA	0.9% (N=10)
Diabetes – T1 &T2	NA	1.4% (N=16)
Kidney disease	NA	0.9% (N=11)
Epilepsy	NA	1.6% (N=19)
Sickle cell Disease	NA	0
Chronic Gastrointestinal disease	NA	0.9% (N=11)
Asthma/other chronic pulmonary Disease	NA	12.4% (N= 144)
Chronic Urinary Tract Infections	NA	5.4% (N=63)
Chronic Vaginal Infections (e.g., yeast infections	NA	1.7% (N=20)
Sexually Transmitted Infections	NA	Data not analysed separately from Chronic Vaginal Infections
Mental Illness (eg Depression, eating disorder, substance abuse)		22.5% (N=261)
Other (please define)		8.4% (N=97)

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.

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

	Intake	36 Weeks of Pregnancy	Postpartum -6 weeks	12 months	18 months
Anxiety, (n, % moderate + clinical range)		**Unlikely** 79.5% (N=750) **Borderline** 12.6% **(**N=119) **Probable** 5.7% (N=54) **High likelihood** 2% (N=19)	**Unlikely** 76.2% (N=689) **Borderline** 12.3% (N=111) **Probable** 7.9% (N=71) **High likelihood** 3.7% (N=33)		
Depression, (n, % moderate + clinical range)		**Unlikely** 90.8% (N=854) **Borderline** 6.5% (N=61) **Probable** 2.4% (N=23) **High likelihood** 0.2% (N=2)	**Unlikely** 87.9% (N=793) **Borderline** 7.4% (N=67) **Probable** 4.0% (N=36) **High likelihood** 0.7% (N=6)		
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	**Smoked at any time intake:** 39.9% (N=452) **Smoked in last 48 hrs:** 26.8% **(**N=304)	**Smoked at any time 36 wks:** 34.9% (N=333) **Smoked in last 48 hrs:** 22.6% (N=215)	**Smoked at any time 6 weeks:** 38.3%(N=354) **Smoked in last 48 hrs:** 30.3% (N=280)	**Smoked at any time 12 months:** 41.2% (N=264) **Smoked in last 48 hrs:** 34.5% (N=221)	

	Mean number 10.1	**Mean number** 8.7	**Mean number**: 10.5	**Mean number**: 12.7	
Alcohol, (n, % during pregnancy, units/last 14 days)	**Drank alcohol in last 14 days:** 1.1% (N=12) **Excessive:** 0.3% (N=3)	**Drank alcohol in last 14 days:** 0.6% (N=6) **Excessive:** 0.2% (N=2)		**Drank alcohol in last 14 days:** 19.7% (N=126) **Excessive:** 15.9% (N=102)	
Illegal Drug Use is recorded at Intake and 36 weeks	**Illegal drug use in last 14 days:** 0.1% (N=1)	**Illegal drug use in last 14 days:** 0.1% (N=1)		**Illegal drug use in last 14 days:** 0.5% (N=3)	
Excessive Weight Gain from baseline BMI during pregnancy (n, %)					
Mastery, (n, mean)	**Intake** **Low mastery** 15.4% (N=175) **Not low mastery** 84.6% (N=959) **Mean:** 22.1 (Range 9-28)	**24 Months** **Low mastery** 13.5% (N=65) **Not low mastery** 86.5% (N=418) **Mean:** 22.6 (Range 13-28)			
IPV disclosure, (n, %) – **Data not collected at present**.					
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %)	81.4% (N=630)	82.6% (N=546)	81.3% (N=449)	78.9% (N=426)	
Subsequent pregnancies, (n, %)	2.3% (N=18)	8.2% (N=54)	15% (N=83)	23.5% (N=127)	
Breast Feeding, (n, %)	**Initiation** 44.9% (N=451)	**6 weeks** 8.4% (N=78)	**6 months** 3.7% (N=27)	**Average** duration for exclusive	

				Breastfeeding: **4.1 weeks**	
Involvement in Education, (n, %)	**Intake** **In Education:** 43.1% (N=491) **In both education and employment:** 9.4% (N=107)			**24 months** **In Education:** 29.8% (N=161) **In both education and employment:** 7.6% (N=41)	
Employed, (n, %)	**Employment:** 23.2% (N=265) **In both education and employment:** 9.4% (N=107) **Not in education or employment (NEET):** 43%(N=491)			**Employment:** 22.2% (N=120) **In both education and employment:** 7.6% (N=41) **Not in education or employment (NEET):** 55.6%(N=300)	
Housing needs, (n, %)	Data not collected.				
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	Data not collected. Monitored at Supervision.				
Father's involvement in care of child, (n, %)	**6 months:** **Daily contact:**	**12 months:** **Daily contact:**	**18 months:** **Daily contact:**	**24 months:** **Daily contact:**	

	50.3% (N=389) **Weekly:** 16.9% (N=131) **Less than weekly:** 4.3%(N=33) **No contact in last 3 months:** 22.5%(N=174)	48.4% (N=320) **Weekly:** 18.9% (N=125) **Less than weekly:** 6.1% (N=40) **No contact in last 3 months:** 22.5% (N=149)	46%(N=254) **Weekly:** 18.1%(N=100) **Less than weekly:** 5.4%(N=30) **No contact in last 3 months:** 27%(N=149)	43.9%(N=237) **Weekly:** 23.5%(N=127) **Less than weekly:** 4.6%(N=25) **No contact in last 3 months:** 25.7%(N=139)	
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)**:** Breastfeeding rates are recorded as: **Breastfeeding Initiation, 6 weeks infancy, 6 months infancy, exclusive breastfeeding status**

In which areas is the program having greatest impact on maternal behaviors? Positive outcomes in relation to Mastery, Breastfeeding, A&E attendances, Immunisation status, Hospital Admissions due to injury or ingestion.

Which are the areas of challenge? Reducing maternal smoking remains a challenge especially for those clients who have experienced trauma and have multiple Adverse Childhood Experiences (ACE'S)

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

Extremely preterm (less than 28 weeks' gestation)	**N=4**	**0.4%**
Very preterm (28-32 weeks' gestation)	**N=8**	**0.8%**
Moderate to late preterm (32-37 weeks' gestation)	**N=66**	**6.6%**
Low birthweight (please define for your context)		
Large for Gestational Age (LGA) (please define for your context)		
Other (please define)		

Further analysis and quality assurance of Low birthweight and Large for Gestational Age is required. There are plans to do this moving forward.

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	94.9% (N=705)	93.7% (N=608)	96.2% (N=510)	97.7% (N=509)
Hospitalization for Injuries	2 infants (0.3%) had I hospital admission	6 infants (0.9%) had 1 hospital admission. 0 infants had 2 or more admissions.	7 infants (1.3%) had 1 hospital admission. 1 infant (0.2%) had 2 or more admissions	10 infants (1.9%) had 1 hospital admission. 0 infants had 2 or more admissions
ASQ scores requiring monitoring (grey zone)	**4 months:** **Communication**: 1.5% (N=11) Mean 56.2 **Gross Motor**: 4.4% (N=32) Mean 55.0 **Fine Motor**: 1.8%(N=13) Mean 54.9	**10 months:** **Communication:** 1.1% (N=7) Mean 55.7 **Gross Motor:** 15.6% (N=99) Mean 50.0 **Fine Motor:** 3.5%(N=22) Mean 56	**14 months:** **Communication:** 1.9% (N=10) Mean 53.7 **Gross Motor:** 6.8%(N=35) Mean 53.9 **Fine Motor:** 2.5%(N=13) Mean 53.8	**20 months:** **Communication:** 6% (N=30) Mean 51.8 **Gross Motor:** 3%(N=15) Mean 56.3 **Fine Motor:** 3.2%(N=16) Mean 60.8

	Problem Solving: 1.5%(N=11) Mean 56.4 **Personal Social**: 1.8% (N=13) Mean 55.9	**Problem Solving:** 3.5%(N=22) Mean 54.7 **Personal Social:** 1.7%(N=11) Mean 54.0	**Problem Solving:** 2.5%(N=13) Mean 52.7 **Personal Social:** 1.5%(N=8) Mean 55.6	**Problem Solving:** 1.8%(N=9) Mean 53.3 **Personal Social:** 3%(N=15) Mean 55.6
ASQ scores requiring further assessment/referral				
ASQ-SE scores requiring monitoring (grey zone)	**6 months:** 1.8%(N=13)	**12 months:** 0.8%(N=5)	**18 months:** 1.9%(N=10)	**24 months:** 3%(N=15)
ASQ-SE scores requiring further assessment/referral				
Child Protection (please define for your context)				
Other (please define)				

Please comment below on your child health/development data:

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. This can include collated client feedback, a case study or by clients providing video evidence etc.

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:

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:
  Supporting Positive Behaviour Change in relation to smoking to enable clients to reflect on their smoking practice and facilitate those making positive changes in their smoking behaviours. This could be to stop smoking, reduce smoking or make changes around second hand smoke in their child's environment.

- Outcomes of CQI program for the reporting period: Updates on smoking cessation training have been progressed at Trust level. Smoking remains a difficult issue to tackle, however teams continue to liaise with their Trust smoking cessation team, maintaining links which ensures accurate sharing of information. We would like to see further reduction in smoking among the young people on the programme. Information would suggest that young clients are more receptive to making changes around smoke free homes and reducing second hand smoke in their child's environment. More work needs to be undertaken to evaluate what young people see as the barriers to stopping smoking. Plans have been made to use ECHO – a virtual platform which brings specialist teams together to share and adapt learning to improve outcomes.

- Lessons learned from CQI initiatives and how these will be applied in future: The barriers to smoking remain for our young client group and they return to smoking - especially once the baby is born. We need to explore this further; however anecdotal information would suggest that those clients who have had serious trauma and adversity do not see smoking as a priority. Rather they see it as an escape, or something that reconnects them with their peer group. This needs further analysis and discussion so that we can change mind-sets and intergenerational views on the impact of smoking both now and in the longer term.

- Goals for CQI in next year: Use ECHO NI to bring together clinical specialist teams and FNP Nurses and Supervisors to 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 introduce the EPDNS and GAD7 Screening Tool and strengthen the Perinatal Care Pathway
- Complete the regional feasibility study of the augmentation and integration of an Intimate Partner Violence (IPV) innovation into existing practice into Northern Ireland. Client interviews need to be completed. This work was being progressed in Dec 19/Jan20 but was put on hold due to Covid 19 Pandemic when Trusts were asked to begin progressing contingency plans for service delivery.

Program innovations tested and/or implemented this year (this includes both international and local innovations)

- Program innovations tested[1]:
  In June 2018, FNP NI commenced a regional feasibility study of the augmentation and integration of an Intimate Partner Violence (IPV) innovation into existing practice into Northern Ireland. The IPV innovation includes nurse and supervisor education and a clinical intervention (including a clinical pathway to guide decision-making) previously developed and tested for use with FNP clients in Canada and the USA by Professor Susan Jack (McMaster University, Ontario, Canada) and colleagues. The proposed service evaluation will be conducted by the FNP Health Intelligence Manager and FNP Research and Information Officer, in collaboration with Professor Susan Jack, to explore the feasibility, acceptability and application of the IPV Innovation to FNP in Northern Ireland. This will allow for reflection on the feasibility and acceptability of introduction of the IPV innovation into practice into each setting.
  Family Nurses have participated in focus groups to explore issues relating to the integration of the clinical pathway into existing practice from the perspective of the Family Nurses. These will help determine acceptability, integration and nurse knowledge and confidence in identifying and addressing IPV in their practice.
  Client interviews are still to be progressed to complete the study.

  The clinical lead has been involved in the international Reflective Supervision Project to develop a guidance document and Reflective Supervision Framework/model for NFP. This outlines the purpose, core standards, principles, and expectations; identifies recommended practice approaches; and provides resources to support successful implementation and evaluation'.

- Program innovations implemented:
  IPV currently being 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.

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

- Findings and next steps:
  Complete client IPV interviews to understand their acceptance and understanding of the intervention.
  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

The Revaluation Study provides assurances that FNP in Northern Ireland is providing an effective service to vulnerable young parents. The process highlights value inherent in five key FNP components:

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

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. 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.

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 Quality Improvement training for all members of the Family Nurse Partnership teams
3. Explore the options on the way forward with Information System

Progress against those objectives:

1. IPV Logs have been completed and are being analysed. Family Nurses are using the IPV Pathway and have incorporated the guidance into the visiting schedule. Focus Groups with Family Nurses and individual interviews with Supervisors have been completed. **ACTION:** Interviews with clients need to be completed. Start to write up the Research findings
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 had meetings with our colleagues in BSO and DXC to progress work on the 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. The central team have now established contact with a new lead 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 to make data improvements to reflect the revised Annual Report template
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. Implementation of GADS and EPDS into FNP practice in Northern Ireland using a QI approach

Measures planned for evaluating our success:

- Connections have been made with both BSO and DXC to progress plans to improve the 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.

Any plans/requests for program expansion?

Following the recommendations of the Revaluation Report, the FNP programme has been expanded by 10 nurses, offering an additional 230 places on the programme. This was initially for 18 months but has been extended for a further year. It is hoped that funding can be secured for these posts on a permanent basis.
FEEDBACK FOR UCD INTERNATIONAL TEAM:
The most helpful things we have received from the International team over the last year have been: • Regular meetings and updates on IPV • Reflective Supervision updates • Regular Clinical Advisory Meetings • New content notifications on the International site
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 [ ]

PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

Brief summary of services/support provided by UCD over the last year:

- Information and support to Clinical lead
- Mentoring and guidance to Nurse consultant
- Responses to ad hoc questions and requests for information, clarification, documents etc
- Inclusion in the COVID-19 International project and sharing of 'real time' global NFP/FNP experiences and best practice
- Continued support for international collaborative sharing of plans and experiences in adaptation and testing of IPV innovation
- Inclusion in international reflective supervision international working group
- Access to NFP International website and resources, Clinical Advisory Group, research and analytical leads forum and other International collaborations.

Identified strengths of program:

- The quality of program delivery, as evidenced by the implementation and indicative outcomes data analysis findings of this report
- Quality of leadership for the program – we are especially pleased to see the additional capacity that has been developed for clinical leadership this year
- The investment in, and quality of, program data analysis – both for sites and for the annual report
- The experience, commitment and skills of the FNP workforce
- 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

Areas for further work:

- Further exploration of the characteristics of clients declining the program and an understanding of their reasons for doing so
- 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

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

Any approved Core Model Element Variances:
N/A

Agreed upon activities that UCD will provide through Support Services Agreement:

- Continued access to international community and 1:1 consultation for DW and mentoring for SJ
- Support learning from the IPV evaluation to make further adaptations and adjustments as needed
- Contributing to the international working group on use of telehealth
- Support for the planned QI and developmental projects detailed in this report

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

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: