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Nurse-Family Partnership® (NFP) International

Phase Two Annual Report | 2018.12.07

Phase Two: Feasibility and Acceptability through Pilot Testing and Evaluation
Conduct a pilot test of the adapted Nurse-Family Partnership (NFP) program to inform what additional adaptations may be needed to ensure the feasibility and acceptability of the adapted NFP program.

- Some information may not be applicable in which case note it as N/A
- If you don't have the requested information, you may leave the section blank

PART ONE: PROGRAM OVERVIEW

Name of country: Norway

Dates report covers: Jan-Nov 2018

Report completed by: Tine Aaserud, Kristin Lund, Hans Bugge Bergsund, Marte Dalane-Hval from Regional Center for Child and Adolescent Mental Health, and Benedicte Petersen from the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir)

The size of our program:

	# Who work exclusively in NFP	# Who have additional assignments in implementing agency	**Total**
Fulltime NFP Nurses	**8**		**8**
Part time NFP Nurses	**-**		**-**
Fulltime NFP Supervisors	**2**		**2**
Part time NFP Supervisors	**-**		**-**
Total	**10**		**10**

- We have _____2_____ teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse (+ other staff) ratio: _____1 to 4,5_____
- We have enrolled 154 NFP clients since starting our Feasibility & Acceptability Study

Description of our national/ implementation / leadership team capacity and functions

Clinical leadership, support and guidance:

Norway's Clinical Lead draws on her clinical background as a Midwife from two different municipalities when planning clinical adaptations, implementation support to sites and training of the NFP teams. The Senior Advisor has her clinical background in child welfare and has ample experience from work with vulnerable pregnant women, children and families. Her skills and knowledge about dyadic assessment and tools, especially about Emotional Availability Scales (EAS) and video feedback of Infant-Parent Interaction (VIPI), is particularly beneficial in the process of developing the DANCE "substitute".

The Network of Infant and Toddler Mental Health at RBUP, offers technical and clinical support to the Clinical Lead and Senior Advisor, and facilitates expert discussions and guidance throughout the country.

Description of our National implementing capacity and roles:

- Service / implementing agency development

Implementation partner RBUP has plentiful experience in piloting new programs and methodology and offers implementation research support as part of the testing of new interventions. The Clinical Lead and Senior Advisor at the National NFP Office at RBUP offer daily support to the sites. Clinical Lead is staff manager for both NFP teams.

- Information system and analysis

RBUP has a team of two dedicated staff for NFP data system design, training and support. This year, the team have mostly consisted of one research coordinator working part time (50 %) and one supporting researcher in a 10 % position. We have hired a new research coordinator this fall and for a transitional phase, we have had one research coordinator working 50 % and one working 100 %. The administrators/team secretaries in both sites are trained on data input and data quality, and reports are being run evenly. The family nurses collect data on paper forms, and the administrators handle the data system input/plotting into SPSS. The research team in RBUP manage the data system and develop monthly data reports. They have regular Skype meetings with each supervisor to hand over data reports.

- Senior Nursing Leadership

The Clinical Lead, in her capacity as a Midwife and a Nurse, has gathered support from key stakeholders in nurse leadership in Norway around the testing of NFP. Many years of contributing to the training of midwives at the Institute of Nursing at the Oslo and Akershus University College of Applied Sciences, and more recent contributions in the Master's programme on Health and Empowerment, has built solid ties with this central educational institution, as well as with key individuals. The Clinical Lead also has a history of engagement in the Norwegian Midwives Association, which renders her a voice in central nurse leadership and debate in the country.

- License holder

The license holder for the testing of NFP in Norway is the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir). The Directorate is the technical subsidiary body to the Norwegian Ministry of Children and Equality, and heads the national Office for Children, Youth and Family Affairs. Policy support is strong within both institutions, with senior management and political power behind all efforts.

- Other (please describe)

The national leadership and implementation team is made up by dedicated staff at the licensee, The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), and a dedicated NFP unit within the National Network on Infant and Child Mental Health at the Regional Centre for Child and Youth Mental Health of Eastern and Southern Norway (RBUP). Externally it has been necessary to distinguish more clearly between the role of the Directorate as the license holder and the role of RBUP. The Directorate has as license holder the overall responsibilities for the NFP programme, policy support, framework and budgeting and authority liaison. While the role of RBUP is to be in charge of the programme implementation consisting of clinical adaptations, implementation support to local sites, data collection and management, as well as the training programme for staff.
This said, the collaboration agreement between the Directorate and RBUP regarding implementation cooperation was written up specifically to fit a very close joint effort, and the ethos of the programme has in a profound way impacted on the relationship. All decisions are discussed, reflected upon and finally concluded in dialogue, and the regular collaboration is much closer than the norm for a relationship between a commissioning and a service providing institution.

The National Board of Experts: consisted of senior representatives of the Norwegian Directorate of Health (Hdir), the Association of General Practitioners/General Medicine, the Norwegian Nurses Union, the Public Health Nurse Union, the two national Midwives Unions, the Norwegian Directorate for Labour and Welfare and the Norwegian Union of Local Authorities, as well as representatives of target audience organizations/individuals. In course of 2018 it has become increasingly apparent that the National Board of Experts has not been working optimally and its dedicated members has been declining. The Directorate has therefore after an evaluation this autumn with present Board members decided to terminate the National Board of Experts and have it replaced by a reference group. The intention is that the reference group will have wider representation and be consisting of a broader number of stakeholders (relevant services at central and local level, research institutions, professional organisations and user representatives) who have interests in the NFP-programme or who have sector responsibilities which interrelates with the NFP programme. It will also be important to secure a closer collaboration with the Norwegian Directorate of Health (Hdir), also at management level.

Description of our local and national NFP funding arrangements, including plans for funding for a randomized controlled trial:
During the current phase 2 (feasibility and acceptability), funds for local staff positions and all activity costs (car costs, training costs, equipment etc) are covered by central government allocations. Local governments (municipalities and townships) contribute some funds towards office rent and contribute staff time in the daily management of the local implementation (heading the local NFP boards). All costs related to national level administration of the programme (license holder's costs and national implementation team) are fully covered by central government allocations. Governmental budgets are annual and dependent on Parliamentary approval, hence funding for the programme testing in Norway is the same. However, the commitment to fund the testing of the programme in Norway is as strong as such our budgetary system allows, with multiple references to the programme in various policy documents and national action plans.

The evaluation which is documenting the feasibility and piloting phase is undertaken by the Work Research Institute of the Oslo and Akershus University College (AFI) and is funded by the government. An investment proposal for 2020 regarding phase 3 and the importance of undertaking phase 3 (randomized controlled trial) has been submitted to the Norwegian Ministry

of Children and Equality in November. A decision regarding the proposal will not be clear before August-October 2019. (The investment proposal has been shared prior to this report with Anne Rowe and David Olds.)

Description of our research team and capacity to conduct quantitative and qualitative evaluation:

The evaluation team (of phase 2) is headed by social scientists from the Work Research Institute of the Oslo and Akershus University College (AFI), with participation from the Institute of Nursing at the Oslo and Akershus University College, the Institute of Psychology at the University of Oslo, the Norwegian Institute of Public Health as well as international participation from the University of Melbourne and the Monash University in Melbourne. Evaluation Lead is Eirin Pedersen, senior researcher at the Work Research Institute. She holds a PhD in Sociology on the interrelations between welfare systems, socio economic status and fertility choices. Wendy Nilsen is contributing senior researcher from the Work Research Institute, with a PhD in developmental psychology.

RBUP is making quantitative data gathered by nurses available to the evaluation team for their quantitative analysis of progress of participating families within key areas. Sharing of data is governed by specialized contracts, building on templates from the Norwegian Data Protection Agency.

AFI have submitted the second partial report in November which covers the period from the summer 2017 up to spring 2018. The quality of the report is not quite of the standard that one would have hoped for. More information about the report follows under Part 4. AFIs final report is to be submitted in December in 2019. It will unfortunately not cover data collection for the whole of phase 2 (running till June 2021) due to delays in the programme implementation and partly due to managerial/budget limitations.

Current policy/government support for NFP: (Including plans for responding to challenges and opportunities in government policy, funding constraints, professional changes):

The piloting of the Nurse Family Partnership in Norway is mandated as a measure in several central Government policy documents like: “A good childhood lasts a lifetime”. Plan of Measures to combat violence and sexual abuse of children and youth (2014-2017)”, “Children living in poverty. Government Strategy (2015-2017)”, ”Escalation Plan on Substance Abuse (2016-2020)” and in the “Escalation Plan against Violence and Abuse (2017-20201)”. Most recently it has also been included in the Governments’ new “Strategy on parent support (2018-2021)”. In the mentioned strategy it is being stated under measure 9 that one will consider extending and expanding the NFP programme if the programme can demonstrate good results.

As mentioned in previous annual reports the initiative to test NFP for use in Norway has grown out of the Government’s concern that vulnerable families, and in particular their children, do not benefit fully from the universal services offered, and that socioeconomic disadvantage is inherited across generations, despite efforts to curb and counteract social inequalities in the population. The commitment to the program still appears to be strong when looking at how the programme is being referred to in many key policy documents regarding prevention of violence and early identification of children at risk. However, in January 2018, there has been a change of Minister for Children and Equality, and it is currently headed by Ms. Linda Hofstad Helleland. She is less familiar with NFP than her predecessor Ms. Solveig Horne, who was personally engaged in the programme.

Reference is also made to two studies commissioned and finalized in 2018. For more information please be referred to part 4.

Description of our implementing agencies/sites:

- High level description of our implementing agencies/sites:

Oslo municipality (of which two townships function as a joint site) adopted its municipality strategy "Smart, Safe, Green. Oslo towards 2030" in 2015, with its introduction chapter focusing on child and youth participation. Target area 2 under "Safe" deals with high quality services and target area 3 deals with equal rights to a beneficial and active life. Early intervention towards families in need is mentioned.

Sandnes municipality, the host municipality within the three municipality joint site in the South West, has its own municipal child and youth council. Its municipality strategy "Sandnes - front and centre of the future" was developed with the participation of children and youth and contains a section on public health specifically mentioning prevention of persisting social inequalities in health. Two out of the three municipalities in the south western site have received central government seed funding to develop more coordinated efforts of early identification and intervention aimed at parents to children 0-6 suffering from mental illness or substance abuse (including in pregnancy) and see NFP fitting in very well with capacities and outreach strengthened through these focused efforts.

- Current number of implementing agencies/sites delivering NFP: 2 sites

- How we select and develop new sites:

No new sites have been selected since starting the piloting. However, we experience a high level of interest in the program and receive regular requests for information and presentations of the program from potential future sites and organizations.

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

In general, we receive much positive feedback from participants, collaborators and NFP nurses. In the South West site, they still get many referrals and therefore clients have also been rejected due to limited capacity. There has been less referrals in Oslo, this can be understood in the context of a strategy to avoid rejection and that some services have been under the impression that the trial period ended in August. The directors in the two Oslo townships are positive to the NFP program, especially after meeting one of the participants with her child, in June 2018. Moreover, there has been a visit by a politician from the Parliament at the South Western team this autumn. A meeting is being planned for January between a local politician from Oslo and the local NFP advisory board with participants and NFP nurses. After a time without a politician in Oslo NFP advisory board, there is now a new politician in the board, which is perceived as an advantage. There has been a politician in the advisory board in South West since the beginning, she is both community midwife and local politician.

The local NFP boards are active, and currently the focus is more about cooperation with the other services. Written agreement for cooperation between the NFP team and the local child welfare clinics have been developed and a more formal cooperation with the local child welfare services has started. It has been useful to start these cooperation's with help from the local advisory boards.

Regarding the local sites it is a significant challenge that the teams are still employed by RBUP. The process to transfer this responsibility to the local sites has been hard to move forward. The perspective of secure budgets for only a year at the time seem difficult for them to handle/accept, even if their attention is drawn to the fact that there is a longer term political commitment to the programme. As mentioned the NFP programmes is referred to in many of the national key political documents related to preventive work and safe guarding children a secure upbringing. There has also been repeated communication that phase 2 of the programme will most likely be running till mid- June 2021 and that a priority investment proposal has been handed in from the Directorate to the Ministry proposing preparations for an RCT as from 2022. The latter being a proposition that Bufdir at this point in time do not know the outcome of. The local advisory board in Oslo seem to be exploring the possibilities for local employment more actively. Despite of mentioned insecurities both sites express a desire to keep offering the programme to their local population and stay on board with a possible expansion in the future of the programme.

Other relevant/important information regarding our NFP program:

N/A

PART TWO: NFP CORE MODEL ELEMENTS (CMEs)

Core Model Element	Success and challenges in meeting each CME
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	All clients participate voluntarily. In 2018, 23 clients have been discharged after they were included in the program, of varied reasons.
2. Client is a first-time mother	All clients are first-time mothers.
3. Client meets socioeconomic disadvantage criteria at intake	As previously agreed in the CME annex to our licence agreement, the right benchmark for this specific criterion is part of our acceptability and feasibility study. Most clients are in a position of socioeconomic disadvantage, with the majority being below the average national gross income. Additionally, a large number of clients are not employed at the time of enrolment and the majority have not completed education above the high school level.
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.	9 (27 %) of the 32 clients recruited in 2018 were recruited by week 16 gestation and all the clients were recruited by week 28 gestation. The clients enrolled in the program in 2018 were on average in their 20th week of pregnancy. In the attachment "Annual Data Report 2018", there is a bar graph which shows week of pregnancy when the clients are recruited. It has been challenging to recruit clients early in the pregnancy and to reach the goal of 60 % recruited by week 16 gestation. Especially in Oslo, the pregnant women don't meet a midwife before later in the pregnancy and since 58 % of the referrals came from a midwife, this has been a challenge. In addition, there have been a challenge with nurses having a full caseload and changes in the staff. Some potential clients have been on a waiting list, while waiting for the new nurses to be trained and ready for clients. These clients have therefore been enrolled later in their pregnancy.

5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	We have had a change of staff in four nurses over the course of the program, two in each team. In 2018 we have had change of two nurses, one each site. In Oslo, one nurse chose to go back to her former job on permanent basis. A new family nurse has been engaged. In SouthWest the supervisor was "headhunted" to a PhD study in her competence-area and a family nurse overtook her role and a new family-nurse has been engaged. The changes in nurses has evidently led to the drop-out of five clients. This underlines the importance of the therapeutic relationship as a CME and a success factor in client retention and progress. Further it can be considered that it is important to focus on that every NFP nurse deliver the NFP program.
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.	The clients are mostly visited in their home. Of the 1520 home visits in 2018, 1326 (87.2 %) of them were in the clients' home. 18 (1.2%) of the visits were in a family member or friends' home, 21 (1.4%) of the visits were at a public health center and 154 (10.1%) of the visits were at another place (not specified).
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 schedule agreed upon between the client and nurse.	All clients are visited according to an agreed upon schedule. Due to the comprehensive nature of Norwegian health and welfare services, the compound needs of our participants, as well as the decision to offer NFP in addition to rather than as a substitute of existing services during pregnancy and post-partum, it is sometimes challenging for clients to manage the number of visits prescribed in the visit-to-visit guidelines. We are monitoring the development in delivery.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	In Norway all NFP-nurses are registered nurses with additional training and recognition as public health nurses or midwives.
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	Our first batch of nurses concluded their NFP training program November 2017. The new recruited NFP nurses has received the foundation training in Scotland. In September 2018 the Clinical Lead and Senior Advisor delivered the Infancy training. Two of the newly recruited nurses attended the Toddler training in December 2017. Two of the nurses has not attended the Toddler training yet, they started in NFP in May and September 2018. Regularly we organize regularly national meetings with both teams to share experiences and needed training. We assess and discuss upfront of the meetings the need for training/themes to work on with the nurses. We have experienced the need for these meetings on a regular basis.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit	The nurses utilize the Visit to Visit Guidelines and use their professional knowledge, judgment and

Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	skills aim to meet the client's individual needs. The focus on consolidating their acquired knowledge and learning is important to keep fidelity to the program. For information about the mean percentage of time the nurses have spent on each domain in their home visits, please be referred to the attached see the attached Data Analysis report.
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	The teams use their knowledge of theoretical framework to guide their clinical work. The supervisors also aim, during supervision, to connect the theories to the clinical work. The supervisors and the clinical lead meet approximately every 6 weeks and have regularly focus on the Core Model elements to keep up fidelity to the program. We have learned that these meetings that lasts for 1.5-2 days are very important both for SV and clinical lead to keep on the same track and develop.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	The two supervisors provide supervision to their nurses on a weekly basis, individually and jointly as a team. There has been a change of one of the supervisors this year, and one of the nurses has been promoted to become supervisor for this team. Keeping up the consistency of weekly supervision, especially individual supervision, is challenging in a practice where schedules change constantly due to participants' needs, meetings with other services etc. At the same time both nurses and the supervisors high light that the supervision is increasingly important.
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.	The Norwegian NFP data system is now up and running. The administrators/team secretaries are plotting collected data into the platform. The research coordinator develops reports for use to guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.
14. High quality NFP implementation is developed and sustained through national and local organized support	We work closely with leadership in the sites and use the engagement of the local advisory boards to ensure local implementation will be sustainable.

Any requested CME variance(s): ☒X No ☐ Yes (please attach completed variance request form

PART THREE: PROGRAM IMPLEMENTATION

Reflections on clients, family members, and the community
• # of NFP clients participating in the program over the last year: 32 enrolled, 111 currently active

- % of those eligible clients offered the program who have enrolled over the last year: 75 %

- Our initial reflections regarding the characteristics of our NFP clients: We experience that our NFP clients fall within the target group of the programme. What is most common for our NFP clients are challenges in their early life and challenges with mental health (see the attachment 'Annual Data Report 2018'). The nurses report about motivated women and families, but also a lot about their ambivalence. A trait among our participants is the complex network of services they are in contact with on a regular basis. Our nurses often attend meetings with other services together with the women, and this cooperation seems necessary and important for both the families and for the support agencies to have an overview of who does what to support the family and meet their compound needs.

- Client engagement in the program (including client retention): Our retention rate is currently at 74 % (114 remaining out of 154 included) for the full program period (i.e. 2016-2018). Client-initiated discharge is the most common reason for drop-out, followed by moving out of the service area and pregnancy loss/child. The most common reason clients gave for program discharge was refusing to work with a new nurse home visitor and refusing to continue with the program after a report had been made to the Child Welfare Services. As for client engagement, our experience is that they have a high degree of program involvement. The mean client engagement score is high, according to the home visit data. The clients have a 4.5 score on involvement, 4.3 score on understanding the material and 4.4 score on acceptance of material. The nurses report that the clients mainly are very positive towards receiving the visits and the content of the visits. At the same time, they meet clients with a higher degree of ambivalence towards being in the program or towards working with focus on change in certain areas of their lives. The nurses have some challenges in meeting the client and the child when the child starts in kindergarten and/or when the mother starts at school or work. It then gets challenging to find time to meet. We have tried to make this more manageable by increasing the salary and adding to the employment agreement that it is expected with two days a week when they can work until 8 pm

- Engagement of fathers: Our data shows that fathers were present and participating at 422 (27.8 %) of the 1520 home visits in 2018. In addition, fathers were present and not participating at 55 (3.6 %) of the home visits. On average the father has a 4.1 score on involvement, 4.1 score on understanding the material and 4.2 score on acceptance of material in the home visits. This data suggests that the father's engagement in visit are quite high. This correlates with the experiences of the nurses. In Norway, fathers have about three months of parental leave during the child's first year of life. NFP offers no systematic data collection for fathers, yet we assume their influence is important to the child's development, where a father figure is present. The level of fatherhood engagement, and the unparalleled level of parental leave allotted to fathers in the child's early life, is a question we may want to consider if there are more options for data collection around in the Norwegian context.

- Engagement of other family members: Family members (client's mother or father, foster parent(s) and other family members) were present and participated at 33 (2.2 %) of the 1520 home visits in 2018 and were present but did not participate at 95 (6.3 %) of the home visits.

- Engagement of community, in particular primary care providers and child welfare agencies: We have experienced that close cooperation is very important. The midwives and public health nurses in universal pregnancy and post-partum services are very willing to meet with us to share experiences learnt from testing the program. Here we have developed a written agreement for cooperation. We continued the process of building relationship with the

universal services and the municipal child welfare agencies and we have started having meetings. We have a child welfare expert liaising with each team of NFP nurses, as well as child welfare leadership representation in both of our local advisory boards in the sites.

- Success/challenges with receiving referrals: There are continues referrals in the South Western site and the challenges is to handle the rejection of new clients due to capacity limitations. We work hard to keep up good cooperation while the nurses have almost full caseloads. It is challenging for the nurses to say no to a new client when they have full caseload. A way we raise this challenge with the local advisory boards, is to present the cases of those clients who have not been included due to limited capacity. In this way we hope to illustrate the importance of continuing the program.

Program Implementation

- Any adaptations, changes, enhancements made to: Visit-to-Visit Guidelines, Nursing Assessment/Data Collection Forms etc.: Only minor adjustments according to Norwegian context.

- Brief description of our nursing education program: Our nurse education program consists of three training modules, including program content as well as program delivery during the three phases of pregnancy, infancy and toddlerhood. In addition, our nurses have been trained and certified in Newborn Behavioural Observation (NBO), trained in Motivational Interviewing (MI, this training is regularly followed up and boosted), Marte Meo (Video feedback of Infant-Parent Interaction, VIPI) and they have also received training on how to use ASQ and ASQ:SE. PIPE education is received in the infancy training, and three times during the gatherings we have regularly with both teams.

We also plan for training in IPV for the new nurses (January 2019).

- Any enhancements we have made to the program:

We hope that our dyadic assessment tool (DANCE replacement combining NBO and VIPI methodology with EAS scoring) may prove an enhancement of the program. To date the experience is that the IPV (Initimate Partner Violence) strengthening we currently are testing adds to the confidence and skills of nurses and fits well with the policy context of the program pilot in Norway.

Program Fidelity

- Our assessment of program dosage patterns and length of visits in relation to client strengths and risks to date: According to data our nurses spend approximately 80 minutes on a home visit.

- Our assessment of program content delivered to date (domains): For information about the mean percentage of time the nurses spent on each domain in their home visits, please see the attached Data Analysis report.

- Our assessment of any other program fidelity benchmarks: We will still need to focus on earlier inclusion of participant to achieve the benchmark of recruiting 60% or more clients before pregnancy week 16.

- Our reflections on the issues revealed and actions we are taking /planning in response to these:

  - The nurses have worked well with the issues around program dosage both in national meetings and team based.

  - As for the challenges with inclusion before week 16, it is more so in Oslo since pregnant women in Oslo often get their first appointment with the midwife in week 24 of pregnancy. Fortunately, there is a change going on locally on this matter.

NFP program innovations

- We are using/plan to use the following program innovations/enhancements (e.g. STAR Framework, DANCE, IPV, Mental Health, other):

STAR Framework: We are working to support all nurses to use the STAR framework. As we are beginning to graduate client it become increasingly clear that both setting goals and undertaking strength and risk assessment are very important to do from the beginning of the programme.

DANCE replacement: The dyadic assessment we use in the testing phase of NFP instead of DANCE is Newborn Behavioural Observation (NBO) from birth until the baby turns 3 months, followed by elements from Marte Meo, called Video feedback of Infant-Parent Interaction (VIPI) from 6 to 9 months of age, as well as at 12 and 18 months. To collect data that captures emotional availability during caregiver-child interactions we use the Emotional Availability Scales (EAS).

Newborn Behavioural Observation (NBO): All the nurses have been certificated by the NBO-system, either before they became employed as NFP-nurses, or afterwards. They agree that the NBO-training did not just teach them a tool to be used to observe babies together with their parents, but also a change of mindset about how to think about the babies. The first four weeks after birth NBO is included in the home visits. By giving NBO weekly, it allows the parents to follow the child's development, and because NBO is about relationship-building and sensitizing the parents, the nurses can help parents to link up and understand their child in appropriate ways. The nurses register which of the 18 neurobehavioral items being focused on during the home visit. When the NBO is finished, parents are asked to use a questionnaire to describe what they knew about their baby before NBO and what they have learned about the baby after the NBO is finished. Our data suggests that the mothers are very pleased with NBO and have learned a lot about their babies. Between 94% and 98% (depending on which question) of the mothers respond that they have learned a lot, or quite a lot about what their baby can do, how the baby can communicate with their parents, how they can respond to their baby, how they can help their baby when he/she is crying and how they can make eye contact and interact with their baby.

The mothers also report that they feel more confident as a parent after the conversations with the family nurse (70.8% answered a lot more confident and 29.2% answered quite a lot more confident). When asked about how they feel in general that the conversations with the family nurse has been regarding getting knowledge about their baby, 82.7% answers “Very good”, 13.5% answers “Good” and 3.5% answers “Fair” and 0% “Poor”.

Video feedback of Infant-Parent Interaction (VIPI) is offered when the child is 6, 12 and 18 months old. In the planning of the intervention, we aimed to give video feedback from 3 months of age, but the nurses had a hard time managing doing it straight after the NBO intervention, so we agreed to wait until the age of 6 months. Once the nurses got more familiar with the tools, and the NFP program in general, they expressed that it would have been good for the families to have the video intervention at 3 months as first planned. The video filming is of course voluntary for the families, and since the mother is the client in NFP, it is her and the child being filmed. The nurses do a video for 3-5 minutes of the interaction and do the analysing together with the Marte Meo supervisor before the next home visit. The focus is based on what the clients say they need guidance on, and we link it to the six elements in VIPI, starting with looking at "the child's contact initiative and need for pauses". The focus in the clips we choose, is always of the child. We want the parents to register the child's needs for contact and when the child needs to take a pause. When the child turns away, it does not necessarily mean that he/she is fed up or wants a big change, but just to have a small recap for itself. It is important that the parent wait for the child to return to the dialogue, without taking new turns again and again. We often see that the parents are too eager to interact with the child, which results in intrusiveness, instead of following the child. It takes often two or more video feedback sequences to make sure the parents understand this. When the parents integrate this important element, we go to the next element in VIPI, which is "to register the child's initiative", and now we also focus on "the confirmation of the parent". We are interested in turn taking, and the importance of interacting every second time. This is focused in element 3: "await the child's reaction". The next element to follow is "naming" what the child do/feel/say, and for the parents to name their own actions/feelings and what they plan to do. This can make things more predictably for the child. Next element in the VIPI intervention is about "structuring and leadership". After these five elements are reviewed and integrated, we take a break from the video filming, until the child turns 1 year. The element to focus at this time is about expansion; "the child's interest directed at objects and the child's attention directed at others outside the dyad". Our experience is that the families don't necessarily get through all the six elements, because the families struggle to follow the child. They need reminders of the importance of specific elements, so the nurses often need to focus on this topic again and again.

The nurse takes new videoclips (3-5 minutes) for each time/home visit, which makes it easy to see if the parents really have integrated the themes in practice. Together with the supervisor, they find suitable clips that highlight the elements in focus. This takes time, and the nurses struggle with getting time to prepare for the sessions. But they all say it is a superb way to get the parents understand the importance of following the child, and to help them read the child in a proper way. Some of the nurses have integrated PIPE lections to be used together with the elements in VIPI. The topics are related to each other in reasonable ways, so this is something we aim to continue developing.

The Emotional Availability (EA) Scales: The assessment tool we use in this trial, is Emotional Availability Scales, 4th edition, and the coders are all trained by Zeinep Biringen. The nurses do 20-minutes videotape of interactional sequences in the families' homes, at three points; when the child is 6, 12, and 24 months. The recordings are scored by coders that do not know the story of the families. The Emotional Availability (EA) Scales (Biringen 2008) describe and assess six dimensions, with four on the adult side (sensitivity, structuring, non-intrusiveness, and non-hostility), and two on the child side (responsiveness to adult and involvement of adult). We use

the data from EA for research, and for supervision of nurses and their guidance of the families. The 20 minutes videoclip done at 6 months is the starting point of the video feedback interaction at this age. We use suitable clips from the 20 minutes film to highlight the first element in the video feedback interaction that starts when child is 6 months old. So far, we have 56 EA recordings at 6 months, 29 at 12 months and 1 at 24 months. (The first child turned 2 in November this year.)

Intimate Partner Violence (IPV): We have used some time in the national meetings during the year, to make sure we use the IPV intervention as planned. It is challenging for the nurses to handle these different interventions at the same time as they learn about the NFP program in general. Time is also regularly focused in the SV – Clinical Lead meetings to make sure the nurses use the materials/IPV pathway etc. We chose to postpone the IPV training to January because of the study trip to Scotland, but now plan to invite both SVs to the training to give them better possibilities to support the IPV work/intervention

- Assessment of our successes/challenges in implementing/adapting these program innovations:

Challenges with the training in NBO and VIPI: NBO and VIPI requires training and practice. Nurse training in NBO consists of five days of education, followed by six weeks of practice, supplemented by group guidance where nurses bring video clips from their own observations. Nurse training in VIPI consist of three days of theory, one day of video feedback practice followed by individual guidance on each video clip, during the interventions in the families. To have enough time to practice and prepare before the home visits is always a challenge. The nurses need guidance and supervision to deliver NBO and VIPI.

For EAS we notice time challenges for the nurses. To make a 20 minutes recording, is sometimes difficult, due to of lack of time. It is also a fact that filming can be a stressor to the families. The families want to show their best sides and filming can sometimes make them more active/intrusive than they usually are. Such behavior could seem like performance on stage and to not be authentic and spontaneous. The child also enjoys interactions with the adult, and because EA is a dyadic assessment tool, the mother cannot “look” good without the child (Biringen 2008).

Successes with NBO and VIPI: Most families like this way of guidance. For NBO, the nurses have integrated the thinking in their daily practice. For VIPI, the preparation is more demanding, but the nurses are getting more and more experienced in using the video tool, and they see the benefit of using it.
For EAS we experience that filming a session as we do in EA allows for a more precise look at inter-rater reliability and coding of data. We also assume that there is a success that the coders are unfamiliar with families, because they do not have knowledge about the background and challenges in the families that may interrupt the neutrality of the coders. Clinically, the nurses express that it is valuable to have a second person observing the interaction. The EA coding system is known internationally, and it is used in many studies all over the world. The fact that we use the results clinically, is also a success. The nurses say that the feedback and discussions of the results from coding, help them to provide a better understanding of the families’ needs.

- Any alternate tools we will use/are using and why:

In Norway, the Circle of Security (COS) is often used to describe the needs of a child, and sometimes this circle has been useful in the NFP home visits.

Our information system and analytical capacity:

- How we are currently collecting, analysing and using NFP program data (information system, data quality, how it is used at NHV, supervisor, team/site, national levels etc.):
  The nurses collect the data on paper data forms and the administrators/team secretaries plot the data into the SPSS data program, developed for NFP data management by our research team. The research team have regular data-report meetings with the supervisors, focusing on different data forms and various subjects. The supervisors use the data in individual supervision and in team meetings. We also have data-report meetings with the teams, where we discuss findings and how they can be useful in their clinical practice.

- Our reflections on our information system and what we need to do to improve its functionality, usefulness and quality: We have regular meetings (almost weekly) in the national implementation office at RBUP (including the supporting researcher) to discuss how we are progressing and what we need to develop and adjust with regards to the data collection and information system. We have started the process of adjusting the data forms for the future based on our experiences in the test phase.

Our plans to develop a Continuous Quality Improvement process: Now, as we have started to graduate clients we begin to see more clearly which areas we need to work on to improve. We have planned to continue our regular meetings in the national team where we will develop an improvement plan for the year to come. We are continuously assessing the needs for training and also discussing plans for education further ahead.

- Please provide:
  - A summary of your annual program data collected through your NFP information system or other data collection method (client referral data, NFP nursing assessment/data collection forms, etc.); or
  - Attach a copy of your annual data report
    Please be referred to the Annual Data report.

Nursing Workforce

- Reflections on NFP nurse/supervisor turnover/retention during reporting year: It has been challenging to handle the turnover of 2 nurses and 1 supervisor. Because of the small teams, the capacity to handle referrals are quickly getting vulnerable. It is also a matter of keeping fidelity to the programme. Still, we do experience that we can handle the turnover in a good way.

- Successes/challenges with NFP nurse/supervisor recruitment: We experience that we know more about how to go through the interview process to find the qualified staff we need. It works very well to use client in the process where we arrange “speed dating” with the applicants. There is a lack of trained public health nurses in Norway. Still ,we have received good but few applicants for the recruitments.

- Successes/challenges with delivery of core NFP nurse/supervisor education: It has been a huge support to cooperate with Scotland NFP in education of the new staff. All four new recruited nurses have been in Scotland for foundation training and we experience that they are very well trained, and we have so many similarities in the two “NFP/FNP families”.

- Successes/challenges with ongoing (integration phase) NFP nurse/supervisor education: Senior advisor and clinical lead have had the first infancy training week for the 4 new recruited nurses. It was a clear advantage to have been through the training with our international mentor Ann Rowe with the first cohort. As the new supervisor started in her job

we provided 1,5 days of education and both Cl.Lead and the other SV support her on weekly basis. There are plans for more SV training in 2019. We aim to develop an education plan for the time ahead.

- Successes/challenges with delivery of NFP nurse reflective supervision: We believe that our supervisors are highly skilled and are doing a very good job. They are using the supervisor forms together with the nurses. We work to develop the use of the data reports in a good way. The supervisors and the clinical lead have regularly meetings where they among other issues keep focus on supervision.

- Successes/challenges with delivery of reflective supervision to our supervisors: The Clinical Lead work closely together with the supervisors, and have Skype meeting every week and face to face on a regular basis every 6 week. The challenge is to work continually and more focused with the reflective supervision when there is a lot of other matters to handle at the same time. The personnel and manager role for the clinical lead for both teams is time consuming, but also important.

- Any plans to address nursing workforce issues: We hope to be able to expand. It has been discussed in the local advisory boards the possibility of supporting the teams with two more nurses in each team. It appear challenging for the sites to find good ways to organize local employment of the nurses but it is also a question about priority for the sites.

Summary

- What have we achieved this year:

We reached client number 150. Both teams are work very well and we have active local advisory boards. The data collection is also working well. The IPV intervention has been implemented and we have learned much from the work with the dyadic tools and assessment in Norway. The great cooperation with Scotland both regarding training/education, supervisor cooperation and sharing experiences about implementation and the NFP program is of great mutual value.

- What challenges do we face?

The unpredictability regarding the future for the program is challenging. How to keep up the positive focus both in the teams and on the sites, while waiting for clarifications? The considerable workload of the Clinical Lead due to personnel responsibilities of the two teams. As well as the challenge in having the employment of the two teams transferred to the local sites.

- Anything else:

It will be important to establish a solid and skilled reference group which can provide important advice and be a sounding board for the further piloting of the programme. This includes the reference groups involvement in defining the outcome measurement in view of a possible RCT. It will also be important to secure a closer collaboration with the Directorate of Health at leadership level and have them included in the reference group.

Any other relevant information: N/A

PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

Our feasibility & acceptability study:

- Goals:

Norwegian pilot phase evaluation consists of two main components; a "traditional" feasibility and acceptability study/process evaluation (qualitative) and a pre- and post intervention outcome evaluation (quantitative). Goals of the evaluation are to:

• explore the feasibility and acceptability of the programme in the Norwegian context
• document adaptations of the programme from international standards to Norwegian realities
• discuss overlap/conflict with existing welfare services in a high-service societal context
• document experiences from families and nurses with a focus on feasibility, acceptability and usefulness in the Norwegian context
• document the criteria and process for inclusion and recruitment of participants
• explore success indicators/tendencies of effect/improvement for participating families

The evaluation is undertaken by AFI.

- Methods:

For the process evaluation (qualitative acceptability and feasibility study), the focus has been on exploring the mechanisms at work in the implementation of NFP and their relevant outcomes. Regarding recruitment of participants, the focus has been on criteria and practical working methods and preventing drop out. Data sources for this part of the study include qualitative interviews with implementers, local NFP board members, NFP nurses and participants, as well as other stakeholders. Written questionnaires and document studies, including analysis of public reporting data (local to central government reporting system KOSTRA) was to supplement interview data.

For the outcome evaluation (quantitative study) to be finalized in December 2019, the hope is to identify some success indicators/tendencies of effect/improvement for participating families. The data used for the analysis consists of various mappings, scoring and data gathering already integral to the NFP information system. For targets with more than one point of data input, for instance regarding the mental health of the mother, pre- and post-analysis or development analysis (for example growth curves) will be used to track indications of positive developments. For targets with only one point of data input, such as birth outcomes (birth weight, Apgar score etc.), the aim is to compare data to available national figures for similar populations, available figures from NFP evaluations in other countries, or available data from other studies/programmes in Norway. But given the fact that final report is being finalized in December 2019 and therefore not capturing the whole cycle of phase two of the programme can limit the possibility to identify success indicators/improvements for the participating families.

- Sample:

In accordance with the license agreement, 150 families are the sample size for quantitative analysis in the outcome evaluation.
In the AFI report part 2 submitted in November the following stakeholders have been interviewed: 10 families, group interview of the two NFP teams, individual interviews with the two team leaders, individual interviews with Clinical Lead and senior advisor at RBUP, 7 interviews with representatives from the two sites involved in the local advisory boards and a few representatives from collaborating partners. In hindsight AFI have discovered that more of the mid wives at referring clinics should have been interviewed regarding the collaboration between

NFP nurses and the child care health clinics. This will be addressed in the final report to be finalized in December 2019.

Please notice that Bufdir has renegotiated an agreement with UCD where the programme is allowed to enroll up to 240 families in the programme. This is to be reviewed in December 2019. However, additional families beyond the 150 first families will only to a limited degree be reflected in the ongoing evaluation report.

- Progress to-date:

The first report from the evaluation was finalized in early spring of 2018. The report focused on the preparation and adaptation phases, the start of local implementation and challenges and barriers to date. In November 2018 the second partial report was submitted to Bufdir. The report is long and will be translated to English. Unfortunately, it will not be ready to share with UCD before the 15th of January.

Data from feasibility & acceptability study:

- Key findings from our data

As the AFI report part 2 mainly includes data till May 2018, the attached Annual Data Report gives the most updated statistical data regarding the profile of the families being included in the programme, as well as those excluded. It also gives an updated figure of the number of home visits undertaken, as well as the average time spent at each home visit, time spent on each domain, referral source and data on retention and drop-out.

As for the AFI report the most important findings are the descriptions and data of the families being enrolled in the programme and of those who refrain from joining or who decides to leave the programme. As well as, the findings regarding how the programme is being perceived by the participants, which is overwhelmingly positive, though several participants were reluctant at the beginning of the programme. It is being highlighted in the report that the participating families perceive that the quality of the relationship between them and the nurses is unprecedented compared with their relationship with other service providers and their previous experiences with various public services. The report also describes some of the challenges that the NFP nurses are facing when investing in the families and overall handling of work load. The report captures that the nurses in the programme in Rogaland (the smallest municipality)seem to have prevented two losses of parental custody. AFI also concludes that there seem to be little reported overlap between the services provided by the NFP nurses and the universal services. According to the AFI report there is a high compliance and fidelity to the NFP programme and its core model elements. The nurses report that they experience that the NFP program with its modules is of great value and that they appreciate the many tools that they have to their disposal as well as the structure of the programme.

- Reflections on our findings/results

Based on the AFI report and the inclusion criteria it appears that the participants in the NFP programme is less vulnerable than participants in other NFP countries. This can maybe be explained by the rather wide spectrum of services in Norway for instance for pregnant women with severe drug abuse and will therefore in the Norwegian context not be included in the NFP programme, but considered too heavy. This also goes for parents with limited mental capacity. It is evident from the AFI report that the families being included often have multiple vulnerabilities. A large proposition of the participants has signs of depression/psychological challenges though at various level (58%). Many of them have also limited social network or live in high conflict relationships (38%). The drop out rate so far according to AFI is quite modest (32 of 150

participants), this can be interpreted to imply that the nurses are successful in identifying the families who benefit from the programme. It also becomes evident from the report that the nature of the relationship that the nurses can offer in NFP programme is seen as a strong asset and value for the families included in the programme. In the report it is being described that many of the families have previous negative experiences with various public services where the element of control and judgement has been characterizing the relationship according the participants, rather than the emphasis of empowerment and acceptance. At the same time, it might be a concern that one of the main reasons for drop out is the change of nurses when a nurse is leaving the programme. What can therefore be done to prepare a family that this might happen and if it happens that other NFP nurses are ready to step in and willing to offer the same high-quality relationship? The report concludes that in terms of fidelity and compliance with the programmes core elements it seems to be high. One could maybe have expected a stronger data base from AFI to back up their conclusion. One would maybe also have expected more data and findings regarding identification of needed adjustments of the programme in the Norwegian context beyond what was identified in phase 1 of the programme? A particularity in the Norwegian implementation of the programme is its awareness on the father role. Fathers/partners has not been interviewed and the data collected is therefore slim and is basically drawn from the interviews with the mothers. It would have been interesting to collect data to explore more on whether the fathers/partners presence during the home visits influence the families benefit of the home visits and sharing of knowledge and reflections?

- Any actions planned based on results

In terms of the quality of the report from AFI a dialogue has been started to secure that the final report will be limited to 25 pages and that it focuses on analysis and conclusions, and possible recommendations for phase 3 and an RCT.

Anything else that would be helpful for UCD to know?

For further details about the feasibility and acceptability study from AFI please be referred to the full AFI report which will be shared with you in mid-January 2019.

There has been commissioned two other studies by Bufdir. One study is regarding structural and systemic questions about future sustainable placement and organization of NFP within the Norwegian welfare system at local and central government levels if the programme is to be rolled out more widely. As well as issues regarding recognition of the training and competency gained by the nurses through their employment within the programme. This study was undertaken by Sintef and high lights several reasons for placing the programme under the sector responsibility of health and the Ministry of Health. Recommendations from the study provides an important complement to the ongoing acceptability and feasibility “plus” evaluation by AFI.

The other study is a social economic analysis of the NFP programme and its expected cost-effectiveness for municipalities in the pilot areas. This report has been conducted by Oslo Economics and was a response to a direct request from the Local Advisory Boards. The study has its limitations in the sense that the researchers has only been able to stipulate the costs of preventing loss of parental custody and transfer of children to foster homes. While there are many other aspects which could have been relevant to have priced in terms of preventing drug abuse, violence, adverse child development etc. However, it stipulates that a programme of the current size which is being piloted can at least prevent two losses of parental custody. This was discussed with the researcher from Oslo economics and it was concluded that the program is currently probably preventing around two cases of placing the child in custody, per family nurse. (Approx. 14% of 120 clients). With the aforementioned pre-conditions the report concludes that

NFP programme is cost-effective for the municipalities in a long term perspective, while it in the shorter run is less cost-effective.

PART FIVE: ACTION PLANNING FOR NEXT YEAR

Our planned program priorities for next year:

- Risk analysis and risk management:

Bufdir will follow closely how the investment proposal will be dealt with by the Ministry and keep RBUP closely updated. A high-level risk analysis is being developed for 2019 regarding the NFP programme in order to manage the identified risks. The plan if the investment proposal and the RCT is being accepted is pretty clear as described in the investment proposal. However, there also need to be a plan B for how to handle a turn down of the proposal, as well as a possible request from the Ministry to plan for a lighter version of an effect evaluation. We expect a first clarification from the Ministry in March/beginning of April. Depending on the feedback then we will have to delineate the two remaining scenarios.

- Establishment of reference group:

The establishment of the mentioned reference group will be a top priority. As well as starting the process to develop the outcome measurements for the NFP programme in view of the planned and proposed RCT.

- Transfer recruitment of the teams:

It will be crucial to transfer the employment of the teams to local level. RBUP and Bufdir will be collaborating to facilitate this transition.

- Arrange a NFP conference:

Explore the possibilities for arranging a NFP conference in March linked to David Olds visit where we can share the learning and experiences from the program so far with internal and external stakeholders in order to inspire and secure better knowledge about the ongoing piloting of the NFP programme. Bring forward the voices of participating families, the nurses and collaborating partners (child protection services and social welfare services).

- Education:

Review and revise the educational programme for family nurses and supervisors so that it incorporates learning from phase 2 and is ready to for the expansion phase in 2020. This will include review of the dyadic interaction components for feasibility and sustainability

- Data analysis

Continue to analyse data being collected in phase 2 to deepen understanding of current progress and develop analytical processes for future regular reporting

Any plans/requests to UCD for program expansion/adaptation?

Bufdir has already applied for and received approval from UCD for an expansion up to 240 families to be able to continue the recruitment during phase 2.

If the investment proposal will be accepted, Bufdir will have to apply for a further expansion of the programme as described in the investment proposal already shared. A scaling up of the programme is then starting from 2020. A decision from the Ministry will be expected by October 2019, though it might be turned down at an earlier stage.

This is what we think we need to be doing next year to adapt and improve the quality of our NFP program in the coming year:

The RBUP research coordinator will work on revising and adapting the data collection forms, that are currently being used, in preparation for phase 3. We continue work to develop the program material to the Norwegian context. The experience of being through the hole program cycle and the experiences with graduation shows us what we need to develop and to do more training on. We have already started work on goalsetting.

Our research/program evaluation priorities for next year:

To take learnings from the AFI report, part 2. To have the final report from the feasibility and acceptability study completed by December 2019. It will be interesting to see if the final report can provide us with some information about success indicators/tendencies of effect/improvement for participating families. It is a weakness that the final report will not fully cover phase 2 of the programme. On the other hand, the data collection and analysis done by RBUP will complement the AFI final report.

How we will know if we have been successful in meeting our objectives?

Basically, if the planned program priorities have been realised partly or in full scale. It will also be of key importance that the participating families keep on being satisfied with the program and that the teams keep on appreciating to work within the framework of the NFP programme and its core elements.

This is what we would like from UCD through our Support Services Agreement for next year:

Reference is being made to previous shared outline and dialogue with Ann Rowe for 2019.
In terms of specifics we would like the following support;

- Input and reflections on how to proceed to identify relevant outcome measurements for an RCT in the Norwegian context.
- Possibly concrete advice on outcome measurements to be included
- Input and advice on alternative ways to evaluate the effect of the programme if an RCT is being turned down by our Ministry. Provide support in the design.
- Share experience from other countries where phase 3 and RCT has been turned down/discontinued
- Advise and share experience from conducting RCTs and what to be aware of in the design and commission of an RCT
- Support and supervision from international mentor to Clinical Lead
- Visit in March by David Olds and Ann and contribute to the aforementioned conference

Our suggestions for how NFP could be developed and improved internationally are:

- Systemize experiences across countries regarding feasibility studies during face 2 (do and don't)
- Systemize experiences across countries undertaking RCTs of the NFP programme (do and don't)
- Consider to include some minor mapping (data collection) of partner/father when present during home visits as part of the regular data collection

PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following meeting to review annual report)

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

- Access to International Clinical Advisory Group, specialist clinical teleconference meetings re IPV intervention and STAR revisions, program materials and international resources via the international NFP website and annual newsletter
- Clinical consultation and mentoring for Tine Gammelgaard Aaserud
- Strategic consultation calls with Benedicte Petersen
- Involvement in the international reflective supervision project

Identified strengths of program:

- The commitment and talents of the clinical and strategic leaders
- The experience and commitment of the nurses and supervisors
- The development of the dyadic assessment components for feasibility testing
- Development of the strategic plan and development of the reference group to develop research plans
- The development and success of the Local Advisory Boards
- The willingness of all involved to continue to learn, adapt and improve the program in Norway

Areas for further work:

- Development of further analysis of the data set
- Further preparation of the educational curricula for future sustainability
- Development of ministerial support for strategic plans
- Development of the reference group

Agreed upon priorities for country to focus on during the coming year:

- As agreed in part 5

Any approved Core Model Element Variances: None

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

- Input to national conference, meeting with researchers and with NFP teams in March
- Support for RCT design and outcome measure selection or alternative scientific research methodology development
- Support for clinical lead for personal development, clinical guidance and further development of educational curricula

