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International Nurse-Family Partnership® (NFP)

PHASE THREE ANNUAL REPORT – SCOTLAND 2019-20

Phase Three - Randomized Controlled Trial (RCT).
This phase is established to estimate program effects on outcomes of clear public health importance that align with the outcome domains in the original US trials and that address additional goals of that country. This work is designed to determine the added value of the program for the populations and contexts in which it is being delivered. The expected research methodology is a Randomized Clinical Trial (RCT) as this provides the strongest evidence of program impact. In some circumstances, it may not be feasible or appropriate to undertake an RCT (e.g. where the population size is too small to estimate benefits reliably or where there are serious cultural concerns). In these circumstances, consideration will be given to use of quasi-experimental designs. Countries are encouraged to conduct complementary qualitative studies, which can be helpful in understanding results of the RCT. During this phase, the implementing entity may seek approval to continue recruitment of clients in existing pilot and/or RCT sites until analysis and reporting of the RCT data are complete. Countries are expected to continue completing annual reports during this phase.

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

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.

PART ONE: PROGRAM OVERVIEW

Name of country: Scotland

Dates report covers (reporting period): 1st April 2019 to 31st March 2020

Report completed by: Scottish Government

Date submitted: 25 Sept 2020

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	**151**	**151**
Part time NFP Nurses	**22**	**22**
Fulltime NFP Supervisors	**32**	**32**
Part time NFP Supervisors	**2**	**2**
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	**N/A**	**N/A**
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	**N/A**	**N/A**
Total	**207**	**207**

- We have 32 teams (supervisor-led groups of NFP Nurses)
- **Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them**): 1:5

- **Current number of implementing agencies/sites delivering NFP**: 11 Health Boards
- **Current number of NFP teams**: 32

- **Number of new sites over the reporting period** - 1 NHS Dumfries and Galloway
- **Number of new teams over the reporting period** – 3 (Dumfries Team A, Ayrshire Team C and Lothian Team F)

- **Number of sites that have decommissioned NFP over the reporting period** - None

- **Successes/challenges with delivery of NFP through our implementing agencies/sites:**
  Being a standardised programme with a national governance structure and national education delivery has been a success factor in delivering FNP across Scotland. This has enabled the learning between sites to be shared and gives staff a sense of consistency and coherence.

  There are challenges with the geography of the country and the variety of complex public sector structures within and across which FNP operates. There is a need to be mindful of the local context and ensure adaptability without compromising the ethos and the structure of the programme.

  Nationally when working across many different partner agencies it is evitable that there will be changes in personnel; it can therefore be challenging to continually ensure a good understanding of FNP throughout all levels of these organisations and to be consistently included in any guidance or policy documents.

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

License holder name: Scottish Ministers are the license holder for the programme
Role and Organisation: Oversight functions are carried out by Scottish Government policy leads and NHS Health Boards.

Description of our National implementing capacity and roles:

- **Clinical Leadership:**
  There is a distributed model of leadership in Scotland. The clinical governance sits with sites via the supervisors, Lead and the FNP sponsor.

  Sites are supported by FNP Leadership team in Scottish Government and the FNP Education team in NHS Education for Scotland.

- **Data analysis, reporting and evaluation:**

Following significant analysis, review and development our new data system for FNP in Scotland (TURAS FNP) went live in October 2019. To aid its introduction there have been bespoke training sessions for staff to help navigate the system and increase understanding on how data could be viewed and analysed to support

- management information,
- learning,
- development and
- quality improvement.

During the development and deployment of TURAS FNP, accessible information to support the clinical delivery of the programme in 'real time' by Family Nurses and Supervisors was prioritised. Family Nurses and Supervisors are encouraged to use the data system during supervision sessions to help inform practice and learning.

A reporting function was also developed to support local and national oversight. This functionality is at an early stage of delivery and implementation.

As part of the development of TURAS FNP, the data forms underwent a significant review, led by the National Clinical Lead. Post implementation evaluation and feedback of the new data forms and the new system has been gathered and analysed and will form part of the next stage of development and improvement plans. The first phase is now due to be completed in late 2020.

The next tranche of data forms, planned for early 2020 will focus on information to inform supervision and workforce planning. Evaluation questionnaires will be developed alongside this, as part of our ongoing improvement process of feedback and review.

As well reviewing and refining the data that will be collected through TURAS FNP we also undertook a data migration exercise from legacy systems.

This will be used to conduct a broad analysis of data over the last 10 years of FNP. We aim to look at trends in the overall programme to enable us to highlight successes and areas for improvement. We also aim to report on a range of data regularly to allow for greater transparency and, where possible, in a themed basis alongside other national reports on public health topics.

- **Service development/site support:**

Service development is encouraged in all layers of the organisation. Family nurses and supervisors are very keen to be involved in new developments and sharing of learning.

A powerful initiative to include student nurses having a placement in FNP teams have been very successful, learning has been shared nationally. This is now common place across the majority of sites which have reached sustainability.

National priorities can also be drivers for change and innovation such as the Core Model Element 4 exceptions to enter the programme post 28 weeks. This has been very positively received at site level and led to greater scrutiny of other local services and supports to continue to explore why some pregnant women access services very late into their pregnancy .

Sites are supported by FNP Leadership team in Scottish Government and the FNP Education team in NHS Education for Scotland.

- The National Strategic and Programme Lead provides general oversight, programme funding and strategic direction within Scottish Government
- The National Clinical Lead provides direct support to sites for clinical issues, and leads a regular forum for Supervisors to share their experiences and insights and clinical aspects for local and national improvement.
- The National Quality Assurance Lead provides direct and indirect support to sites, through leading reviews of national guidance and materials, including the Core Model Elements and aspects for national improvement.
- The National Lead for Sustainability and Improvement provides direct support to sites to develop their sustainability models and aspects for local and national improvement
- The National Information Lead works alongside the National Clinical Lead and provide direct support for sites operationally to improve their information knowledge to get best value out of the data and TURAS FNP system
- The National Lead for Education and Training supports the strategic development of the education programme and aspects for national improvement

- **Quality improvement:**

National leadership team

Quality improvement is a continual and dynamic process inherently built into the model through which NHS FNP sites provide assurance to the Scottish Government (SG) of the quality and safety in the delivery of the programme in Scotland.

The FNP leadership team reviewed their membership and working model during 2019. The purpose was to test out a more robust suite of processes to evidence all aspects of governance and quality improvements to address common themes emerging from local implementation and sustainability, through a coherent system. This would enable the team to consider adaptations or amendments that could be made at a national level, in a systematic way in line with the licensing requirements. A key objective of the governance review was to ensure robust systems and processes were in place to support decision making, quality improvement activity, implementation and evaluation. This would support the national leadership team to drive forward the standardisation, the rapid sharing of learning through the development of improved communication and planning for FNP in Scotland.

There are five work streams currently being progressed:

- Education and learning
- Clinical practice
- Research and quality improvement
- Information and monitoring
- Quality assurance and guidance

The new national data system TURAS FNP went live on 9th October 2019. The Site Annual review process will be collated in a two stage cycle period October - September to align with the new system implementation and the overall annual review period, as well as planning for local and national funding This will capture areas for learning and further improvement.

FNP sites QI activity 2019/20

- 10 year anniversary celebration in NHS Lothian site included past clients and their families. A short report will be produced on the feedback from those who attended linked to their overall experiences post FNP.
- Successful pilot of antenatal book bug within two FNP sites. This initiative evaluated well will be expanded to all sites during 2020.
- National FNP conference 2020 was planned to celebrate the FNP year of the Nurse and Midwife. The conference planning was to give sites the opportunity to take part in showcasing there quality improvement activities – due to COVID 19 this was cancelled and will take place as soon as it is safe to do so.
- Testing a contraceptive champion role in other sites (shared learning from FNP Lothian)
- Develop a model for delivering the programme to diverse communities (FNP Glasgow)
- Scottish Council for Voluntary Organisations – Connections Scotland 'Digital Inclusion' project. Is being tested with FNP clients who lack access to digital devices due to issues relating to finance, literary skills and or ability to access services. (FNP Highland)

- **NFP Educators:**

The Family Nurse Partnership Scotland Education Programme is developed, facilitated, evaluated and governed by NHS Education for Scotland (NES) and the FNP Leadership Team. Education is facilitated by two Principal Educators who are employed by NES and had previous roles as FNP Supervisors. One Principal Educator has a Master of Science degree in Healthcare Education and the other has a Master's degree in Advanced Practice Nursing with Applied Education.

The Principal Educators are supported by a complement of part-time core and sessional educators equating to 1.4 whole time equivalent. Three of the current educators are studying for post graduate qualifications in education. All educators work in substantive posts in FNP Clinical Practice and therefore Family Nurses and Supervisors benefit from a range of educationalists and contemporary practitioners.

Description of our local and national NFP funding arrangements:
The Scottish Government remains committed to fully funding this programme, as it has for the past 10 years. Locally, the funding sites receive is protected to ensure that delivery of the model continues to be optimised.

Current policy/government support for NFP:
The First Minister for Scotland continues to provide personal and political support for the programme. The strategic development and direction of the programme is led by the National Strategic and Programme Lead within Scottish Government. This provides clear opportunity to engage with wider cross-cutting policy, within

Scottish Government, to ensure the currency of FNP within the Scottish context. The programme is strongly supported by the Chief Nursing Office for Scotland as an important aspect of the nursing family in this country.

With a focus on reducing current and future inequalities, early years, prevention and early intervention, the FNP programme remains at the forefront of making a difference for this cohort of the population and their children.

How our NFP supervisor and nurse education is organised:

1.0 Processes to support education delivery

FNP Education Schedules, which outline proposed dates and venues for future cohorts of Family Nurses and Supervisors, are shared and agreed with the FNP Scotland Leadership Group.

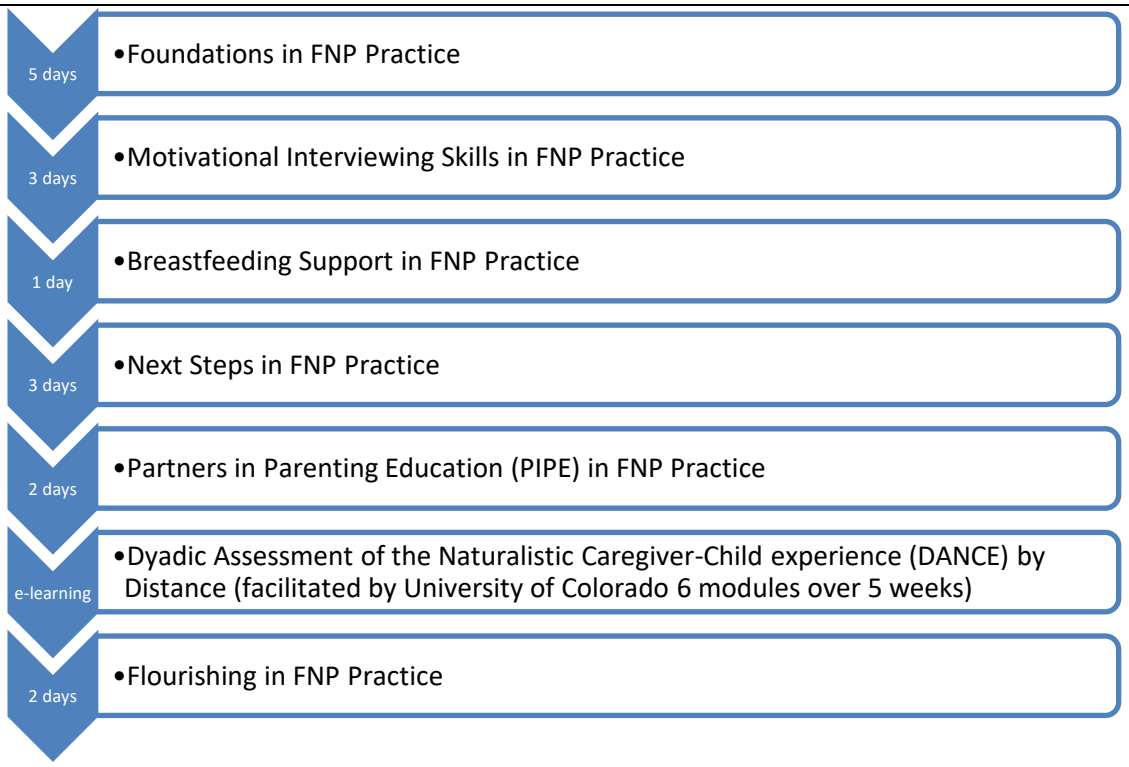
The employing organisations, either NHS Boards or Local Authorities, follow a Standard Operating Procedure (SOP) to inform NES of their requirement for a place on education for a new Family Nurse or Supervisor. Places on the education programme are confirmed with the FNP Lead and/or Supervisor.

At commencement of employment in an FNP role, access is provided by NES to TURAS Learn. This is a national platform for licenced clinical and educational materials.

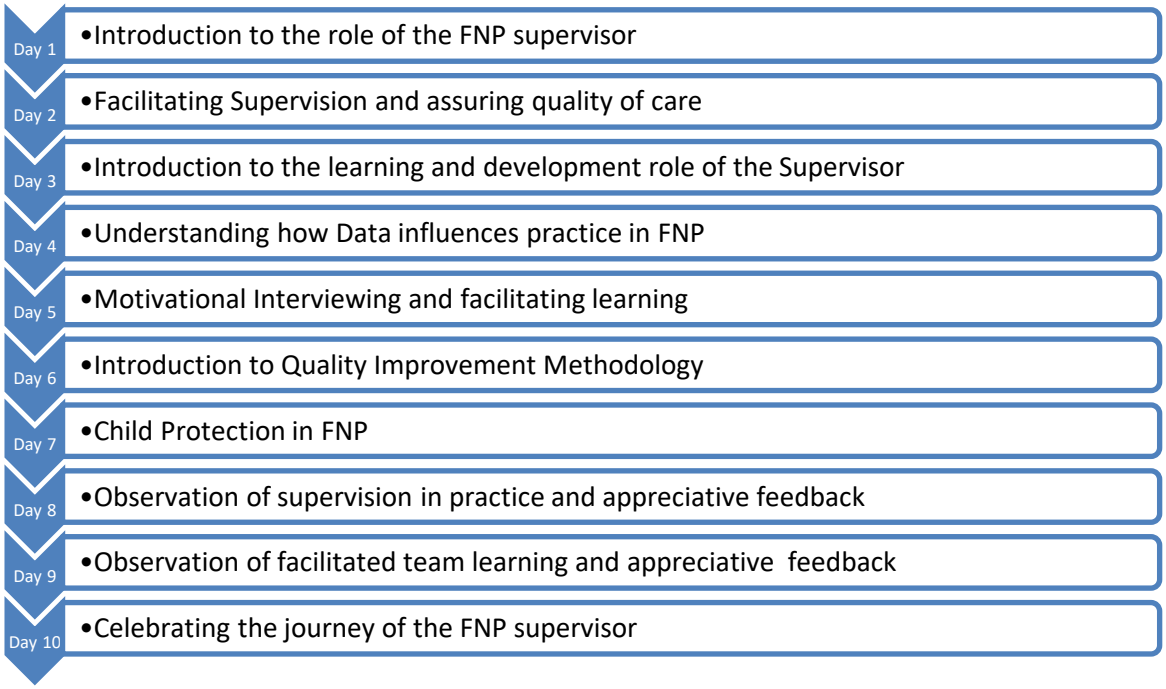
A data base is populated with appropriate details to enable NES to track an individual's progress through the education programme and to enable re scheduling if an individual is absent for any education. The data is held in compliance with General Data Protection Regulations (2018).

1.1 FNP Education curriculum

Family Nurses and Supervisors who are new to FNP undertake an 18-month education programme. The core education programme's curriculum is designed to meet the requirements of Core Model Element 9 and the Guidance Document -International Nurse-Family Partnership Nurse and Supervisor Education (2019). Pre-course learning and consolidation of learning is facilitated by a supervisor at site. The curriculum is organised as outlined below:

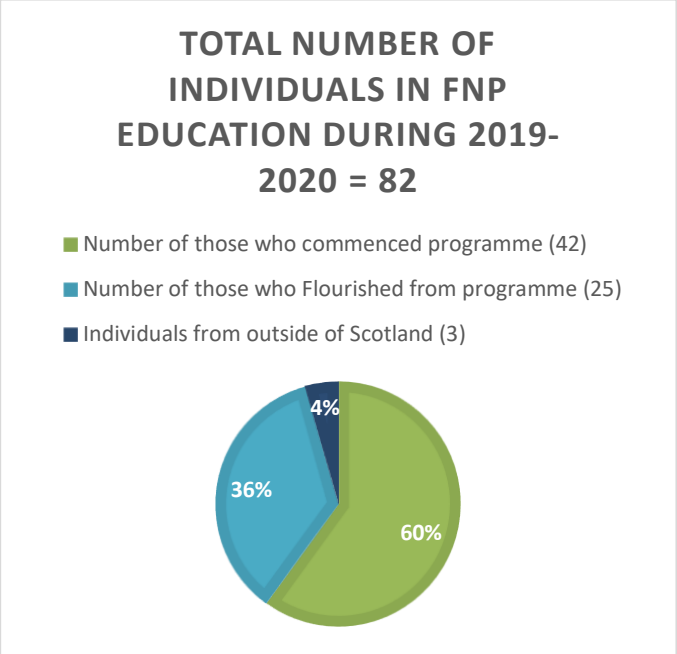


The Supervisor Education and Mentoring programme is facilitated over a 12-month period and the curriculum is outlined below.



In addition, a two day 'Supporting Effective Child Protection Supervision' course is offered after a Supervisor has been in post for one-year. The core FNP education curriculum is enhanced through a programme of continuing professional development (CPD), relevant to identified education and learning needs and national priorities.

1.1 Quantitative data



The chart represents data from six cohorts, which included two colleagues from Norway. Seven supervisors are currently engaged in the Supervisor Learning and Mentoring Programme, with one of the seven from Northern Ireland.

1.3 Quality Assurance

Each element of the education programme is evaluated through anonymous online questionnaires (using Questback) which contributes to our quality assurance processes. During this year, the average response rate was 62% (2% increase on the previous year) with 100% of respondents either strongly agreeing (83%) or agreeing (17%) that the quality of education was high. Qualitative responses provide evidence that the learning environment is safe and conducive to learning; the client's voice is reflected in the teaching; and learners recognise modelling of the ethos and values of FNP by the Education Team.

Learners complete a learning needs assessment and competency framework with their supervisor following Foundations in FNP Practice, which identifies areas of growth and evidence of progression.

All educators invite peer feedback on their teaching and have formal annual observation and feedback. The process to observe and offer feedback on an educator's capability and proficiency highlights the parallel process used throughout FNP practice. Through educators engaging in postgraduate studies in education, programme delivery has benefitted this year from contemporary concepts in student engagement and assessment.

2.0 Successes and Challenges

2.1 A variety of teaching and learning methodologies are utilised to engage learners and support progression during the programme, with most learning facilitated face to face. The education programme is complemented by Supervisors at site level who facilitates pre-course learning and support consolidation

through guided learning packs; supervision; team learning; case presentation meetings; and accompanied home visits.

An example of continuous improvements within the FNP Education Programme is development of new resources to enhance learning in practice. Most recently, additional films to support Motivational Interviewing (MI) skills and PIPE facilitation in practice were finalised. This project required collaboration with and support from Family Nurses and Supervisors and are based on what the nurses shared would be helpful to their practice. An innovative part of this project was the capturing of a PIPE lesson being facilitated with clients for whom English is not a first language. The suite of eight films is now being edited and will be available for use by Autumn 2020.

'Supporting Breastfeeding in FNP Practice' benefitted from the lived experience of a client who agreed to support nurse education. The client offered the new Family Nurses her reflections on the importance of walking alongside clients, rolling with resistance and unconditional positive regard. These were the skills she recognised her own Family Nurse had utilised in guiding her to her decision to breastfeed. This client has gone on to become a Breastfeeding Peer Supporter in her community. The evaluation of this session clearly demonstrated the power of the 'client's voice' in the classroom.

Dyadic Assessment of the Naturalistic Caregiver-Child Experience is facilitated by University of Colorado (UCD) using an e-learning platform. The transition to DANCE by Distance is now well embedded within the Scottish curriculum and is enhanced by monthly contact between UCD and NES to continually review and enhance the learning experience.

2.2 One of the challenges recognised within the Education Team is the lack of PIPE Educators. Currently there is only one who has completed the education and training endorsed by the 'How to Read your Baby' team in USA. However, recent collaboration with colleagues in the FNP National Unit in England has indicated an opportunity for more education and training to increase the number of PIPE educators.

All Family Nurses are registrants with the Nursing and Midwifery Council (NMC), educated to degree level with a variety of clinical experiences prior to FNP. During the past year in the education setting, the education team have reflected and recognised challenges for some individuals in demonstrating the level of emotional intelligence needed to understand and manage the complex work of FNP. Further scrutiny indicated potential correlation with limited or no experience of working with complexity in the home environment.

Virkstis, Herleth and Rewers (2019)[1] identified the concept of the 'experience-complexity gap' which has supported discussions with the FNP Leadership Team in considering any potential impact to programme delivery. This concept also initiated design of an in-depth evaluation to explore the effectiveness of the education programme in supporting transition from theory to practise. In addition, Principal Educators could positively contribute to recruitment processes by offering a different perspective as part of interview panels. The experience-complexity gap may also be addressed as a result of the successful revisions to national job descriptions and person specifications.

Description of any partner agencies and their role in support of the NFP program:

FNP is delivered locally alongside a range of partner agencies, including 3rd sector and more specialist support. It also sits alongside other nurse led community health provision, including health visiting, and ongoing collaboration and joint learning is key to ensure that all families continue to receive the support they need when they need it.

[1] Virkstis, K., Herleth, A and Rewers, L. (2019) Closing nursing's experience -complexity gap. The Journal of Nursing Administration. Vol.49(12) pp.580-582.

Other relevant/important information regarding our NFP program:
As we move from implementation to becoming a fully sustained service it is important that the governance structures are adapted to accommodate this transition. Governance structures are changing within FNP Sites (NHS Boards) and we are working closely with them to ensure that the decision making around operational and strategic aspects to support the programme continue to be made well.

Having moved into the 10th year of delivery across Scotland, there is a need to focus on sustainability, quality assurance and improvement. We need to ensure that FNP remains relevant in a fast moving health and social care landscape.

PART TWO: PROGRAM IMPLEMENTATION

Clients

# of NFP clients participating in the program over the last year: 2893

- Current clients: Pregnancy phase (%): 485 (20%)
- Current clients: Infancy phase (%): 1202 (49%)
- Current clients: Toddler phase (%): 759 (31%)

Uptake rates in Scotland are provided to Scottish Government from sites in their monthly reports. At the moment these figures are cumulative and not broken down into individual years. There are plans for this to be captured on the new TURAS FNP data system and will in future be broken down in date periods.

% of those eligible clients offered the program who have enrolled over the last year: N/A

- Our national benchmark for % of eligible women referred/ notified who are successfully enrolled onto the program is 75%

- Cumulative total % of eligible women referred/ notified who were successfully enrolled onto the program was 79.5%

- Our reflections on this figure:

We have cause to celebrate the teenage pregnancy rate in Scotland as it has continued to fall[2].

However, those who continue on with pregnancy to give birth are those that live in the areas with the highest levels of deprivation as measured by Scottish Index of Multi Deprivation[3] therefore, these young women are those that we need to reach the most. The level of complexities in the family nurse caseloads has risen and yet we have continued to have very high uptake rates for the programme in Scotland.

According the most recent teenage pregnancy statistics, **those from the most deprived areas are 15 times more likely to continue with their pregnancy than those from the least deprived areas** within Scotland. This is even higher than when FNP began in Scotland, ten years ago, and further evidences the vulnerabilities that are likely to be occurring across the caseloads of our nurses. (see chart in Appendix)[4]

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: Child's father 18%, Clients Partner 2%,
- % of home visits, where other family members are present: see table below

Participants involved in visit	Percentage of visits in 2019/20
Client only	49%
Child's father	18%
Client's mother	12%
Other family member	8%
Other	6%

[2] https://beta.isdscotland.org/media/5314/2020-08-25-teenpreg-report.pdf
[3] https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/
[4] https://beta.isdscotland.org/find-publications-and-data/population-health/births-and-maternity/teenage-pregnancies/

Client's father	3%
Friend	2%
Client's partner (if not biological father)	2%
Foster parent/guardian	1%

- **How we engage fathers/partners/other family members in our program:**

It is understood by family nurses that families where both parents are involved generally have better outcomes. Family nurses encourage their clients to have those closest to them and those who participate in the parenting of their child to take part in the visits. The facilitators encourage the involvement of others such as fathers in the programme with dedicated materials for them.

- **Our reflections on father/partners/other family members engagement:**

Engagement of fathers can be challenging for a number of reasons:-

- Fathers working; particularly during the antenatal period when the therapeutic relationship is most developed
- Intimate partner violence
- Although we are seeing some changes recently; culturally fathers have not been well catered for in maternity and parenting groups in health and social care settings therefore they are less likely to engage

Scottish Government, as part of the Pregnancy and Parenthood in Young People[5][6] strategy, are prioritising the exploration of the needs of young fathers. This will be a multidisciplinary and multiagency approach.

Nursing Workforce

Average nurse caseload: 23.1 clients

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	166	33		199
# of staff who left during reporting period	10	1		11
% annual turnover	6%	3%		
# of replacement staff hired during reporting period	17	2		19
# of staff at end of reporting period:	173	34		207
# of vacant positions	4.4	1.2		5.6

- **Reflections on NFP nurse/supervisor turnover/retention during reporting year:**

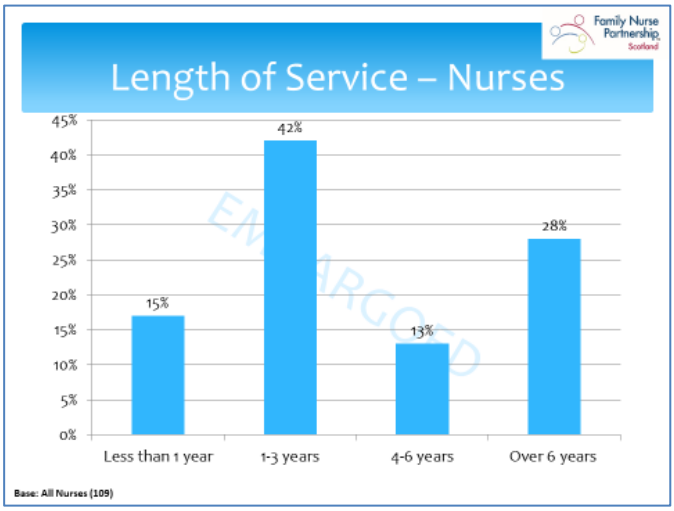
The therapeutic relationship continues to be a central tenet of FNP in Scotland and is maintained as high priority at national and NHS Board level and embedded within the FNP Scotland Education programme. Recruitment of new Supervisors and Family Nurses in Scotland continues to be both value and competency based to ensure that those appointed reflect the spirit and ethos of FNP and have the capacity to form professional, trusting therapeutic relationships. The recruitment process continues to be supported by valuable client participation and a robust process of strength based feedback for candidates.

[5] https://beta.isdscotland.org/find-publications-and-data/population-health/births-and-maternity/teenage-pregnancies/
[6] https://www.gov.scot/publications/pregnancy-parenthood-young-people-strategy/pages/1/

That said, in some parts of the country we are experiencing a downward trajectory of interest in Family Nurse Partnership posts and thus a reduced selection of candidates demonstrating the required level of professional maturity and knowledge to navigate complex systems with their clients.

- **Successes/challenges with NFP nurse/supervisor recruitment:**

Now that FNP has been delivered for over ten years in Scotland there is emerging evidence that the profile of nurses length of service is beginning to change, with many newer nurses now in post. Nurses and Supervisors have significant variation in backgrounds and experience. This diversity can enhance the learning and creativity in teams however, there appears to be increasing evidence that the level of experience within teams over the last few years has reduced. While this creates opportunities to mentor and guide staff for more experienced nurses it can also impact on the level of support and training required to ensure competence and confidence to work with an increasingly complex and diverse caseload.



Furthermore, while the majority of staff within FNP plan to continue to work within FNP over the coming two years (85%), around 7% are due to retire and 8% plan to move to roles outwith FNP. It is important that we understand the drivers for any movement in order to maintain a quality, sustainable service moving forward.

- **Any plans to address workforce issues:**

There is a plethora of research evidence which concludes the benefits of developing a consistent nurse/client therapeutic relationship. The Revaluation[7] of FNP commissioned by Scottish Government, Adverse Childhood Experiences[8] work nationally and Transforming Psychological Trauma Framework (NES)[9] contribute to this evidence. Overcoming trauma requires a foundation of stable, nurturing, loving relationships and the emerging evidence for one significant adult in a vulnerable client's life, sometimes the Family Nurse, is compelling.

[7] Scottish Government. 'Revaluation of the Family Nurse Partnership in Scotland.' Edinburgh: 2019. https://www.gov.scot/publications/revaluation-family-nurse-partnership-scotland/
8 Katy Hetherington, K. (2020) Ending childhood adversity: a public health approach. Edinburgh: Public Health Scotland http://www.healthscotland.scot/media/3107/ending-childhood-adversity-a-public-health-approach.pdf
[9] NHS Education for Scotland (2017) Transforming Psychological Trauma: A knowledge and skills framework for the Scottish workforce. Available at : https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf

However, it is essential that we recognise the impact of vicarious trauma, the complexity of client need and the concomitant potential for 'burnout'. Diverse population demographics and health and social complexities mean that some NHS Board areas have higher client representation of, for example, young parents with care experience; trauma; poverty; human trafficking; and exploitation. Additional factors relating to cultural diversity and language barriers require high level cultural competence for Family Nurses and Supervisors. Listening and supporting Family Nurses in relation to caseload size, reflective of complexity, through a needs-based allocation of clients is essential.

There need to ensure that the Scottish Government Leadership Team in collaboration with FNP Leads and Supervisors enable Family Nurses to develop, maintain and sustain therapeutic relationships with clients through a salutogenic approach, that is, creation of an environment of support, appropriate workload based on need, psychological safety, space for reflection and development of self-awareness.

To align ourselves with the Nursing 2030 Vision for Scotland[10] we need to endeavour to support the workforce to continue to develop FNP as a personalised, rights based service, where caring and compassionate relationships take account of the client's wider psychological and social needs. We also need to prepare Family nurses in terms of technical competence and leadership skills whilst supporting their health and wellbeing. It is essential that the education system is adaptable and flexible to support the differing learning needs of individuals, please see the section relating education for further details.

It is essential that we learn from our response to the Covid-19 pandemic which has provided an opportunity to discover more about programme delivery using telehealth which may remain a feature in the future, therefore we will need to support Family Nurses to develop therapeutic relationships in this medium. There is evidence in the literature on the importance of maintaining the wellbeing of leaders and frontline practitioners, which in our context are Supervisors and Family Nurses. It is essential that there is flexibility in working hours and patterns to ensure that we retain highly trained and motivated staff.

NFP Information System

- **High level description of our NFP information system, including how data are entered:**

Our new bespoke data system (TURAS FNP) was launched in October 2019. The system can be viewed by all staff in FNP; access is based on the role they currently hold within the organisation. Over time that data forms will be entered directly on to the system by family nurses and supervisors. However, during early implementation period and to ensure accurate feedback for early improvement it was agreed that only data managers would enter the data onto the system during the initial stages post implementation.

- **Commentary on data completeness and/ or accuracy:**

We have high levels of accuracy in our data system, with robust processes in place across sites and within the TURAS FNP system to support that.

Site data governance process

[10] https://www.gov.scot/publications/nursing-2030-vision-9781788511001/

- Once a nurse has completed a data form it is checked for accuracy by a supervisor and a data manager prior to entry on to the system.
- The system has a number of validity checks which highlight potential anomalies or inaccuracies to the person entering the data on to the system; they are asked to check before proceeding.
- The system has a function that indicates to nurses what forms are due to be completed.
- Supervision sessions include the review of data and include discussions relating to how data is gathered and used to consider the clinical implications.
- Data management and governance forms part of the core education programme.

- **Reports that are generated, how often, and for whom:**

Throughout the organisation staff have access to live reports; individuals access is based on the role. The data can be accessed at a very granular level, as well as summary level. This offers the flexibility to that is required across all levels of the programme to maintain quality.

The live reporting functionality, at this time, relates mainly to the fidelity of the programme such as number of visits, uptake rate and attrition; going forward there will be further reports released in relation to the outcomes of the programme such as educational attainment, smoking and breastfeeding rates.

Adhoc reports can be requested via the TURAS FNP system project team.

National data analysis is completed by the analytics teams in Scottish Government and shared with sites via FNP Leads meetings, Supervisors quality assurance and learning forums and via the annual review process.

- Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality:

The system has been highly successfully in improving the key benefits of usability and data visibility. It has enabled access to 'real time' information. During implementation, as with any new system, there have been areas identified for further development and refinement. This is now part of a planned programme of work over the next 12 months.

It is important for us to move towards having the full suite of reports available to all users, and this a key deliverable as part of the overall plan.

Continuous Quality Improvement (CQI) Program

- **Brief description of CQI processes:**

  The Quality Assurance and Improvement Framework being tested by the National Leadership Team is progressing. However timescales have been delayed due to COVID 19. The ambition is to maintain and develop the quality of delivery through a robust continuous quality assurance, improvement and sustainability infrastructure for FNP in Scotland.

- **How we use qualitative and quantitative information as part of our CQI program:**

  Information is gained from a variety of sources and triangulated to test the quality. This includes feedback and evaluation from:

- Family Nurses and Supervisors
- FNP leads/sites
- NHS Education Scotland
- Stakeholders
- Data and intelligence gained through new systems implemented for communication with the national leadership team
- TURAS FNP
- Through direct clinical observation/coaching/support/attendance at advisory groups/annual reviews and site visits
- International learning
- Work stream groups and subgroups

- **Successes/challenges with our CQI approach:**

Successes

- New National Leadership Team in place
- Improved two-way communication with FNP sites in Scotland through regular newsletters
- Implementation of the TURAS FNP data system and wholesale review of data forms
- FNP Data migrated to the TURAS FNP from Legacy systems
- Scotland's FNP Education and learning program

Challenges

- New National Team not co-located/managing virtual working alongside other roles
- Changes of senior leadership within Health Boards reducing the historic knowledge base of FNP locally and changes to local governance structures
- COVID 19 pandemic
- Delay progress on key aspects of the TURAS FNP development programme
- Staff turnover/demographics and filling vacancies (for some sites)

(see also part four for details of CQI improvement program and findings)

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 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: (e.g. by signed informed consent)	**100% voluntary participation**	
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Only first time mothers are referred onto the programme, this is checked at first visit during pregnancy	**100% first time mothers**	
3. Client meets socioeconomic disadvantage criteria at intake	The socioeconomic disadvantage inclusion criteria for our country are: We do not have this criterion for first time mothers under 19 years. All mothers aged 19 and under are eligible for the programme in Scotland. Application of these criteria are assured and monitored by: N/A	**Not Applicable** % clients enrolled who meet the country's socioeconomic inclusion disadvantage criteria	In Scotland 72% of all births to mothers aged 19 and under are within the two most deprived quintiles within the Scottish Index of Multiple Deprivation. With around 5% (N=70) of births to mothers under 19 in the least deprived areas.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	**96% of NFP clients receive their first home visit no later than the 28th week of pregnancy** **79.1% of eligible referrals who are intended to be recruited to NFP are enrolled in the program** **46 % of pregnant women are enrolled by 16 weeks' gestation or earlier** **50% of pregnant women are enrolled more than 16 weeks but less than or equal to 28 weeks and 6 days**	Those who enroll beyond 28+6 meet the agreed eligibility criteria set out in the CME#4 exception. **2.4% (N=32) are enrolled at more than 28 weeks and 6 days. This is mostly due to late presentation at first contact with Health Services for various reasons including not entering the country until late into pregnancy (immigration) and concealed pregnancy.** 2.1% (N=27) have enrolled later due to transfer from a site out with Scotland i.e. England (having had FNP there)
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**	There have been a few challenges in relation to long term staff absence and/or staff turnover in some sites. This has meant that small minority of clients have had required a change of nurse. The family nurses have worked hard to ensure a robust handover and shown tenacity in engagement therefore attrition rates have remained very low.
6. Client is visited face-to-face in the home, or	National benchmark set is: 100% visits take place in the home	**85% visits take place in the home**	85% of visits take place in the family home

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.		**15% breakdown of where visits are being conducted other than in the client's home**	15% take place in another venue that has been agreed between the FN and the client i.e. contact centre, partners home, café. We do not capture the exact details just that they are outside of the family home.
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.	National benchmarks for: a) Program visit dosage patterns in relation to client strengths and risks benchmarks are:	• **100% of clients being visited on <u>standard</u> visit schedule** • Average number of visits by program phase for clients on standard visit schedule is: • **Average no of visits in pregnancy phase: 8.3 (phase completers only)** • **Average no. of visits in infancy phase: 17.6 (phase completers only)** • **Average no. of visits in toddlerhood phase: 11.2 (phase completers only)** • **0% of clients being visited on <u>alternate</u> visit schedule**	The visiting schedule for FNP client in Scotland remains as per the standard. The visits are tailored to meet individual needs (agenda matched). For professionals working within the early year's agenda in Scotland national policy promotes the use of the National Practice Model11 and National Risk Assessment Framework12 to enable practitioners to support families using a consistent and balanced approach whilst taking into account the inevitability of changing circumstances. These tools are used in supervision to support the nurses to consider the visiting schedule according to need of individual clients.

[11] https://www.gov.scot/publications/girfec-national-practice-model/
[12] https://www.gov.scot/publications/national-risk-framework-support-assessment-children-young-people/pages/2/

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	b) Length of visits by phase country benchmarks are: c) Pregnancy phase: 60 minutes d) Infancy phase: 60 minutes e) Toddler phase: minutes f) Client attrition by program phase country benchmarks are: • At least 90% should complete pregnancy (i.e. 10% or less attrition) • At least 70% should complete infancy (i.e. 20% or less attrition in this phase) • At least 60% should complete toddlerhood (i.e. 10% or less attrition in this phase)	**Length of visits by phase (average):** • Pregnancy phase: 67 minutes • Infancy phase: 63 minutes • Toddler phase: 62 minutes **Client attrition by phase and reasons:** 2.5% attrition in Pregnancy phase 6.9% attrition in Infancy phase 4.6% attrition in Toddler phase	This data excludes transfers to other sites. Given the lag time between a client enrolling and either leaving the programme early or graduating from FNP, a client who left in toddlerhood in 2019/20 would have been enrolled as early as October 2017. To calculate the attrition rate for clients who left during 2019/20 we have included all clients enrolled between 1st October 2017 and 31st March 2020. During this period, 3336 clients were enrolled in Scotland and, in addition to the 213 who left in the period 1st April 2019 to 31 March 2020, a further 252 clients left in the interval 1st October 2017 to 31st March 2020.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by (e.g. standardized job description); Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.	**100 % NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree**	The job descriptions and person specifications will be reviewed and updated over the next year.
9. NFP nurses and nurse supervisors develop the	100% of NFP nurses and supervisors complete the required NFP educational	**100% of NFP nurses and supervisors complete the required NFP**	Approx. 30% of family nurses are participating in the core learning

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	curricula 100% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	**educational curricula and participate in on-going learning activities** **100% completion of team meetings, 100% completion of case conference and 100% completion of education sessions**	programme. This is due to a number of sites that are still scaling up to full complement of staff and other sites that are established are now seeing a turnover of staff which is mainly due to: • Promotion • Retirement • Moving to another FNP post Data in relation to this is gathered via a written quarterly report from sites. These are facilitated by the Supervisor of teams however, during times of absence such as annual leave or sickness the meetings are facilitated by a nominated family nurse. Going forward this will be captured on a data form on the TURAS FNP system.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of	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*

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
each family, and apportioning time appropriately across the five program domains.			
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.	100% 1:1 supervision and home visit observations undertaken against expected (calculated by time – working weeks- and number of nurse)	**100% 1:1 supervision and home visit observations undertaken against expected** Supervision, team meetings, education sessions, and accompanied home visits ensure that FN's and SV's are working within the framework.	FNP Scotland had a system of peer support for supervisors via a partnership arrangement which enabled appreciative feedback to be given following direct observation of aspects of the role. This was difficult to maintain during the scale up across Scotland however, following evaluation/review this is to be reinstated.
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 nurses). 100% of 4-monthly Accompanied Home Visits completed (against expected).	**100% of NFP teams have an assigned NFP Supervisor** **100% of reflective supervision sessions conducted** **100% of 4-monthly Accompanied Home Visits completed**	The sites have provided written quarterly reports for this information. Sites have stated that the only exception to the achievement of this is during times of annual leave and/or absence. Work is in progress to have this data captured on a supervision data form, which will be entered on to the TURAS FNP data system.
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program	No benchmark. Monitored/assured by: FNP Scotland has a distributed model of leadership, each board area has an FNP	Progress: **The introduction of the new TURAS FNP system has given access**	There is a need to release all reports to the live system.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.	Lead through whom clinical governance and quality is assured. The gathering of information, analysis and learning is conducted through various means including: • Core education programme • CPD education • FNP national leads meeting • FNP leadership group • Supervisors Quality assurance meeting • Supervisor learning forum • Supervisor support calls • Data system • Supervision with nurses • From client feedback • Annual review process • Annual conference • FNP newsletter • Data managers forums • Data managers support calls • Child Protection Advisors annual forum • Psychology biannual meeting • FNP Advisory Boards	**throughout the system to 'real time' data which will help drive quality assurance and quality improvement.**	
14. High quality NFP implementation is developed and sustained through	100% of Advisory Boards or equivalents held in relation to expected	**100% of Advisory Boards or equivalents** **73% attendance at Advisory Boards**	Most NHS Board areas have a well-established and maintained FAB. In a small number there have been challenges in relation to the buy in

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
national and local organized support	73% attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation): FNP Scotland has a distributed model of leadership, each board area has an FNP Lead through whom clinical governance and quality is assured. As senior managers in NHS Boards these leads are linked into numerous professional groups in health and social care partnerships, where learning is shared and developed. The leads are linked into the Scottish Government via a number of routes including the SG leadership Group and the Leads meetings. There are various communication tools that are used to share information and receive feedback. Themes identified are shared via various routes throughout the organization and more widely if appropriate.		for the FAB, there are plans in place to support the understanding in those individual boards.

Domain coverage*

Please complete with your 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%	33.5%	14-20%	20.4%	10-15%	17%
Maternal Role (My Child and Me)	23-25%	28.8%	45-50%	41.9%	40-45%	41.1%
Environmental Health (My Home)	5-7%	11%	7-10%	11.4%	7-10%	12.1%
My Family & Friends (Family & Friends)	10-15%	14.7%	10-15%	14.2%	10-15%	14.3%
Life Course Development (My Life)	10-15%	12%	10-15%	12.1%	18-20%	15.5%

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
CME#10 states "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 six program domains."

It is recognised that family nurses who are able to "agenda match" the needs of the individuals with programme delivery and attainment of outcomes are more likely to have continued engagement of clients it is therefore significant that FNP Scotland has a high uptake rate and low attrition rate. The use of national tools (previously discussed) in supervision helps nurses to understand the needs of clients and supports decision making around planning for future visits. The increasingly complex nature of the clients lives can impact on the delivery of the programme; it is essential to ensure that family nurses have a structured approach; there is a need to deliver the programme balanced with the ability to support clients that are in crisis. This requires reflection in action this is a skill that takes time to build and perfect however, significant numbers of staff have less than 5 years' experience. It is important to recognise that many aspects of people's lives and their choices are impacted by what is going on in the wider environment i.e. austerity measures and availability of support groups etc. Discussions are underway to consider workforce planning and education as discussed in previous sections.

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/or 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 (range and mean)	**12.9-25.3 years - mean 19.1 years**	**13.2-25.2 years - mean 19.1 years**
Race/ethnicity distribution		

	2018/19
White	95.4%
Other ethnic group	2.4%
Asian, Asian Scottish or Asian British	1.3%
African, African Scottish or African British	0.3%
Carribbean or Black	0.3%
Prefer not to say	0.3%
Don't know	0%

	2019/20
White	96.2%
Other ethnic group	1.6%
Asian, Asian Scottish or Asian British	1.5%
African, African Scottish or African British	0.4%
Carribbean or Black	0.1%
Prefer not to say	0.1%
Don't know	0.1%

Father involvement

Frequency of communication with baby's biological father	Percentage of clients at enrolment
Daily – live with father	43.1%
Daily – do not live with father	35.2%
At least once a week	7.9%
Never	7.6%
Less than once a month	1.9%
Not applicable	1.7%

		At least once every two weeks 1.4% **At least once a month** 1.3% ***** Due to the implementation of a new data system during financial year 2019/20 only partial data are available from early May 2019.
Income (please state how this is defined)	Income is not directly collected	Income is not directly collected
Inadequate Housing (please define)		Of the housing tenure types, the following may be considered 'Inadequate Housing': temporary accommodation; all forms of no fixed accommodation; safe housing. In 2019/20, a total of 6.2% of clients occupied these types of housing. There are two further questions asked at enrolment about accommodation both relating to clients' experience of homelessness. These are new questions and were not asked prior to May 2019. However, since that time 14.4% of clients reported that they were 'Registered Homeless' and 2.5% of clients reported that they considered themselves homeless.
Educational Achievement		

Educational Qualification	**2018/19**	**2019/20**
First Degree, Higher Degree, SVQ Level 5 or equivalent	0.00%	0.51%
Professional Qualifications (e.g. teaching, accountancy)	0.00%	0.04%
HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent	1.16%	3.29%
Other higher education qualifications	0.00%	0.78%
Other post-school, but pre-higher education qualifications	0.04%	1.13%
Higher Grade, Advanced Higher, SCQF Level 6 and 7 Freestanding Units, Scottish Baccalaureate, A Level, National Certificate, Higher National Certificate	8.74%	8.84%
Standard Grade, GCSE or equivalent, national 3-4	52.43%	54.85%
SVQ Level 1, SVQ Level 2, National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent	8.29%	6.81%
SVQ Level 3, ONC, OND, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent	9.72%	3.87%

	Foundation Apprenticeship, Modern Apprenticeship	6.06%	2.43%
	National 1, National 2, Access 1, Access 2 or equivalent	2.94%	3.29%
	Employability, Enterprise and Employability, D of E Leadership, Employability and Personal Development, Skills for Work, Certificate of Work Readiness, National Progression Awards or equivalent	0.04%	3.95%
	Other school qualifications	0.67%	1.96%
	No Qualifications	8.07%	6.30%
	Don't know	0.09%	1.45%

Employment		**Employment Status**	**2019/20**
		Working full time	22.20%
		Working part-time	13.70%
		In full time education	12.90%
		In part-time education	3.10%
		Full-time carer	1.10%
		Part-time carer	1.30%
		Volunteering full-time	0.10%
		Volunteering part-time	1.00%
		Actively looking for work	4.50%
		Unemployed	30.60%
		Other	1.60%
		None of the above	7.80%
Food Insecurity (please define)	Not collected	Not collected	
In care of the State as a child		In 2019/20, 3 clients were enrolled who were *currently* on the Child Protection Register at enrolment. In addition, a further 108 clients reported that they had ever been on the Child Protection Register when they enrolled to FNP.	
Obesity (BMI of 30 or more)	Not collected	Not collected	

Severe Obesity (BMI of 40 or more)	Not collected	Not collected
Underweight (BMI of 18.5 or less)	Not collected	Not collected
Heart Disease	Not collected	Not collected
Hypertension	Not collected	Not collected
Diabetes – T1	Not collected	Not collected
Diabetes – T2	Not collected	Not collected
Kidney disease	Not collected	Not collected
Epilepsy	Not collected	Not collected
Sickle cell Disease	Not collected	Not collected
Chronic Gastrointestinal disease	Not collected	Not collected
Asthma/other chronic pulmonary Disease	Not collected	Not collected
Chronic Urinary Tract Infections	Not collected	Not collected
Chronic Vaginal Infections (e.g., yeast infections)	Not collected	Not collected
Sexually Transmitted Infections	Not collected	Not collected
Substance Use Disorder	See substance use data below	See substance use data below
Mental Illness	See below (Anxiety/Depression)	See below (Anxiety/Depression)
Other (please define)	Not collected	Not collected

Please comment below on the vulnerability of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time.

Those who continue on with pregnancy to give birth in Scotland are those that live in the areas with the highest levels of deprivation as measured by Scottish Index of Multi Deprivation[13] therefore, these young women are those that we need to reach the most. The level of complexities in the family nurse caseloads

[13] https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/

has risen and yet we have continued to have very high uptake rates for the programme in Scotland. Our forthcoming analysis of 10 years of FNP in Scotland will illuminate these issues. The Revaluation[14] report highlighted the level of vulnerabilities with the client group.

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**	**12 months**	**18 months**
Anxiety (n, % moderate + clinical range) Depression, (n, % moderate + clinical range)	In FNP Scotland, the following measures of mental health and/or wellbeing are recorded at Pregnancy intake, 36 weeks gestation and at various stages throughout infancy and toddlerhood: Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS); Edinburgh Postnatal Depression Score (EPDS); Each of these tools measures a different aspect of mental health and wellbeing. We adopted these tools in 2019 and are currently developing a method for consistent analysis as such this data and analysis can be supplied at a later date.				
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	**29%**	**26%**	**33%**	**27.9%**	**33%**
Alcohol, (n, % during pregnancy, units/last 14 days) *drank alcohol in the last 30 days	2.7%	0.9%	2.4%	4.10%	5.2%
Marijuana, (n, % used in pregnancy, days used last 14 days) *smoked cannabis in the last 30 days	5.3%	4.10%	2.4%	3.7%	4.6%
Cocaine, (n, % used in pregnancy, days used last 14 days) *used cocaine in the last 30 days	0.70%	0.60%	0.10%	0.50%	0.20%
Other street drugs, (n, % used in pregnancy, days used last 14 days) *taken other street drugs in the last 30 days	1.20%	0.30%	0.20%	0.50%	0.30%
Excessive Weight Gain from baseline BMI - Pregnancy, (n, %)	Not collected	Not collected	Not collected	Not collected	Not collected
Mastery, (n, mean)	Generalized Self-Efficacy Score (GSE) is used to measure mastery. Similar to the anxiety and depression scales that have recently been adopted we are currently developing a method for consistent analysis as such this data and analysis can be supplied at a later date				

[14] https://www.gov.scot/publications/revaluation-family-nurse-partnership-scotland/

IPV disclosure, (n, %)		42% - current or previous IPV (3.4% currently experiencing IPV)	45% - current or previous IPV (8.5% currently experiencing IPV)	58% - current or previous IPV (12.5% currently experiencing IPV)	
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %)	63%	62%	59%	57%	
*Condom Use	17%	14%	12%	13%	
Subsequent pregnancies, (n, %)	8.2%	16.4%	26.5%	34.2%	
Subsequent Births	0%	1.2%	9.5%	15.7%	
Breast Feeding, (n, %)	4.7%	4.4%	3.3%	4.6%	Initiation of breastfeeding post-partum – 46% Any breastmilk at 6 weeks – 16%
Involvement in Education, (n, %)	See above				
Employed, (n, %)	See above				
Housing needs, (n, %)	See above				
DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.)	Not collected				
Father's involvement in care of child, (n, %)	See above				
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)**:**

We are currently planning a longer term analysis of data over the last 10 years. However, due to the introduction of a new IT system this has been slightly delayed. It is anticipated a report on trends will be compiled and published in late 2020, early 2021.
This will align with the publication of the FNP Data Linkage Study being undertaken by the University of Cardiff.
Our REvaluation report was published in June 2019. A further report on nurse experiences is due to report late in 2020.

In which areas is the program having greatest impact on maternal behaviors?

Although difficult to obtain quantitative data in relation to attachment and the maternal role aspects of the programme there is increasing evidence that this is where the most significant outcomes are achieved. Tapping into the intrinsic motivation to be good parents gives the foundation from which to work with clients and bring about change. From this foundation the strengths of the parents can be affirmed and change in other aspects of their lives can then follow. It is increasingly understood that having a secure attachment enables better development in all areas of child's wellbeing.

Which are the areas of challenge?

It is very challenging to deliver the programme during times of austerity and widening inequalities gap.
The teenage pregnancy rate has dropped significantly in Scotland however, those who continue and go on to give birth are those from the most challenging backgrounds**;** the levels of complexity has risen. It is recognised that FNP Scotland are therefore targeting the most in need. However, this leads to an increased workload and is very emotionally draining for staff.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks gestation)	**3**	**0.2%**
Very preterm (28-32 weeks gestation)	**16**	**1.2%**
Moderate to late preterm (32-37 weeks gestation)	**83**	**6.3%**
Low birthweight (please define for your context)	**108**	**8.2%**
Large for Gestational Age (LGA) (please define for your context)		
Other (please define) Normal Birth weight (2500-4200g) Large birth weight (>4200g)	 **1154** **49**	 **88%** **3.7%**

Please comment below on your birth data:

Further analysis is required to consider the link between prematurity and low birth weight:

7.7% premature births

8.2% low birth weight

Further analysis is required to consider trends in FNP over the years. This will be included in the 10 year analysis.

Across all births in Scotland[15] there are
6.6% of singletons born prematurely
13% of births with large birth weight
5.6% of singletons with low birth weight.

Child Health/Development

	6 months (% of total)	12 months (% of total)	18 months (% of total)	24 months (% of total)
Immunizations Up to Date	91%	92%	94%	93%

Hospitalization for Injuries and ingestions

A&E attendances and hospital admissions for injuries and ingestions

	Number of children at this stage	Number with at least one hospital visit in the last 6 months		Number of A&E attendances that resulted in an in-patient admission	
6 months	1208	48	4%	7	0.6%
12 months	1159	122	11%	11	1%
18 months	849	87	10%	8	1%
24 months	808	74	9%	7	1%

ASQ scores requiring monitoring (grey zone)
ASQ scores requiring further assessment/referral
ASQ-SE scores requiring monitoring (grey zone)

ASQ	Percentage on schedule	Percentage requiring monitoring	Percentage requiring further assessment
4 months			
Communication	96%	4%	1%
Fine Motor skills	90%	9%	1%
Gross Motor skills	90%	8%	2%
Personal/Social development	98%	2%	1%
Problem Solving	94%	4%	1%
8 months			
Communication	83%	6%	11%
Fine Motor skills	91%	4%	4%

[15] https://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2018-11-27/2018-11-27-Births-Report.pdf

	Gross Motor skills	92%	5%	3%
	Personal/Social development	89%	7%	3%
	Problem Solving	94%	4%	2%
	14 months			
	Communication	94%	5%	1%
	Fine Motor skills	94%	5%	1%
	Gross Motor skills	90%	5%	5%
	Personal/Social development	96%	3%	1%
	Problem Solving	94%	4%	2%
	20 months			
	Communication	83%	6%	11%
	Fine Motor skills	91%	4%	4%
	Gross Motor skills	92%	5%	3%
	Personal/Social development	89%	7%	3%
	Problem Solving	94%	4%	2%
	*where percentages do not add up to 100% this is due to rounding			

ASQ-SE scores requiring further assessment/referral	0.5%	1.5%	3.1%	4.5%

Child Protection (please define for your context)		**Infants currently in receipt of this intervention as of 31st March 2020**	**Infants ever in receipt of this intervention as of 31st March 2020**
	Assigned a social worker	6.0%	6.3%
	Look after children – accommodated	1.2%	1.3%
	Looked after children – at home	0.1%	0.1%
	Looked after children – kinship care	1.1%	1.2%
	Subject to child protection order	0.7%	0.8%
	Subject to supervision order	0.6%	0.6%
	Name placed on the child protection register	2.5%	4.8%
	* In 2019/20 the following significant events were recorded • 24 children relinquished into long term care • 12 children where parental rights terminated		

Other (please define)				

Please comment below on your child health/development data

We are currently exploring this data and our plan is to collate this in a way that will enable comparison to the wider Scottish Data. ASQ is now the standard tool in Scotland and is collected for all children. We aim to start producing a publication on this annually from 2021 in line with the wider Scottish approach.

We note that this appears to be an area where FNP children are excelling and will conduct a thorough analysis to highlight this.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts: We plan a 10 year analysis of all FNP data this year/early next year and plan to also publish regular data that can be compared to more universal services. We aim to produce a series of documents on an annual basis moving forward.

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. We are working to include regular feedback from clients at key intervals throughout the programme with feedback and evaluation forms being designed for implementation within phase 2 of the data system development. This will allow for regular monitoring of programme content and delivery and will feed into our continuous improvement cycle. NHS Lothian recently held a 10 year celebration event where a significant number of the first cohort of clients and their children attended. The clients expressed a desire to share their experience of having a family nurse. The feedback gathered from this event is expected but delayed due to the COVID pandemic restrictions. We published a national report on FNP (Revaluation) which included case studies and quotes from participants on the programme and their family members in June 2019. This has helped to illuminate FNP and provide a source of evidence on how the programme works to change lives in the Scottish context. The full report has been published can be viewed here: https://www.gov.scot/publications/revaluation-family-nurse-partnership-scotland/

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	• <5 neonatal deaths (death in the first 4 weeks of life) • <5 infant deaths	The majority these deaths although tragic for individual families they were not unexpected. There were underlying health conditions; the deaths were unavoidable. For a very small number there was some learning for health care staff in another area of the system however, there was no direct learning specifically for FNP nurses or supervisors.
Maternal death	**Zero maternal deaths**	
Other		

Any other relevant information or other events to report:
There is one ongoing significant case review underway relating to a case of child neglect. Once published the learning from this will be fully shared and implemented. The guidance for this process can be found here https://www.gov.scot/publications/national-guidance-child-protection-committees-conducting-significant-case-review/pages/6/

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- **Briefly describe your system for monitoring implementation quality;**

  Sites are required to inform the FNP Leadership Team of any QI projects including how this will be evaluated. Decision making in terms national implementation is agreed through the leadership group and the FNP Leads meeting. SV's regularly share their experiences of QI projects at the Supervisor learning forum and Supervisor quality assurance group.

- **Goals and Objectives for CQI program during the reporting period:**
  Please see above section Part 4.

- Outcomes of CQI program for the reporting period
  - Expansion of placement in sites for nursing students
  - Further sites trialling the contraceptive champion model
  - National implementation of antenatal bookbug[16]

    bookbug.docx

  - TURAS FNP system – further reports to be released and phase 2 work begun

- **Lessons learned from CQI initiatives and how these will be applied in future:**

  There has been further evaluation of the initiative to engage clients that are 20-24yr.

- **Goals for CQI in next year:**

  Research use of telehealth to assist with roll out to remote and rural areas such as the Island Boards.

  Work with Scottish Government partners to test the use of Routine Enquiry and Response relating to trauma and adversity.

  To consider more fully the why there has been a reduction in dosage, what has been the impact of this and share the learning.

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

- **Program innovations tested:**

  We have implemented a bespoke IT system this year which allows more direct access to FNP data at a team, site and national level.

[16] https://www.scottishbooktrust.com/bookbug

The testing of the exceptions to Core Model Element 4 is still underway. This will require significant time as the numbers are so small and therefore conclusions and learning are difficult to achieve.

Our main innovations are QI projects (see above) and then we assess if these will be rolled out if the evaluation suggests they will be beneficial.

- **Program innovations implemented:**
  As above

- **Findings and next steps:**
  As above

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

The testing of the exceptions to Core Model Element 4 is still underway. This will require significant time as the numbers are so small and therefore conclusions and learning are difficult to achieve.

RCT or equivalent commissioned Research

Research team and their institutions:
The University of Cardiff
Michael Robling
Rebecca Cannings-John
Fiona Lugg

Brief outline of research methodology:
Scottish Government have commissioned Cardiff University to undertake a Data Linkage Study using a natural experiment approach. The study will use data on all participants from the initiation of FNP in Scotland to present, with an intervention and a control group of over 3,000 individuals in each.

Details of progress to date:
The project has been be externally commissioned by the Scottish Government and is managed by the FNP analytical programme manager. Data is currently being analysed. Initial findings will be presented internally late in 2020 with full findings report published in 2021.

Expected reporting period and consultation with UCD prior to publication:

UCD has been kept up to date with the developments of this study we will share some interim findings by the end of 2020.

PART FIVE: ACTION PLAN

LAST YEAR:

Action	Update	Progress
Planning for delivery adaptations to test to suit remote and rural	Full implementation has not yet been achieved, however we have implemented FNP now across all of mainland Scotland. The challenges that the islands represents is complex and we are still working with the boards to try to find the best solution to implementation. The advancements in telehealth use in Scotland during the current pandemic will be a useful insight into how this technology could be harnessed and aid in the delivery of the programme particularly in remote and rural settings in the future. Learning from sites that have already supported this type of model in the past has been critical to managing the overall complexity and taking a systematic approach to implementation. ON track to deliver NHS Highland/NHS GGC model in 2020/21	
Delivery of a new data system in line with business benefits identified	The successful delivery of the new data system for FNP in Scotland has been a particular highlight this year.	
Ongoing review of data system implementation	The development and delivery of the new data system has taken longer than initially expected, therefore the development and delivery of the phase 2 forms has been slightly delayed.	
Training for FNP TURAS	All Supervisors, Family Nurses and Data Managers have undergone either face to face training or online training	
Review CME/AAME's - set fidelity benchmarks	CME review group established. Benchmarks for 3,5,6,and 12 under consultation. Meeting to discuss AAME for Scotland relating to the universal health visiting pathway being progressed. ON TRACK to deliver end November 2020	
Initial output Data Linkage study	Delays in data transfer led to overall delays in delivery. Initial findings due by November 2020. Final Report Early 2021	
Complete RE:evaluation project and consider implications of findings for future practice	The Revaluation project has been completed with the full report published[1]. This has been circulated widely and has already influenced current practice.	
Develop systematic tool for capturing vulnerabilties across Scottish cohorts	This is a project that has been set up more widely within government and is linked to the Scottish Governments approach to adverse childhood experiences. A tool to look at adverse childhood experiences more widely is being considered and the work of the vulnerability analysis undertaken within FNP has fed into this. Work has begun with Scottish Government partners to test the use of Routine Enquiry and Response relating to trauma and adversity.	
CQI programme initiation	Review of FNP sites performance and achievements in progress. Linking with rest of UK partners to explore more systematic sharing of improvement projects.	
Review education priorities	The advancements in telehealth use in Scotland during the current pandemic will be a useful insight into how this technology could be harnessed and aid in the delivery of the education programme. Accreditation work was underway but has stalled recently but should be continued in the future. Education strategy under development by NES due Sept 2020	
Review of retention of nurse workforce	This is being aligned with the CME review	
Site Annual Review programme	A new process is being tested, using site self assessment tools and will be reviewed over the next year.	
High level data analysis	Analysis of sites self assessment / in progress. This will be complimented by the high level, 10 year analysis of FNP outcome data due by end of 2020	
Improving communication channels across FNP	FNP SG quality newsletter in place. Implementation of a new suite of processes to improve communication and planning is being tested with FNP sites (FNP communication and RICE process). FNP Leadership team and workstream model approach being taken forward.	
Develop systematic sharing with other health professionals	Ongoing. Developments are iterative.	
Commission 20-24yr old learning capture	Still to be commissioned - on hold due to COVID	

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Reflections on our progress:

There has been a significant amount of collective effort and expertise put into the formation and delivery of our new data system, Turas FNP. This has been the culmination of years of work, and is already planned to be used by other parts of the UK to deliver FNP. Our National Clinical Lead took a leadership role for this work, and has created a system that we should all be very proud of.

During 2019/20 the FNP sites across Scotland have continued to deliver the programme with high quality and to the fidelity measures. The Education programme continually receives positive evaluation. The ongoing commitment to the programme, through the FNP Leadership team, is enabling early identification of areas for improvement, and the collective and individual expertise is deepening our appreciation for this programme.

It goes without saying, that the Covid-19 pandemic has brought into sharp relief the challenges that some families face, and the exacerbation of existing vulnerabilities, in this new context, continues to make life extremely challenging for the most disadvantaged in our society, including young, first time mothers. The dedication of the workforce to continue to find innovative ways to continue to connect with their clients and deliver the programme, is very powerful to see. We are exploring how we can collect that learning and use it to inform the next phase of FNP in Scotland.

Aligning closely with the work for all young parents through the national Pregnancy, Parenthood and Young People strategy will enable us to continue to shape our work to meet the needs of young parents across Scotland, in a more holistic way. This is a two way process, with learning from FNP shaping some of the national direction, including around access to welfare advice and other community based provision, crucial to improving a range of outcomes for all the family across the FNP core aims.

NEXT YEAR:

Our planned priorities and objectives for next year:

1. Further refinement of TURAS FNP system – in line with overall business benefits and quality assurance requirements
2. Routine Enquiry and Response – review of tools and techniques
3. Completion and implementation of Supervision review
4. Completion of CME review/identification of AAME for Scotland – test monitoring/performance/improvement tools e.g. self-assessment
5. Telehealth - review of usage and other learning from COVID-19 pivot to inform next steps
6. Remote and rural boards – expansion planning and implementation
7. Explore workforce challenges and models for improvement, linked to Education strategy
8. Explore more systematic approaches to client voice in the programme
9. Continue to build evidence base in Scotland and create stronger links with UK (data linkage, high level 10 year analysis)

Measures planned for evaluating our success:

- We will map evaluation and measurement tools across all the components of FNP, including education and workforce, to identify areas of success, for further improvement and where there are opportunities for scale and spread for sustainability and quality assurance purposes
- We plan to undertake a full 10 years analysis of FNP this year and to compare FNP data to universal services data where applicable.
- We also aim to look wider within the international context at areas recorded within FNP that may illuminate the findings within FNP.
- We will also publish the FNP natural experiment data linkage study in early 2021.
- We have recently commissioned a piece of research to understand better how FNP is being delivered during the current pandemic and aim to use learning from this to further enhance the programme in Scotland, in relation to telehealth.

Any plans/requests for program expansion?

We aim to deliver the programme in more remote and rural areas of Scotland including the Island NHS Boards and have been working with Boards and programme leads on this.

FEEDBACK FOR UCD INTERNATIONAL TEAM:

The most helpful things we have received from the International team over the last year have been:

It has been very valuable to take part in the reflective supervision review.
Access to the international website is useful for sharing learning.

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

Consideration of how NFP sustainability is in place across countries, and key principles that should be considered to further integrate it into local country delivery models for community based provision
This what we would like from UCD through our Support Services Agreement for next year: Early insight into any emerging research or findings for NFP development Working together to agree any AAME's for Scotland

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:

- COVID-19 project, in which resources and learning has been rapidly shared between countries. Scotland is also participating in the working group relating to ongoing use of telehealth in NFP.
- Reflective supervision working group activities re RS documentation and reporting.
- Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
- Access to the international website forum for discussion of issues with leads in other NFP implementing countries
- Development and dissemination of international guidance documents on program content and implementation that draw on the experiences of all NFP implementing countries.
- Sharing and updating the international data collection manual and program guidelines.
- Provision of the international Clinical Leads' Advisory Group meetings.
- Sharing new program innovations developed and researched by PRC and all implementing countries
- Developing new opportunities for international collaboration and networking, such as the recently initiated data analytic and research-leads forum.
- Facilitating the sharing of good practice between countries on particular topics.
- Access to expert consultation re IPV from Dr Susan Jack and learning from other countries adapting and testing the intervention
- Sharing new NFP international research outputs from all countries via the website.
- Promoting NFP internationally as an example of a program that ensures high quality replication in all contexts and maintains its international reputation for effectiveness and quality.

Identified strengths of program:

- There is a deep and enduring commitment to delivering FNP with excellence throughout the system.
- The quality and comprehensiveness of the education delivered by NES and its adaptation to new challenges presented
- The analysis and use of data to inform program progress and areas of challenges, as presented in this report.
- The collaboration with local sites to ensure strong local delivery of the program and sustainability of the program within the Scottish context
- The commitment to QI approaches to inform new adaptations and improvements
- The development of a robust information system and a continued commitment to using data to inform ongoing QI.
- The quality of program implementation, as evidenced through the attainment of CME benchmarks (including client retention and father involvement)
- The attention paid to the wellbeing of nurses and supervisors and the extent of informal feedback from teams to inform developments and decisions taken.
- The level of client engagement with the program and family nurses, as evidenced by the retention data presented in this report.

Areas for further work:

- Implementation of the IPV intervention, including nurse education, in response to the rates of IPV disclosure and relatively low levels of data completion in this area
- Further development of the 'contraception champion' initiative across sites to address the relatively low levels of contraception use and levels of subsequent pregnancies
- Consideration of the measurement of DANCE scores as indicators of progress in caregiving over time.

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

- As per section 5, with the addition of the suggested areas for further work above

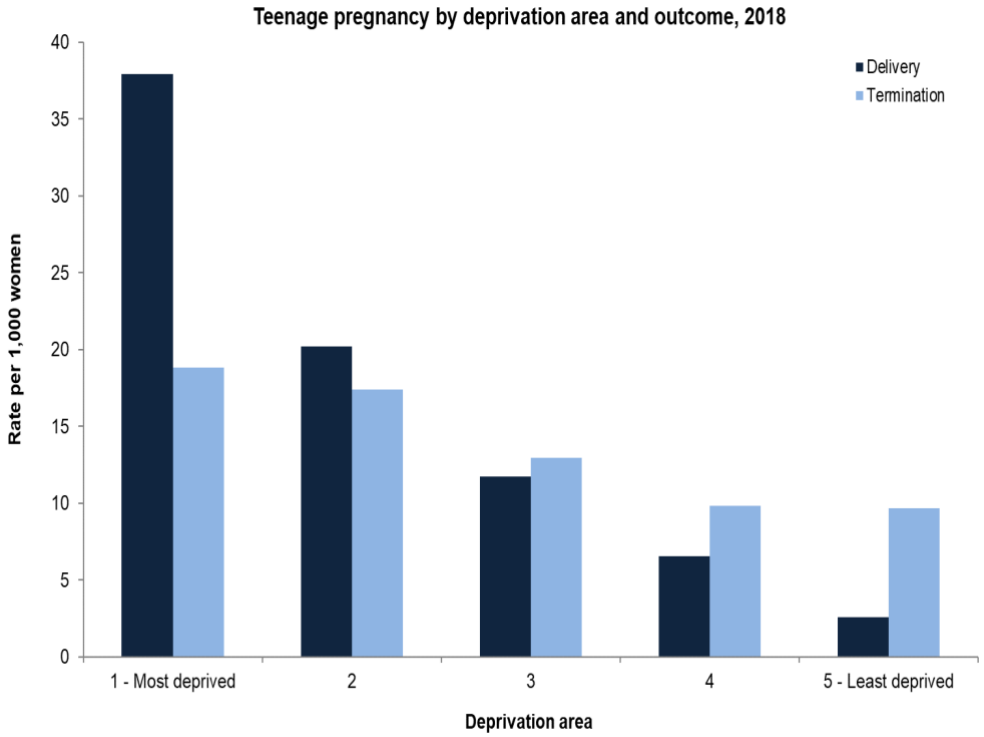
Any approved Core Model Element Variances:

- CME#4
- To continue to monitor impact. Discussion of findings will be undertaken when sufficient numbers allow

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

- Monitoring of the license and oversight of fidelity
- CME Variance monitoring
- Expert input on research findings
- Respond to ad hoc queries and advice
- Annual meeting with national clinical lead and national education leads to support planning of clinical additions or changes
- Twice yearly consultation calls with CW

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



Includes all pregnancies in women aged under 20. The rate is calculated using the female population aged 15-19.
Source: NRS birth registrations & Notifications of abortions performed under the Abortion (Scotland) Regulations 1991.

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:

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Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
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