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International Nurse-Family Partnership® (NFP)

Phase Four Annual Report

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

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data is 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.

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

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

PART ONE: PROGRAM OVERVIEW

Name of country: England

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

Report completed by: Sarah Tyndall, FNP Nurse Consultant

Date submitted:

The size of our program:

	Number	Total
Fulltime NFP Nurses (more than 34 hours per week)	**237**	**237**
Part time NFP Nurses (less than 34 hours per week)	**100**	**100**
Unknown F/t P/T nurses	**13**	**13**
Fulltime NFP Supervisors more than 34 hours per week)	**46**	**46**
Part time NFP Supervisors (less than 34 hours per week)	**15**	**15**
Unknown F/T P/T SV's	**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	**413**	**413**

- We have 63 teams (supervisor-led groups of NFP Nurses)

- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 5.5

- Current number of implementing agencies/sites delivering NFP: 63
- Current number of NFP teams: 63

- Number of new sites over reporting period: 0
- Number of new teams over the reporting period:0
- Number of sites that have decommissioned NFP over the reporting period: 10 + 5 site mergers

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

This year has been one of success and challenge. The successful delivery of the ADAPT project required resilience and commitment from the teams involved as well as from staff in the National Unit and our partner organisation Dartington Social Design Lab.

The subsequent preparation for national implementation of the personalised delivery model was keenly anticipated by teams, provider organisations and commissioners and engagement with the preparation has been good.

The pressure on local authority funding has continued to impact on FNP teams with 10 sites decommissioning over the year. The level of commissioner and provider organisation commitment to FNP continues to vary across the sites with some being very aware of, and engaged in, the benefits that FNP brings to clients and their children as well as to the wider system. In other areas frequent changes of

personnel and increasing demand on limited budgets make this more challenging. Alongside financial constraints the perception that FNP value is limited because of its specificity to young parents is often stated as another reason for decommissioning.

The transition into PHE has been reported to have increased confidence in some local areas where it is seen to be an endorsement of FNP at national level.

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

License holder name: The Secretary of State for Health, Dept of Health and Social Care
Role and Organisation: The Secretary of State is the license holder with the responsibility for administering this delegated to Public Health England.

The National Unit (NU) is funded by Public Health England (PHE) with the Tavistock and Portman NHS Foundation commissioned to provide the NU service. This contract terminated on the 31.3.20, at the end of this reporting period, when the FNP NU Transitioned into the Nursing, Maternity and Early Years Directorate of Public Health England. Local sites are commissioned and funded by local authorities through the public health grant.

Description of our National implementing capacity and roles:

- Clinical Leadership:

This year has marked a significant change in the senior leadership of the National Unit with Ailsa Swarbrick, who had led the Unit since 2012, reducing her role as Director to two days a week in June 2019. In January 2020 Ailsa stepped down as Director and Lynne Reed was appointed to the role. These changes to senior leadership, the preparations for transition to PHE and the response to the early stages of the Covid pandemic have highlighted the resilience of the National Unit staff team as they have continued to deliver work of high quality and ensure FNP teams across England receive the support they require.

Clinical leadership for the programme is led by Lynne Reed as the most senior nurse in the organisation. At the start of the reporting period Lynne was Head of Clinical Quality Improvement moving into the role of National Unit Director in January 2020. Lynne continued to lead the Clinical Quality Improvement Team after taking up the post of Director as the Unit was preparing to transition from The Tavistock and Portman NHS Trust into PHE in April 2020.

Lynne has previous experience as an FNP Supervisor and Provider lead as well as many years' experience of operational and strategic leadership within children's services and safeguarding. Her professional and academic qualifications are as follows: RGN; RSCN; Dip HV; BSc (Hons) MSc Advanced Practice in Leadership. Lynne is also a Queens Nurse and Q Community Member

The Clinical Quality Improvement Team consists of three WTE Clinical Quality Leads all of whom are experienced public health nurses with evidence of an ongoing commitment to high quality service delivery and their own professional development. They have all delivered the programme as supervisors or family nurses. All three have worked in the National Unit for a number of years and they provide a strong, cohesive clinical team.

Alongside the Clinical Quality Leads, two WTE Quality Improvement leads provide site support, quality improvement expertise and extensive knowledge of the commissioning landscape in which FNP operates in England.

The Clinical Quality Improvement team are responsible for facilitating and maintaining high quality implementation of the FNP programme locally, in line with clinical governance processes, and for ensuring

FNP National Unit led quality improvements are informed by evidence based clinical practice. In addition, the team design, deliver and evaluate the FNP Learning and Implementation programme. The team have extensive external links including with the Public Health England Nursing and Maternity Directorate and NHS England Safeguarding Team; Queens Nursing Institute and the Institute of Health Visiting. The team are also contributing to work being undertaken nationally to ensure all children in England have the Best Start in Life, led by Public Health England.

The team are also active members of the international NFP community.

- Data analysis, reporting and evaluation:

The data analysis team is made up of a Data Science Lead and a data scientist. The current FNP information system is provided by NHS Digital and due to outdated infrastructure is no longer viable to fulfil the requirements for FNP data collection in England. A major project has been underway during the reporting period to procure a new information system, with National Education for Scotland securing the contract. Work on the development of the new system began in earnest during this year with the anticipated launch of the new system scheduled for September 2020.

The importance of data to the delivery of the programme is central and the value of the data collected over the last eleven years means that the importance of data migration and data retention has been central to the planned switch to a new system. All the data that can be successfully migrated from the current system to the new system will be, with all historical data remaining accessible should it be required for any future reporting purposes.

- Service development/site support:

The National Unit has continued to provide site support with a strong focus on service development. The successful completion of the ADAPT project in October 2019 and preparations for national implementation of the personalised service delivery model, that was tested as part of the project, have been central to the work of the National Unit this year. In Q4 all teams, who had not participated in the ADAPT project, attended two days of face to face training in Personalisation. In addition, teams were provided with resources to complete to ensure site readiness for the change to service delivery as well as resources for team-based learning to consolidate the face to face training.
Alongside the development work site support has continued to ensure sustainability of FNP with the quality improvement team coordinating quarterly site surveys as well as attending Annual Reviews and offering individual site consultation when required.

All this work is supported by a communications manager and learning coordinator who provide monthly bulletins to sites and to wider stakeholders as well as responding to site queries.

- Quality improvement:

Quality improvement has continued to be a focus over the course of this year with some staff receiving training in quality improvement methodology, a small-scale quality improvement project on smoking cessation in pregnancy (reported Sept 2019) and work to apply quality improvement methodology to review the process around Annual reviews (commenced in Q4 due for completion in Q2 20/21).
A number of staff were also trained in facilitation as part of embedding Agile DSDM methodology in the work of the Unit.

- NFP Educators:

The National Unit has contracts with sessional educators and practice development leads. These are Family Nurses and Supervisors who are seconded to support the work of the clinical team. The sessional educators specialise in one area: Communication skills; DANCE or PIPE.
The five practice development leads (previously known as Regional Lead Supervisors) support the clinical team in aspects of clinical work as well as providing the mentorship for new supervisors.
All secondees have an induction programme and are expected to participate in ongoing practice development time annually as part of their seconded hours.

Description of our local and national NFP funding arrangements:

The National Unit (NU) is funded by Public Health England (PHE) with the Tavistock and Portman NHS Foundation Trust commissioned to provide the NU service. This contract terminated on the final day of this reporting period (31.3.20) when the FNP NU integrated into the Nursing, Maternity and Early Years Directorate of Public Health England.

Local sites are commissioned and funded by local authorities, with the ongoing impact of austerity been seen throughout the reporting period. The number of sites has reduced from 76 at the end of March 2019 to 63 at the end of March 2020.

Current policy/government support for NFP:
The decision to transfer the National Unit into PHE at the end of the contract with Tavistock and Portman NHS Trust reflects policy support from the Department of Health and Social Care. This endorsement has been positively perceived by local sites. One of PHE's priorities is reducing health inequalities with the Best Start in Life Programme focussing on improving outcomes for all children and strengthening access to parenting programmes.

It also offers potential opportunities to influence work across the wider system and to engage with Local Authorities that may never have had FNP or may have previously decommissioned FNP.

How our NFP supervisor and nurse education is organised:

The core FNP nurse education is delivered using face to face residential learning, online preparation and consolidation modules and materials to support team learning at site level. The learning sessions are designed and primarily delivered by members of the clinical team. They are supported in this by sessional educators who support with the communication skills, DANCE and PIPE learning. Dance is currently delivered face to face by trained sessional educators and led by a member of the clinical team. Consideration is underway to move to online DANCE training and the Clinical Quality Lead has begun discussions with UCD to explore this.

The Supervisor learning programme is delivered over a period of approximately 13 months with an initial residential two day introductory face to face session, followed by a series of one day face to face learning days. The safeguarding supervision learning is embedded within this programme. This is led by a member of the clinical team with clinical team colleagues contributing. Every new supervisor receives mentorship from an experienced supervisor which includes observation of supervision and facilitation of team learning. The mentorship programme is organised and overseen by one of the Clinical Quality Leads.

The Moodle eLearning platform is used to support all the nurse and supervisor education.

Ongoing supervisor face to face learning days take place three times a year and cover any updates on programme development, learning from national safeguarding reviews as well as covering key topics such as trauma informed care; Adverse Childhood experiences.

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

The National Unit has worked closely with Dartington Social Design Lab on the ADAPT project as well as developing a productive partnership with Triangle Consulting to develop and refine the New Mum Star.

There continue to be good links with partner agencies working in early intervention and an away day included presentations from experts in implementation science and behaviour science. Some work with the National Institute of Health Research Applied Health Centre (NIHR ARC) and the Centre for Implementation Science, King's College London (KCL) led to a half day workshop to refine the approach to evaluating the implementation of a personalised delivery model. This provided a useful framework which is being used as part of the implementation of personalisation and which can be applied to other adaptations that are introduced in order to support effective evaluation. The feedback from colleagues from NIHR ARC and KCL was very affirming in terms of the depth of knowledge and the commitment to effective implementation that the National Unit demonstrates.

The work to develop the neglect adaptation, which was part of the ADAPT project, included use of the GCP2 tool developed by the NSPCC and this has led to an ongoing collaboration to look at the impact of the use of the tool in FNP, as well as potential future work on an antenatal tool for assessing neglect.

The changes to national safeguarding arrangements resulting from the Wood Report (2016) have led to the establishment of a National Safeguarding Panel with FNP identified as a stakeholder in this work.

Other relevant/important information regarding our NFP program:

This year has seen the culmination of the FNP Next Steps programme of work with the ADAPT (Accelerated Design and Testing) project coming to a conclusion in October 2019. This was marked with a very successful two-day residential event for all teams that had participated in the project providing an opportunity to reflect, celebrate and analyse much of the learning from the project. The event was quickly succeeded by a project to implement the adaptation for personalising the service delivery model to the sites who had not been involved in the ADAPT project. The final quarter of this reporting period saw the training of around 300 FN's and SV's in use of the New Mum Star and the personalised delivery model. This training was complete for all but one team by the time the country went into lockdown due to the Covid 19 pandemic in March 2020.

The National Unit has continued to invest in developing knowledge and skills around quality improvement work and a quality improvement project which was initiated in February 2019, aimed at increasing the numbers of pregnant women who stop smoking, reported in this period. The project involved five local sites and confirmed the benefits of regular CO2 monitoring as well as the importance of focussed interventions and training to support nurse confidence. It demonstrated the useful role QI methodology can play in investigating hypothesise and improving practice as well as the vital role of linking data analysis, project management and communication capacity to successful deliver the project. This learning is now available to all FNP teams to apply in their local context.

PART TWO: PROGRAM IMPLEMENTATION

Clients

# of NFP clients participating in the program over the last year: 7,617 (ever active within the reporting period) and 5,154 (active at the end of the reporting period).

- Current clients: Pregnancy phase (%): 639 (active clients at the end of the period)
- Current clients: Infancy phase (%): 2,393 (active clients at the end of the period)
- Current clients: Toddler phase (%): 2,122 (active clients at the end of the period)

% of those eligible clients offered the program who have enrolled over the last year: Collected locally and reported to the local FAB

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

- Within this year the % of eligible women referred/ notified who were successfully enrolled onto the program was __N/A____%

    - Our reflections on this figure: These figures are collected and monitored locally with reports to the FAB and at the Annual Review.

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: 17%

- % of home visits, where other family members are present: 13% (mother is present) and 3% (a friend is present)

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

  Family Nurses show a strong commitment to engaging with fathers/partners and other family members. Time is spent in the core learning considering the role of partners and wider family members both in terms of the potential benefits and the requirement for ongoing assessment to support positive impact as well as to identify and respond to any safeguarding concerns. Family Nurses frequently report how much clients want the child's father to contribute to the care of the child and how strongly they aspire to creating a 'family'. Family Nurses use this desire to support clients and their partners to really explore what being a parent means, what a healthy relationship looks like and how that relationship will impact on their child's health and development.

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

  There is increasing national interest on the impact that fathers/partners can have on the development of their children and members of the Clinical Quality Team are engaged in some of this work. Taking account of the findings from Serious Case Reviews and experience of working with a client group that has high levels of vulnerability necessitates that this work is developed in a way that recognises both the potential benefits and the potential risks if we are to ensure the best outcomes for children.
  The ongoing supervisor learning day which took place in October 2019 focussed on learning from serious case reviews with one of the key areas being the risk when there were new males in the house of focusing too much on the adult relationship and losing sight of the impact on the child.

  Family Nurses often describe the importance of building relationships with other family members, most notably maternal grandmother, to enable effective work to take place. Again, time is spent during core learning and within teams reflecting on how the application of good communication skills can help to facilitate this.

Nursing Workforce

Average nurse caseload:

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	401	75		480
# of staff who left during reporting period	**	**		
% annual turnover	**	**		
# of replacement staff hired during reporting period	**	**		
# of staff at end of reporting period:	380	65		445
# of vacant positions	**	**		

** These figures are not recorded nationally.

- Reflections on NFP nurse/supervisor turnover/retention during reporting year:
  Turnover of Family Nurses and Supervisors has been related to retirement, career progression and some decommissioning. Over the course of the year the reduction in overall numbers has been lower that in the previous year with less decommissioning taking place.

- Successes/challenges with NFP nurse/supervisor recruitment:
  FNP is a positive career opportunity with vacancies in local FNP teams continuing to attract a healthy number of suitable applicants resulting in high calibre public health nurses being appointed to these posts. We have continued to see the recruitment of trained supervisors and family nurses who have previously worked in decommissioned sites.

NFP Information System

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

The FNP information system (FNPIS) enables the National Unit (NU) to collect clinical outcome and programme delivery data about clients and their babies. As importantly, it supports a data-driven approach to clinical care and informs programme quality improvement and innovation work.

- Commentary on data completeness and/ or accuracy:
  Data completion is generally good. There have been occasional technical issues on the system that may have had a small effect on data quality. Mitigations have been put in place when such issues were identified.

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

  At its core, the FNPIS is a data capture and reporting tool. Family Nurses enter data about their clients, and this data is delivered back to the nurse and supervisor through a collection of reports and dashboards that can be exported by individual sites. The National Unit has access to the data to perform analysis around programme delivery.

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

  The information system was built in 2009 and has undergone significant development since then to accommodate the expansion of FNP in England. Despite ongoing development work on the system, a number of limitations mainly due to the outdated infrastructure remain. This needed addressing to facilitate accurate data entry and real-time reporting as well as aligning to a more personalised delivery of FNP in England. This has led to the FNP NU commissioning a new information system due to go live in Q3 of the financial year 2020/21. The new system will be more intuitive, have much improved data validation and 'skip logic' in place to support data completeness and data quality.

Continuous Quality Improvement (CQI) Program

- Brief description of CQI processes:
  The main focus of continuous quality improvement during this reporting period was the ADAPT project. This was an ambitious project which spanned three years and aimed to test adaptations to the programme that would support delivery in the current context in England. The full report from the project was published in March 2020 and whilst the planned launch event was cancelled due to the Covid pandemic the report is available and work has continued to maintain momentum despite the delay. The planning and preparation to implement changes to service delivery took place throughout this year with all teams ready to begin implementing the personalised service delivery model by the end of March 2020 (implementation was paused due to the Covid pandemic).

  The commitment to quality improvement has continued and developed with the smoking cessation project (see previous section) as well as work undertaken with a QI expert who provided training to a number of National Unit staff and worked alongside one of the Quality Improvement and Development Leads to review the Annual review process. This resulted in a refreshed process and accompanying paperwork alongside mechanisms to monitor timeliness of annual reports received and National Unit response.

- How we use qualitative and quantitative information as part of our CQI program:
  The ADAPT project used both qualitative and quantitative data to support the rapid cycle testing methodology to assess adaptations to the programme. The combination of different types of data provided rich learning and highlighted how easy it is to have an incomplete picture if only one form of data is used. This was demonstrated on a number of occasions when the quantitative data required an understanding of practice experience to fully inform the benefits and drawbacks of a change. The way that data was used to shape and inform the progress of the project is described in more detail in the ADAPT report which is available here.

- Successes/challenges with our CQI approach:

  Overall the drive for continuous quality improvement has been successful most notably in the culmination of the ADAPT project which was a huge piece of work reflecting the ambition and commitment of staff throughout the whole FNP system in England. There was a great deal of learning some of which is captured in the ADAPT report.

  The Stop Smoking project illustrated the opportunity for successful co-design between the NU and local sites using an agile project management approach and data driven QI methodology. The project also identified learning about the time and resource requirements which can be challenging for busy local teams. In addition, the challenges about how to co design with clients reflected some of the learning from ADAPT which need further analysis to inform future projects

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

Any other relevant information:

The Covid pandemic which emerged in Q4 required the National Unit to respond swiftly to the challenges faced by teams. Whilst teams were advised to follow national guidance the National Unit quickly implemented a process for recording client contact to ensure that it would be possible to identify the difference between face to face visits and contacts undertaken using virtual technology. This provides the opportunity not only to better understand the impact for FNP clients but to be able to analyse impact over the longer term for this cohort of clients and babies. The Clinical Quality and Improvement Team recognised the need for direct communication with sites during this unprecedented time and set up calls to individual supervisors to undertake a questionnaire, as well as scheduling regular site support calls which supervisors and nurses could dial into. These commenced in Q1 of 20/21.

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

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

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

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: (e.g. by signed informed consent) Local sites manage this process. The core learning programme highlights the importance of voluntary participation in supporting the purposeful client engagement in the programme.	100% voluntary participation	As FNP is a recognised resource in many areas clients can on occasion be put under 'pressure' by other professionals to agree to the programme. This is most often reported when clients are presenting safeguarding concerns for themselves and/or their unborn child. The most effective action seems to be the skill of the FN in offering the programme and enabling the client to make as informed a decision as possible.
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Clear guidance regarding eligibility for the programme; Recruitment pathways and reports provided to the FAB.	100% first time mothers	This is not usually a challenge with only very occasional enquiries made to the National Unit for guidance when a previous baby has died soon after birth or been removed at birth.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
3. Client meets socioeconomic disadvantage criteria at intake	The socioeconomic disadvantage inclusion criteria for our country are: first time mothers aged up to 19 years (with some areas extending to 24 years with additional vulnerabilities) Application of these criteria are assured and monitored by: The FNP Information system; robust recruitment pathways and reports provided to the FAB.	100% clients enrolled who meet the country's socioeconomic disadvantage criteria	As a consequence of the success of the national programme to reduce teenage pregnancies, the cohort of young parents are now more likely to have complex vulnerabilities. It is also of note that national statistics show that areas with high levels of deprivation have higher rates of teenage pregnancy. This impacts on the complexity of FNP caseloads. The National Unit receives feedback from Commissioners suggesting that they would like to see a widening of the eligibility criteria in order to better meet the specific needs of their local population.
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	88% of NFP clients receive their first home visit no later than the 28th week of pregnancy 12% clients were registered at 29+ weeks gestation. (*NB*: *6% were clients from ADAPT sites where late recruitment was being tested)* Monitored locally % of eligible referrals who are intended to be recruited to FNP are enrolled in the program	In the ADAPT project recruitment later than 28 weeks was tested. This was intended for exceptional circumstances but led to a larger increase than expected in late recruitment. Following a review of the data, feedback from FN's and conversations with UCD updated recruitment and enrolment guidance was issued in Jan 2020 with very tight criteria for exceptional recruitment beyond 28 weeks. This is reported to the FAB as an exception and numbers will

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		30% of pregnant women are enrolled by 16 weeks' gestation or earlier	continue to be monitored by the National Unit.
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	None, except maternity and sick leave absence and nurse turnover. In these circumstances another FN will cover sickness etc. When a FN leaves, we have designed specific materials to facilitate a supported handover. This means that the 'leaving' nurse is able to work with the client to ensure that the new nurse understands the client, what she's achieved, her needs, goals etc.
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 expectation is that visits will primarily take place in the client's home except when it is unsafe or unsuitable to do so.	83% visits take place in the home which is in line with expectation taking account of the challenging home circumstances in which many clients live. 17% breakdown of where visits are being conducted other than in the client's home: 5% Family/Friend's Home 3% Community Location (e.g. Café) 1% Doctor/Clinic 0% School/College 3% Children's Centre 6% Other	The main challenge can be that a client's home surroundings are not conducive to the work between the FN and client e.g. lots of other people present. In these circumstances the FN may suggest alternative places to meet however the FN would always prioritise making some visits to the home in order to undertake the necessary risk assessments. Where there is a challenge in delivering the programme at home this would be reviewed in supervision.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
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/Country benchmarks for: a) Program visit dosage patterns in relation to client strengths and risks benchmarks are: see challenges and suggested actions column. b) Length of visits by phase benchmarks: • Pregnancy phase: • Infancy phase: • Toddler phase: c) Client attrition by program phase benchmarks: Less than 10% attrition in Pregnancy phase Less than 20% attrition in Infancy phase Less than 10% attrition in Toddler phase	• 96% of clients being visited on standard visit schedule • 4% of clients being visited on alternate visit schedule • Length of visits by phase (average and range): • Pregnancy phase: 01h:09min • Infancy phase: 01h:07min • Toddler phase: 01h:07min *visits need to be longer than 15 minutes Client attrition** by phase and reasons: 3.1% attrition in Pregnancy phase 24.3% attrition in Infancy phase 12.3% attrition in Toddler phase ** the figure in toddlerhood would also include clients who were early graduates.	The figures in this section are difficult to accurately report as we have 20 teams who are part of the ADAPT project and therefore may be offering an alternative visit schedule whilst the others continue to deliver a standard visit schedule. Once all sites are delivering a personalised model we will be able to report more accurately. This is anticipated to be from Q4 20/21 and we are collecting data on the new information system we will be able to report more fully on this. Client attrition rates remain low in the pregnancy phase of the programme, slightly exceed the benchmark in infancy and are just above the benchmark for Toddler. It is anticipated that the change to a more personalised service delivery model will support retention of clients, particularly in infancy, when clients have increased demands on their time and the programme

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			needs to be accurately focused on their priorities at this busy time to maintain engagement. It is important to note that Toddler figures this year include early graduates from the ADAPT sites as this is the only way it could be recorded on the current system. This will be improved on the new information system.
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); Standard job descriptions and pre-employment checks which include confirmation of professional registration. 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	None
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning	100% of NFP nurses and supervisors complete the required NFP educational curricula % of NFP team meetings, case conferences and team education sessions are completed (against expected for time period): see comments in challenge and	_____% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities (see challenge and suggested actions) _____% completion of team meetings, _____% completion of case	All FN and SV's undertake the core learning programme. Team learning, case-based presentation meetings and psychological consultancy are not recorded nationally. During this reporting period the National unit was using quarterly surveys sent to

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
activities	suggested actions.	conference and _____% completion of education sessions	all SV's and FN's to assess engagement with team learning etc. this data is incomplete as the survey for the final quarter was not sent due to the Covid pandemic. However, the data from the previous three quarters indicates that there is good engagement with this CME. Supervisors remain key to ensuring that this CME is sustained, and it is notable from the survey results that supervisor absence, impacts on this. NB: The new FNP information system which is due to launch in September 2020 will routinely collect this data, so reporting will be possible in the future.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	Please complete the section at the end of this table*.		

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
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.	_____% 1:1 supervision and home visit observations undertaken against expected (calculated by time – working weeks- and number of nurse)	_____% 1:1 supervision and home visit observations undertaken against expected	See comment on No. 9 above.
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 % of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurse). Whilst the expectation is that this is happening 100% of the time we recognise that staff sickness, annual leave etc has an impact on meeting this objective. % of 4-monthly Accompanied Home Visits completed (against expected). Whilst the expectation is that this is happening 100% of the time we recognise that staff sickness, annual leave etc has an impact on meeting this objective.	100% of NFP teams have an assigned NFP Supervisor _____% of reflective supervision sessions conducted _____% of 4-monthly Accompanied Home Visits completed	Please see comment box for no. 9 regarding supervision and accompanied home visits.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.	No benchmark. Monitored/assured by: Data from the FNP information system; Annual review reports and attendance; quality improvement project work; work with supervisors and family nurses to gather practice experience feedback and qualitative data.	Progress: There is a high level of commitment to improve outcomes for vulnerable children and families which motivates engagement with data of all types to inform continuous quality improvement and service development. The work on the ADAPT project, procurement of a new information system, QI stop smoking project and the dissemination of Serious Case Review findings reflect this ongoing commitment.	The new FNP information system uses Power BI which will enable the development of a wider range of both local and national reports. This will be alongside the continued work to upskill the National unit staff in QI methodology.
14. High quality NFP implementation is developed and sustained through national and local organized support	Monitored/assured by (including other measures used to assure high quality implementation): Quality Improvement and Development Leads undertake quarterly review of all sites looking at site data from FNP Information system, and other site intelligence including sustainability and quality and prioritise sites for attendance and FABs and Annual Reviews	• 55 Annual Reviews held (82% of sites) • 12 (18%) sites with no Annual Review in 2019/20 (7 of those decommissioning) • 36 held on time • 15 late (Annual Reviews are considered “late” if they are held after the date and in a later quarter of the previous Annual Review)	Work began in this reporting period to apply QI methodology to the review of the Annual Review process. It is anticipated that the outputs from this work will be implemented in Q2/3 of 20/21

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	Quarterly Site report submitted to National Unit Management Meeting	• 45 Annual Reviews attended by the NU (81%) Data not collected on attendance at quarterly FAB's.	

Domain coverage*

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35 -40%	33.2%	14 -20%	20.7%	10 -15%	19.0%
Maternal Role (My Child and Me)	23 – 25%	28.3%	45 -50%	41.5%	40 -45%	39.7%
Environmental Health (My Home)	5 -7%	11.7%	7 -10%	12.6%	7 -10%	12.9%
My Family & Friends (Family & Friends)	10 -15%	15.3%	10 -15%	14.5%	10 -15%	14.7%
Life Course Development (My Life)	10 -15%	12.3%	10 -15%	12.5%	18 -20%	14.8%

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):

There continues to be good alignment with the benchmarks for CME 10 with Environmental health sitting just above the line for each phase of the programme. Reports from family nurses and supervisors would suggest that this is due to high levels of instability around housing in this client population.

PART THREE: PROGRAM IMPACTS

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

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

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

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

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Age (range and mean)	<15 years: 1% 15 years: 5% 16 years: 12% 17 years: 22% 18 years: 25% 19 years: 23% >19 years: 11% * Last 3 years averages	<15 years: 2% 15 years: 5% 16 years: 12% 17 years: 20% 18 years: 25% 19 years: 23% >19 years: 15%
Race/ethnicity distribution	White: 83% Asian: 3% Black: 7% Chinese: 0% Mixed: 6% Other: 2% * Last 3 years averages	White: 84% Asian: 2% Black: 7% Chinese: 0% Mixed: 5% Other: 2%
Father involvement	*Not collected but may be helpful to note that 27% clients recruited have no partner.* ** Last 3 years average*	*Not collected but may be helpful to note that 28% clients recruited have no partner*
Income (please state how this is defined)	*Not accurately recorded and underreported*	*Not accurately recorded and underreported*
Inadequate Housing (please define)	Clients who did not live with their mother or partner: 28% Clients who are currently homeless: 1%	Clients who did not live with their mother or partner: 29% Clients who are currently homeless: 1%

	% Clients who have lived away from parents for >3mths under 18: 43% * Last 3 years averages	% Clients who have lived away from parents for >3mths under 18: 43%
Educational Achievement	Clients 16+ with five GCSEs A*-C (of those with any GCSEs): 39%	Clients 16+ with five GCSEs A*-C (of those with any GCSEs): 38%
Employment	In education, employment and training (EET): 41% * Last 3 years averages	In education, employment and training (EET): 40%
Food Insecurity (please define)	Not collected	
In care of the State as a child	11% Looked after Children (LAC)	12% Looked after Children (LAC)
Obesity (BMI of 30 or more)	10%	10%
Severe Obesity (BMI of 40 or more)	1%	2%
Underweight (BMI of 18.5 or less)	13%	13%
Heart Disease	2%	2%
Hypertension	2%	1%
Diabetes – T1	2%	1%
Diabetes – T2		
Kidney disease	1%	1%
Epilepsy	1%	1%
Sickle cell Disease	1%	2%
Chronic Gastrointestinal disease	0%	0%
Asthma/other chronic pulmonary Disease	1%	1%
Chronic Urinary Tract Infections	13%	12%
Chronic Vaginal Infections (e.g., yeast infections	5%	5%
Sexually Transmitted Infections	Not collected	
Substance Use Disorder	5% receiving services related to substance misuse	5% receiving services related to substance misuse
Mental Illness	35% reporting having a history of mental health problems * Last 3 years averages	40% reporting having a history of mental health problems
Other (please define)	-	-

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

Some work was undertaken as part of the ADAPT project to look at client vulnerabilities. This was particularly focussed on identifying vulnerabilities at intake in order to better ensure that the programme is offered to the clients with the highest level of need, particularly in areas where demand for places exceeds capacity. The work identified high levels of vulnerability particularly when domestic abuse and family dysfunction were added to the list of potential vulnerabilities. It also showed how identification of vulnerability emerges over time as the nurse/client relationship develops, as well as the way that vulnerabilities interact, with multiple lower level vulnerabilities sometimes having potentially higher impact than fewer seemingly more acute issues. The work was challenging and demonstrated most notably the need for further work to explore this area. The development of the new information system will embed some of the learning to support better understanding and exploration as we move forward.

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)	30% moderate or severe symptoms* **combines HADs (threshold: 8+) and GAD7 (threshold 10+)*	29% moderate or severe symptoms* **combines HADs (threshold: 8+) and GAD7 (threshold 10+)*	30% moderate or severe symptoms* **includes only HADs (threshold 8+)*	28% moderate or severe symptoms* **combines HADs (threshold: 8+) and GAD7 (threshold 10+)*	50%*** moderate or severe symptoms* **combines HADs (threshold: 8+) and GAD7 (threshold 10+) ***based on low numbers (13 clients)*
Depression, (n, % moderate + clinical range)	16% moderate or severe symptoms*	17% moderate or severe symptoms*	19% moderate or severe symptoms*	21% moderate or severe symptoms*	35% *** moderate or

	**combines HADs (threshold: 8+), PHQ9 (threshold 10+) and EPDS (threshold 10+)*	**combines HADs (threshold: 8+), PHQ9 (threshold 10+) and EPDS (threshold 10+)*	**includes only HADs (threshold 8+)*	**combines HADs (threshold: 8+), PHQ9 (threshold 10+) and EPDS (threshold 10+)*	severe symptoms* **combines HADs (threshold: 8+), PHQ9 (threshold 10+) and EPDS (threshold 10+) ***based on low numbers (9 clients)*
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	26%	24%	41%	42%	Not collected at this time point
Additional smoking indicators Pregnancy-36 weeks	46% of clients reported at 36 weeks that they smoked during pregnancy 39% of clients stopped smoking by 36 weeks in pregnancy		N/A	N/A	
Alcohol, (n, % during pregnancy, units/last 14 days)	1%	1%	Not collected at this time point	19%	Not collected at this time point
Marijuana, (n, % used in pregnancy, days used last 14 days)	3%	2%	Not collected at this time point	3%	Not collected at this time point
Cocaine, (n, % used in pregnancy, days used last 14 days)	0%	0%	Not collected at this time point	0%	Not collected at this time point

Other street drugs, (n, % used in pregnancy, days used last 14 days)	0%	0%	Not collected at this time point	0%	Not collected at this time point
Excessive Weight Gain from baseline BMI during pregnancy (n, %)	Not Collected				
Mastery, (n, mean)	25% clients with low score *collected at intake and graduation only	Not collected at this time point	Not collected at this time point	Not collected at this time point	30% clients with a low score
IPV disclosure, (n, %)	New IPV form was introduced in Sept/Oct 2019 and the data collected on this does not cover the entire reporting period.				
	6 Months	**12 Months**	**18 months**	**24 Months**	**6 weeks**
Reliable Birth Control use, (n, %)	78%	75%	69%	70%	
Subsequent pregnancies, (n, %)	5%	16%	28%	37%	
Breast Feeding, (n, %)	18%	12%	7%	5%	*39% - 60%** (at birth) 34% (6 weeks)*
Involvement in Education, (n, %), employment or training	23% in education, employment or training (EET)	32% in education, employment or training (EET)	36% in education, employment or training (EET)	39% in education, employment or training (EET)	
Housing needs, (n, %)	Not collected				
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	DANCE score not recorded.				
Father's involvement in care of child, (n, %)	22% not at all 11% less than once a week 21% at least once a week but not daily 45% daily	24% not at all 13% less than once a week 22% at least once a week but not daily 41% daily	27% not at all 13% less than once a week 24% at least once a week but not daily 36% daily	30% not at all 12% less than once a week 21% at least once a week but not daily 36% daily	Not collected at this time point
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):

Please note these figures are for ever active clients within the period, not only the newly recruited

*** Please note that breastfeeding at birth is collected on multiple data forms. As a consequence, calculating this particular indicator based on the different datasets has yield different values. Since all the data collected is equally valid, a range has been provided for the % of clients breastfeeding at birth.*
We are aware of a further issue with the rest of breastfeeding indicators which may have led to underestimation to some extent. Two questions worded'/ slightly differently were used to capture information on breastfeeding
These issues are being addressed in the procurement of the new FNP information system through a review of the forms to ensure there is no room for misinterpretation in the information required to be entered on the system and equally that there is no duplication in the data collected.

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):

34% of clients breastfed their babies at 6 weeks after birth while the official statistic for England is 48% and includes women of all ages. No national comparable figures are available for women of similar age groups and with similar characteristics as FNP clients.

27% of clients reported smoking at intake, 24% at 36 weeks in pregnancy, 41% at birth and 42% at 12 months infancy. Although no national comparable figures are available for women of similar age groups and with similar characteristics as the FNP clients, smoking prevalence is higher in the FNP cohort when compared to smoking prevalence in all women aged 16 to 24 in England which is 15%. However, the FNP programme continues to be effective in reducing smoking in line with recent quality improvement initiatives targeted at smoking cessation. It is important to note that 39% of FNP clients stopped smoking by 36 weeks in pregnancy and this is considerably higher than the national average of 25% (all women aged 16 to 24 in England).

High levels of anxiety continue to be apparent for FNP clients across the duration of the programme with around 30% experiencing moderate to severe anxiety. This reflects the feedback from family nurses who recognise that for many clients who have experienced high levels of childhood adversity and trauma, anxiety is an ongoing challenge. The high levels recorded at 24 months need to be viewed cautiously as they reflect a very small number of clients. The focus on a trauma informed approach, and greater emphasis during core training on the impact of trauma, enhances the family nurse's ability to see beyond the behaviours that clients may present and to foster a trusting relationship which enables engagement with the programme.

Whilst recorded levels of illegal drug use remain low family nurses report that the prevalence and impact is more significant. The use of cannabis is not always seen to be 'illegal' and the use among client's partners and wider family contacts is not captured in our data but is reported to be widespread. The introduction of a facilitator specifically about cannabis use, and newly developed questions for the new Information system are intended to support the development of practice in this area.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	9	0%
Very preterm (28-32 weeks' gestation)	33	2%
Moderate to late preterm (33-37 weeks' gestation)	352	16%
Low birthweight (please define for your context)	160 (baby weight <2500 g)	6% of live births (baby weight <2500 g)
Large for Gestational Age (LGA) (please define for your context)	117 (baby weight> 4000 g)	5% (baby weight> 4000 g)
Other (please define) Percentage of infants, including twins, that were premature (i.e. before 37 weeks gestation)	214	8%

Please comment below on your birth data:

Around 7% of babies in England are born prematurely so the figures for this reporting period at 8% reflect that it is only marginally higher for a population that is at higher risk of preterm labour. Engagement with the Family nurse can often be an effective way of supporting clients to understand the importance of accessing ante natal care for the health of both them and their baby.

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	93%	92%	92%	91%

Hospitalization for Injuries	1%	2%	Not readily available	2%
	4 months	**10 months**	**20 months**	**24 months**
ASQ scores requiring monitoring (grey zone) ASQ scores requiring further assessment/referral	Infants with scores outside the normal range Communication: 1% Problem-solving: 2% Gross Motor Development: 3% Fine Motor Development: 2% Personal Social Skills 1%	Infants with scores outside the normal range Communication: 1% Problem-solving: 2% Gross Motor Development: 11% Fine Motor Development: 2% Personal Social Skills 1%	Infants with scores outside the normal range Communication: 12% Problem-solving: 3% Gross Motor Development: 4% Fine Motor Development: 5% Personal Social Skills 4%	Infants with scores outside the normal range Communication: 19% Problem-solving: 6% Gross Motor Development: 9% Fine Motor Development: 10% Personal Social Skills 11%
ASQ-SE scores requiring monitoring (grey zone) ASQ-SE scores requiring further assessment/referral	Infants with scores outside the normal range: 1%	Infants with scores outside the normal range: 1%		Infants with scores outside the normal range: 1%
Child Protection (please define for your context)	Not readily available. Child protection status collected on various forms at multiple time points for both client and baby.			
Other (please define)				

Please comment below on your child health/development data:

The data continues to indicate positive impact for child health and development. Immunisation rates remain good with 91% of babies on the programme having up to date immunizations at 24 months. At a time when there is a concern nationally at the decline in immunisation rates it is encouraging to see that these figures remain steady at over 90%.

The ASQ-SE scores continue to reflect good social and emotional development for FNP babies with only 1% with scores falling outside the normal range. The ASQ data reflects good development for infants.

The only comparable national data is for ASQ scores at 24-30months which do demonstrate that a higher percentage of FNP babies require further assessment or referral most notably for Communication (FNP 19%: data for England: 12%) this needs to be approached with some caution due to the fact

that FNP clients are assessed at 24 months whereas the window for the England cohort extends to 30 months. However, it will be important to continue to monitor this.

Additional analyses
-

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. This is a blog provided by an FNP client who had graduated from the programme. *'The programme taught me that I am capable, and it helped me to realise my own potential'* 19 June 2019 **Sharron Owusu-Afriyie, FNP Graduate.** I was first introduced to the Family Nurse Partnership when I was 19 years old, 13 weeks pregnant, alone, scared and sleeping rough. I was sleeping rough to avoid my family who had no idea I was expecting until I was 34 weeks. I gave birth at 37 weeks, so they only had three weeks to wrap their head around the fact that the baby of the family was having her own baby. My midwife referred me to FNP after finding out I was homeless and that I had an extremely limited support system - because nobody knew that I was pregnant. Initially I didn't have any feelings towards the programme, I had never heard of it and my mind was dangerously occupied by other anxious thoughts. My first meeting with my family nurse was in a local health centre, I was nervous, but she was friendly and extremely likeable; she made the first meeting

all about me, she talked me through the programme and told me everything I needed to know. We chatted about the aims of the programme and about some goals for me and my baby. It was during that meeting that any anxiety I felt regarding the programme disappeared. My family nurse provided me with a space where I felt safe and could talk openly about my baby- I. Was. SOLD.

After the initial meeting I was optimistic about the programme but to be completely honest I didn't expect to learn anything. I was wrong and naïve. At our weekly meetings my family nurse would present me with new material, worksheets and engaging information on so many topics that I had never really considered to be important.

We talked through all the stages of pregnancy and my changing body. I didn't have much knowledge on how pregnancy would change or affect my body, my family nurse gave me information on how to stay healthy and take care of myself so that I could cope with all the changes. We also talked about childbirth and I really believe that my family nurse gave a realistic idea of what to expect in labour and also how to identify when I was in labour.

These were all very important things that I had given no thought to. We also went through childhood illness, mental health, well-being and so much more. I learnt such a wealth of information, all of it preparing me for the journey of motherhood.

After my daughter was born, the information and worksheets were tailored and specific to what we were experiencing, for example in the early days when I struggled with latching and breastfeeding my family nurse helped me to better understand breastfeeding. She did this through demonstrating and signposting me to specialists who could support me with the different aspects of this. I never felt that I was just being spoon fed or handed leaflets, all the information was specific and so very relevant to me and what I was finding tough.

Not only did my family nurse help me with very practical things, perhaps most importantly, she recognised signs of an unhealthy relationship from the onset - she signposted me to the right services that helped me to leave the relationship and seek the help I required to move on.

My family nurse consistently and actively supported my on-going battle with housing and she went out of her way to make sure me and my daughter safe. Without her input I may not have been able to identify the warning signs of the abuse, get out of that relationship when I did and find a safe place for me and my daughter to live.

I can honestly say that FNP changed my life! Very recently, I was invited to present and talk at my local FNP team annual review; it was such an honour to share my story with health professionals and let members of FNP team know how much of an impact they've had in my life and more so my daughter's life.

Since graduating from the programme, I have also graduated from university. I have completed a course in professional make up and since started my own freelance business. The support I received from my family nurse and the FNP programme helped me to realise that although there are many young mothers in society, the help and resources actually available to us are very limited. Because of this I am in the process of creating a blog/online space where young mothers can connect, express themselves and seek advice. The programme taught me that I am capable, and it helped me to realise my own potential.

I literally had no idea what I was doing when I met my family nurse. She helped me to prepare for the birth of my daughter, get out of an abusive relationship and find the strength within myself to raise my daughter on my own.

My family nurse was the light in my life during a dark time, the skills she taught me and what I learnt through the agencies she signposted me to will stay with me for life and I am so very grateful.

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	**1**	**Awaiting final report.** The baby who died was born very prematurely, was co-sleeping with both parents and alcohol and cannabis noted in the incident report. We have also received 3 serious incident reports regarding non-accidental injuries to babies during this year and one regarding a review for a client who was under 18 years old and was detained under the Mental Health Act. The learning from incidents continues to highlight: • the risk of co sleeping and the need for consistent messages from all professionals to support vulnerable clients to understand the risks and think about strategies to minimise these risks, particularly when they are in unstable housing. • the importance of recognising the impact of intergenerational vulnerability • The importance of exploring the risks presented by wider family dynamics • The needs of care leavers and the importance of assessment and support for both client's and their partners as they become parents.
Maternal death	**0**	
Other		There was one significant incident learning process report published this year for a baby who died in 2018. This commended the work of the Family Nurse involved with the family, noting particularly her collaboration with other professionals and her ability to challenge when risks to the child were not being recognised. The report also noted the potential impact of late recruitment to the programme and a lack of engagement during the pregnancy phase of the programme.

Any other relevant information or other events to report:

-

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- Briefly describe your system for monitoring implementation quality;
  Implementation quality is monitored in a number of ways using routinely collected data, the site annual review process, quarterly nurse and supervisor surveys, intelligence gathered from learning events, attendance at FAB's and informal site contact.
  This data is analysed and reported on a quarterly basis.
  The Quality Improvement Leads work alongside clinical colleagues to support relationships with commissioners and provider leads to facilitate local implementation and quality improvements. This is supported by the requirement for the site to have an annual review to celebrate success, acknowledge challenges and plan for the coming year and to have quarterly advisory board meetings to monitor the progress on this action plan as well as addressing operational issues.

- Goals and Objectives for CQI program during the reporting period:
  The aim during this reporting period was to ensure that the adaptations being tested as part of the ADAPT project were evaluated and developed in response to both qualitative and quantitative data to ensure that they were implemented well and that all clients continued to receive a high-quality service. Monitoring was also undertaken to ensure that outcomes remained equivalent or improved for clients who were part of the ADAPT work. This offered assurance that we were not seeing any early signs of negative impact from the adaptations being made. Alongside this the routine process for monitoring implementation quality was maintained.

- Outcomes of CQI program for the reporting period:
  The continuous quality improvement programme has been maintained throughout the reporting period and has enabled good oversight of programme delivery during a period of change. This has been the change from the ending of the ADAPT project; preparation for delivery of a more personalised delivery model and preparing the National Unit to transition into PHE.

- Lessons learned from CQI initiatives and how these will be applied in future:
  Work during the year reconnected and reaffirmed the importance of the expertise that the National Unit has in good implementation. In the coming year there will be a great deal of change as we implement a new service delivery model and a new information system. The fundamental importance of good implementation in achieving outcomes will be used to inform these important changes.

- Goals for CQI in next year:
  To use continuous quality improvement to monitor the introduction of personalisation and the new information system and to assure that they have positive impact on FNP across England.

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

- Program innovations tested[1]:
  Personalisation
  IPV clinical adaptation tested in 8 sites (International)
  Neglect adaptation tested in 7 sites (Local)
  QI stop smoking project (5 sites)

- Program innovations implemented:

  Personalisation implementation begun in the year 19/20 with full implementation over 20/21.
  Revised reflective supervision paperwork implemented.

- Findings and next steps:

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 two latest variance documents have been attached and as agreed we are keen to discuss the timeline for monitoring these. Due to the Covid 19 pandemic Personalisation across England was delayed and began in August 2020 with the new FNP information system due to launch towards the end of September 2020. Once both are in place the data will start to be collected to enable future reporting on the agreed CME variations.

Research and evaluation

Please tell us about any NFP related research and evaluation efforts currently being undertaken or planned in your country

In progress:

- Building Blocks II (Mike Robling, Cardiff University)
- Production of child development (Gabriella Conti, UCL/ IFS)
- Data Linking Project (Katie Harron, UCL)
- International Covid-19 project (FNP International network)

New proposals:

- Impact of the Covid-19 pandemic on parents and small children (Gabriella Conti, UCL/ IFS) - Exploratory study looking at programme delivery, short-term outcomes with the potential of revisiting with mid-term outcomes)
- Internal exploratory study to draw key insights on the impact of Covid-19 pandemic

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

PART FIVE: ACTION PLANS

LAST YEAR:

Our planned priorities and objectives for last year:
In our previous annual report, we identified two priorities:

- To maintain high quality delivery of FNP in local sites
- To successfully manage the preparation for transition to Public Health England from 1st April 2020.

Progress against those objectives
The programme has continued to be delivered to a high quality whilst also testing and preparing to implement the personalisation adaptation to the programme across England.
The preparations for transition were well managed with staff being kept fully informed. The final weeks leading up to the transition were disrupted by the Covid pandemic and despite this the National Unit was ready to transition into PHE on 01.04.2020

Reflections on our progress:
Alongside these key priorities a new FNPIS was procured and work began on developing the new system. The governance framework was refreshed, and work continued on the IPV and neglect clinical adaptations.

NEXT YEAR:

Our planned priorities and objectives for next year:
Our overall strategic aims are sustainability of FNP delivery in England and wider system impact across the early years with some specific objectives:

- Develop an action plan to sustain and develop the FNP programme in England.
- Implementation of the personalised service delivery model nationally.
- Development and implementation of a new FNP Information System including the development of operational and management reporting following the go live of the new system.
- Prepare for and respond to the findings from BB2-6.
- Integration within PHE and preparation for transition to the new public health arrangements following the restructure of PHE from 21/22.
- Initiate Project to review the Learning and Implementation programme.
- Implement learning from the IPV and neglect clinical adaptation and identify the contribution to Best Start in Life Programme.
- Continue to respond to the Covid pandemic with a focus on providing leadership and support to local FNP teams alongside contributing to the PHE response and working on recovery, renewal and recalibration.

Measures planned for evaluating our success:

- Evaluation of implementation of personalisation plan completed and ongoing evaluation embedded into the new reporting structures.

- Evidence of good adoption and utilisation of the new FNP information system for both informing practice and reporting.
- Inclusion of specific FNP/intensive home visiting deliverables within the Best Start in Life programme.
- Successful completion of the first phase of learning and implementation review project.
- Evaluation of the implementation of learning from the IPV and neglect clinical adaptations.
- Outcomes from the BB2-6 study will have been shared and disseminated to all stakeholders.
- Over 80% of current sites continue to commission the FNP service.
- Successful delivery of the programme within the ongoing context of the Covid pandemic.

Any plans/requests for program expansion?

Not currently although wider access to all Local Authorities now we are part of PHE may create new interest in commissioning the service.

FEEDBACK FOR UCD INTERNATIONAL TEAM:

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

- Annual review and consultation on CME variations
- CAG and international analytical research project meetings
- Ongoing support and collaboration regarding the IPV adaptation

Our suggestions for how NFP could be developed and improved internationally are:
Increased opportunities to share internationally and to present that more widely – e.g. the proposed co-presentation about the IPV adaptation at the international conference which was cancelled due to Covid.

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

- Coordination of CAG and international analytical research project meetings
- Annual review
- Collaboration on the BB2-6 findings with further discussion on how to leverage wider system impact with NFP products.

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 ☐

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. England 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, which England has actively participated in.
- 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
- 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 the National Unit and its adaptation to new challenges presented
- There is an ongoing commitment to further program improvements with a QI approach developed through the ADAPT program providing a strong foundation for further work in the future.
- The transition to PHE in challenging circumstances has been successful and strong leadership for the program is evident
- The analysis and use of data to inform program progress and areas of challenges, as presented in this report.
- The commitment to promoting the work of the program through an active communications strategy
- The collaboration with local sites to ensure strong local delivery of the program

Areas for further work:

- Possible further analysis of the smoking data to detail reported numbers of cigarettes smoked as a baseline for assessing the impact of wider uptake of the smoking cessation adaptation
- Further reflection of the client mastery findings identified in the report
- 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 in section five, with the addition of the suggested areas for further work above

Any approved Core Model Element Variances:

- Temporary variances agreed for CME #4 & #7
- It was agreed that because of the small numbers affected by this, discussion of progress would be extended
- It was noted that the criteria and processes for late recruitment to the program had been strengthened

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
- Ad hoc additional consultation