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International Nurse-Family Partnership® (NFP)

Phase Four Annual Report

PART ONE: PROGRAM OVERVIEW

Name of country: England

Dates report covers (reporting period): 1st April 2020 to 31st March 2021

Report completed by: Andreea Calin & Sarah Tyndall

Date submitted: 26/05/2021

The size of our program:

	Number	**Total**
Fulltime NFP Nurses (34 hours and above)	**238**	
Part time NFP Nurses (less than 34 hours)	**100**	
Unknown F/T P/T	**12**	
Fulltime NFP Supervisors	**45**	
Part time NFP Supervisors	**10**	
Unknown F/T P/T	**2**	
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	**N/A**	
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	**N/A**	
Total	**407**	

- We have 59 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 6.1 – this has been calculated using total number of FN's and total number of supervisors

- Current number of implementing agencies/sites delivering NFP: 59
- Current number of NFP teams: 59
- 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 3 and 1 merger
- Successes/challenges with delivery of NFP through our implementing agencies/sites:

The main challenge this year has been the impact of the global COVID-19 pandemic which has heightened need for already vulnerable clients and families and has seen FNP teams working under immense pressure. The response from teams has also been this year's success. In April there was some initial redeployment of 10% of the workforce which caused disruption however by the end of May only 1% of the workforce was redeployed reflecting the rapid recognition of the need to provide consistent, accessible services for vulnerable families meant that almost all the redeployment was short lived.

FNP teams adapted quickly to the use of virtual platforms to maintain contact and engagement with clients while undertaking risk assessments to ensure that wherever possible face to face contact was maintained for those families facing the greatest levels of challenge and where safeguarding risks required ongoing review and assessment. Supervision has been consistently reported by family nurses as being crucial in maintaining their resilience and safe practice throughout this period.

Meetings with supervisors during the second half of the reporting period reflected a noticeable shift with increasing attention being paid to programme delivery as the number of face to face visits rose. There has continued to be local variation with some areas facing more stringent local restrictions.

The National Unit transitioned into the Nursing, Maternity and Early Years Directorate of Public Health England on the 1st April. As a result of lockdown restrictions, the entire transition took place virtually and the National Unit has worked remotely throughout the year. The integration into Public Health England has gone well and provided opportunities for working with colleagues across the wider public health system. National Unit staff have contributed to developments in the directorate and are contributing to the planning for transition to the new public health arrangements in the coming year.

The publication of the Building Blocks 2-6 findings in February was a high point of the year and offered important recognition of the lasting impact of the programme. It was also an opportunity to engage with key stakeholders both locally and nationally to reflect on the findings and what they mean for children who receive FNP.

The year also saw the implementation of a personalised service delivery model and the launch of the new Turas information system

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

License holder name: The Secretary of State for Health, Department 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.

This reporting period marks the first year that the National Unit has been part of the Nursing, Maternity and Early Years directorate in 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

Clinical leadership for the programme is led by Lynne Reed who is the national lead for FNP and parenting programmes. Following the transition into PHE a new role was established of Nurse Consultant who leads the Clinical Quality and Improvement Team as part of the senior leadership of the National Unit. The establishment of this post marked the ongoing commitment to nurse led quality improvement and the further development of our research focus. Sarah Tyndall was appointed to this post in May 2020.

The Clinical Quality Improvement Team is made up of 1 WTE nurse consultant; 3 WTE Clinical Quality Leads and 2 WTE Quality Improvement and Development leads. The team has undergone some changes during this year with the retirement of one Clinical Quality Lead in November 2020 and Sarah Tyndall taking up the nurse consultant role. The two resulting vacancies have seen the appointment of two outstanding new Clinical Quality Leads, who bring previous experience as FNP supervisors as well as Health Visitors and senior leads in

community health services. The third Clinical Quality Lead has worked for the National Unit over a number of years and the team benefits from her long-standing experience of working within national leadership.
The Clinical Quality and Improvement team has two Quality Improvement and Development leads who provide site support, quality improvement expertise and extensive knowledge of the commissioning landscape in which FNP in England operates.

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 with a project currently underway to review and update the learning programme.
The Clinical Quality Improvement Team are ably supported by a learning coordinator who manages all the training requirements as well as managing all email contact that comes into the National Unit inbox.

- Data analysis, reporting and evaluation:

The data team is made up of a Head of Data and Analysis and a Data Scientist. The current FNP information system is provided by NHS Education Scotland. This is a newly procured system that went live in September 2020 with the minimal viable functionality required to support the FNP programme. Since then, a suite of reports have been specified, most of which have been tested and already rolled out to sites. Some system developments around the reporting interface are still in progress such as developing functionality around recording safeguarding information in a way that supports a trauma informed approach.

Reflecting the importance and the value of continuously learning from data retrospectively, the historical data collected in the legacy system over more than a decade was migrated to the new system where possible to do so. In the cases where the new data collection did not match the old, data could not be migrated. However, historical data remains accessible should it be needed in the future.

The data team implemented a local data warehouse where data is pulled from the information system on a regular basis. This new piece of infrastructure was developed to support the development of additional reporting and ad hoc analysis for management and strategic purposes. The team leads on a project recently started that aims to identify and address additional management reporting needs.

A data user group has also been implemented to support local sites in their familiarisation with the new information system and to allow for constant feedback and review as well as sharing best practice in working with data. Quarterly meetings are organised and include regional representatives, clinical quality improvement and data representatives from the National Unit.

- Service development/site support:

Site support remains a central focus for the work of the National Unit and this year has presented some very particular challenges and opportunities in responding to the impact of the global Covid pandemic. The Clinical Quality Improvement Team undertook a series of meetings with supervisors throughout the period both as a means of providing support and collating feedback regarding the implications for clients and staff of the restrictions on face to face visiting. The position of the National Unit as part of PHE enabled this information to be shared at a national level to continue to advocate for the needs of vulnerable families during this unprecedented time. Individual site consultation continued with Annual Reviews suspended between April and September 2020. The resumption of Annual Reviews in the Autumn provided a good opportunity to evaluate how individual sites were progressing and these have been effectively managed virtually, with sites continuing to ensure that there is client participation at these meetings.

The move into PHE has provided an opportunity to widen the reach of our work with access to all local authority areas via the PHE regional networks. As part of the Best Start in Life strategy, one of PHE's key

strategic aims, the National Unit has increasingly focussed on the wider impact of FNP and what this offers for parenting support across England. This has required collation and review of all the current models that are supported in local areas which utilise the expertise of FNP within the system and the start of a programme of work to develop an offer for all local authorities in relation to intensive parenting support for vulnerable families.

The service development work is supported by a business governance manager.

- Quality improvement:

The focus for development and quality improvement has been the implementation of the new personalised service delivery model and the new Turas information system. Both developments have been introduced while sites have been working under Covid restrictions and have required thoughtful implementation in response to both national and local variation of restrictions over the course of the year. FNP teams have showed great resilience in adopting these new adaptations and participation in implementation support calls and the Turas User group have demonstrated high levels of commitment to maintaining programme delivery and responding to the challenges of adapting practice.

The Annual Review paperwork was reviewed using a quality improvement approach and following an initial trail period was further amended and is receiving positive feedback. The aim was to enable sites to increase their ability to self-evaluate local programme delivery against the core model elements and present it in a summary format as part of the review.

The introduction of the new Turas information system has meant that sites have not been able to access data reports during the second half of the year and whilst this is not ideal there is some anecdotal evidence of unintended benefits with teams engaging with the increased functionality of the system and undertaking their own analysis of what this demonstrates about their local programme delivery.

- NFP Educators:

The learning and implementation programme is led by the three clinical quality leads. The delivery of training is supported by sessional educators with the mentorship of supervisors and programme development work supported by practice development leads. The sessional educators and practice development lead all work as supervisors or family nurses and they are seconded to undertake the work for the National Unit.

- Innovation management team:

The work of the National Unit relies on the Innovation Management Team who provide project management support for ongoing development and quality improvement of the programme. The project managers use Agile DSDM project management to support the work and members of the National Unit are all trained in this approach. The use of facilitation increasingly supports the work and has proved invaluable in managing complex projects such as the new information system and the implementation of personalisation. It has also been useful in supporting integration into the Nursing, Maternity and Early Years directorate over the course of the year.

- Communications team:

The National Unit has a Head of Stakeholder Engagement and Communications and a Communications manager who provide key functions in regular communication with sites and ongoing development of stakeholder relationships.

Description of our local and national NFP funding arrangements:

The National Unit is funded by Public Health England

Local sites are commissioned and funded by local authorities, with the ongoing impact of austerity being seen throughout the reporting period. The number of sites has reduced from 63 at the end of March 2020 to 59 at the end of March 2021.

Current policy/government support for NFP:
One of PHE's key strategic priorities is the Best Start in Life programme and the work of the National Unit is part of that programme of work. The pandemic has shone a light onto the inequalities in England and the work of the National Unit in supporting work to address intergenerational cycles of disadvantage and provide vulnerable families with parenting support which enables children to start school on an equal footing with their peers is a key priority.

How our NFP supervisor and nurse education is organised:

The core FNP nurse education would normally be delivered using face to face residential learning, online preparation and consolidation modules as well as materials to support team learning at site level. The learning sessions are designed and primarily delivered by members of the clinical quality team. They are supported in this by sessional educators who support with the communication skills, DANCE and PIPE learning. Throughout this reporting period all learning has moved to virtual delivery and has continued to be led by members of the clinical quality team supported by the sessional educators. This change has required adaptation to the content as well as attention to creating a safe learning space in which nurses can reflect, explore and practice new knowledge and skills.

DANCE training is now delivered online by the team in Denver and the first two groups undertook their training during this reporting period. The impact of this change will continue to be monitored and we look forward to receiving the academic papers reviewing the evidence base for DANCE when they are published.

The supervisor learning programme would normally be 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. This pattern has been maintained with all delivery being virtual.

The safeguarding supervision learning is embedded within this programme. This is led by the clinical quality team. Every new supervisor receives mentorship from an experienced supervisor which includes observation of supervision and facilitation of team learning and this has continued virtually. 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 learning days have been adapted this year to provide more regular opportunities for supervisors to meet for shorter sessions, with one full day session during this year. Again, all these have been delivered virtually and the sessions are always well attended and evaluated.

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

There continue to be good links with the academic community. Members of the National Unit sit on the steering Committee of a project evaluating the real-world implementation of the FNP in England. The project uses data linkage of a number of administrative datasets and is led by Katie Harron (University College London). A first paper looking at predictors of enrolment in FNP is due to be submitted for publication in May.

Data has recently been shared with Gabriella Conti (University College London) who submitted a proposal for a research project exploring the impact of the pandemic on vulnerable families and their children.

Following the publication of the Building Blocks 2-6 study, the Chief Investigator, Mike Robling and the National Lead for FNP and Parenting Programmes, Lynne Reed will be co-leading a panel discussion [about why research matters] at the PHE Public Health Research Conference and Science Conference.

The preparation for and dissemination of the findings from the Building Blocks 2-6 study has provided a good opportunity to develop our network of stakeholders across government, with partner organisations and across regional and local networks. This work was managed using project methodology which enabled a focused and purposeful approach to the work. It has been exciting to share the findings with a wide variety of stakeholders and to engage in rich discussions about the synergy across organisations and the benefits they demonstrate of improved outcomes for children. We are developing an action plan to leverage the learning from the research which will inform our 2021/22 workplan.

Other relevant/important information regarding our NFP program:

PART TWO: PROGRAM IMPLEMENTATION

Clients

# of NFP clients participating in the program over the last year: 6762 (ever in the period), 5060 (end of period)

- Current clients: Pregnancy phase (%): 482
- Current clients: Infancy phase (%): 1914
- Current clients: Toddler phase (%): 1906

% of those eligible clients offered the program who have enrolled over the last year: *This data is collected and reported locally*

- 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 *this data is collected and reported locally*

- Our reflections on this figure: *While this data is collected locally, it is reported at Annual Reviews and the feedback from the Quality Improvement and Development leads is that the benchmark of 75% is consistently met.*

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: 19.32%

- % of home visits, where other family members are present: 14.97% (client's mother and father are 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:

The crucial role of partners and the wider family on the health and wellbeing of both the client and her child is well understood by family nurses. There are three FNP teams that are currently engaged in the development of specific projects aimed at developing work with fathers of FNP babies. Two

are working alongside a local charity that works with young fathers and the third is working with a designated fathers worker employed by the provider organisation. This work is being developed collaboratively and the projects both have clear evaluation plans embedded. The ownership of these projects remains local with the National Unit providing some facilitation and acting as a 'thought partner' in the development of the work.

Nursing Workforce

Average nurse caseload:

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	380	65		445
# of staff who left during reporting period	**	**		
% annual turnover	**	**		
# of replacement staff hired during reporting period	**	**		
# of staff at end of reporting period:	350	57		407
# of vacant positions	**	**		

** these figures are not recorded nationally.

- Reflections on NFP nurse/supervisor turnover/retention during reporting year:
  During the year 8 new supervisors have been appointed reflecting a mixture of retirements and promotions leading to the vacancies. Quality improvement leads support the recruitment process for supervisors and sit on the interview panels. The calibre of applicant continues to be high with a mixture of family nurses and non family nurses being successful at interview.

- 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.

- Any plans to address workforce issues:
  As part of the learning and implementation project review the continuous professional development of supervisors and family nurses will be updated in line with the changes to the programme and the context in which FNP is delivered.

NFP education

- Briefly describe your NFP education curricula:

  Core training:
  Foundations – (5 days face to face) including introduction to the programme, communication skills + personalisation + trauma informed practice + strengths-based working +supervision + use of data + respectful challenge – opportunities to skills practice throughout the week.
  New Mum Star - (1 day virtual) required training in use of the New Mum Star as per Triangle license requirements.
  Communication skills – (2 days face to face) building on the learning in Foundations these days focus on developing more advanced motivational interviewing skills

DANCE – online – (over 5 weeks but equivalent to 3 days training) required content for DANCE proficiency
PIPE – (2 days face to face) PIPE training including observed skills practice + DANCE steps to link DANCE learning with use of PIPE
Toddler – (1 day face to face) a final day to consolidate learning with a focus on client graduation.

Each of these face to face training sessions has preparation and consolidation modules on the Moodle e-learning platform which nurses access. These modules provide resources to support individual and team learning.

Supervisor learning programme: 11 days over a 13-month period. The training includes the role of the supervisor + supervision model + developing the supervisory relationship + tools to support supervision + safeguarding supervision + leadership + teams + facilitating team learning + data + stakeholder engagement

- Changes to NFP education since the last report:
  The most significant change in this reporting period has been the requirement to move to virtual delivery for all training. This has required modification of the content as well as making use of facilities such as breakout rooms to enable small group work and skills practice. The clinical quality leads have had to attend to creating a virtual learning space that offers the same emotionally and physically safe learning environment. They have worked closely to support the sessional educators to work in this new environment and there are two cohorts of Family Nurses who have received all their training so far in a virtual environment. We are planning to offer these groups some additional face to face learning in the autumn to consolidate their skills.

- Successes/challenges with delivery of core NFP nurse/supervisor education:
  While virtual delivery has worked well in response to the restrictions imposed by the pandemic, it has been challenging for new nurses to have all their learning delivered in this way. They have reflected that they have not had the benefit of informal learning from the group and that this has been compounded by not having the usual opportunities for peer learning from colleagues in the team. Their experience of delivering the programme has only been in restricted conditions, using PPE and being unable to take equipment and materials into home visits. In the initial months they were also having to deliver a high number of contacts virtually. The National Unit is continuing to work closely alongside supervisors to ensure that new family nurses are able to meet their learning needs.

- Successes/challenges with ongoing (integration) NFP nurse/supervisor education:
  Teams have increasingly re-established team learning over the course of the year but again the virtual nature of this and the focus on responding to the challenges of the pandemic means that developing core skills for new family nurses may not have been fully attended to.

- Successes/challenges with delivery of NFP induction, education and CPD for associated team members (Family Partnership Worker/Mediator) N/A

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:
  The importance of supervision has been a strong and recurring theme throughout this challenging year. Between March – July 2020 the National Unit undertook focused work to understand what the initial impact of the pandemic was on practice. A survey completed by 217 family nurses indicated:
  - **93%** of nurses continued to receive weekly supervision with their supervisor with **80%** reporting it had been effective in confident decision making on prioritisation of client contact and **84%** that it had enabled them to maintain plans for safeguarding.
  - **79%** of nurses reported that supervision had helped them maintain healthy working boundaries, role clarity and professional boundaries.

Engagement with teams during the year has continued to reflect how crucial the maintenance of regular supervision has been for supporting ongoing assessment and analysis of vulnerable clients and their babies as well as for supporting the nurse's own wellbeing and resilience.

- Successes/challenges with reflective supervision to our supervisors:
  One of the strong themes that has been reported over the course of the year has been the value of psychological consultancy in supporting both the supervisor and the team to manage the ongoing uncertainty and anxiety caused by the pandemic. The supervisor's role in containing anxiety and enabling clear thinking and robust analysis of risk has been crucial and they have shown great resilience.
  Supervisors have offered each other support via informal networks and have also reported valuing the more frequent supervisor meetings facilitated by the National Unit.

- Successes/challenges with delivery of reflective supervision to our associated team members (Family Partnership Worker/Mediator) N/A

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. Since the implementation of the new information system, some issues have been raised with respect to the system functionality that might impact on data accuracy and data completeness. These have been addressed through guidance, escalating issues to the system provider and working to improve functionality where necessary.
The pandemic has clearly had some impact on programme activity. Data completion appears lower on some items, specifically on those pertaining to face to face assessments or observations. Also, the information system was not initially designed to capture the same level of detail for non- face to face contact as in the case of face to face contact. This functionality was only available from September 2020, when the new system went live.

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

Family Nurses enter data about their clients, and this data is delivered back to the nurse and supervisor through a collection of real-time interactive reports. Reports allow for drilling down to different levels of granularity. Visuals and data behind these are exportable. The National Unit has access to similar reports (pseudonymised 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 new information system was procured in order to address a number of limitations related to the outdated infrastructure of the old system built in 2009 and to support ongoing quality improvement. After its launch in September 2020, it became clear that the new system is by far superior to the legacy system, being more intuitive, having improved data validation and interactive reporting functionality.

This change has required both users in local areas and National Unit staff to embark on a learning journey in order to become familiar with the interface, with how the system works, how to use the reporting functionality to interrogate data and other helpful functionality that supports using data locally. Overall, the system was well-received by users and we feel that this major upgrade using modern software such as Power BI has contributed to users' personal development and will continue to do so in the future.

Continuous Quality Improvement (CQI) Program

- Brief description of CQI processes:
  Continuous quality improvement processes are embedded in the work of the National Unit – please see the description in part 4 describing this reporting period.

- How we use qualitative and quantitative information as part of our CQI program:
  Qualitative feedback from clients and practitioners is used alongside quantitative data from the information system as part of the CQI process. The new Turas information system is providing the opportunity to refine the data we collect and being part of PHE has increased opportunities to access and link with relevant national data sets. A workshop held in November 2020 highlighted a range of opportunities such as data linking to other relevant national data sets and analysis to derive FNP comparator groups from national datasets which we are keen to pursue in the future.

- Successes/challenges with our CQI approach: Please see part 4.

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

Any other relevant information:

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. **Please also explain any missing data or analyses as necessary and comment on data completeness where appropriate.**

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	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
	provided to the FAB.		
3. Client meets socioeconomic disadvantage criteria at intake	The socioeconomic disadvantage inclusion criteria for our country are: 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) 98% 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	92% of NFP clients receive their first home visit no later than the 28th week of pregnancy* % of eligible referrals who are intended to be recruited to NFP are enrolled in the program – see previous comment – this is collected and reported locally.	*This figure is for Q3 & Q4 2020/21 when this data was being collected on the new Turas system. Data errors were noted on the previous system and so this data has been excluded.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		20% of pregnant women are enrolled by 16 weeks' gestation or earlier	
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.	85% visits take place in the home (excludes virtual visits) % breakdown of where visits are being conducted other than in the client's home: 5% Family or friend's home 2% Community location 1% Doctor/ clinic 0% School/ college 1% Children's Centre 6% Other	57% visits delivered face to face 43% visits delivered virtually
7. Client is visited throughout her	National/Country benchmarks for:	• 87% of clients being visited on standard visit schedule	% based on last completed visit.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
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.	a) Program visit dosage patterns in relation to client strengths and risks benchmarks are: b) Length of visits by phase benchmarks: • Pregnancy phase: • Infancy phase: • Toddler phase: c) Client attrition by program phase benchmarks: 10% attrition in Pregnancy phase 20% attrition in Infancy phase 10% attrition in Toddler phase	• Average number of visits by program phase for clients on standard visit schedule –Please see comment box • 13% of clients being visited on alternate visit schedule • Average number of visits by program phase for clients on alternate visit schedule is please see comment box • Length of visits by phase (average): • Pregnancy phase: 67 mins • Infancy phase: 63 mins • Toddler phase: 63 mins Client attrition by phase and reasons: 8% attrition in Pregnancy phase 9% attrition in Infancy phase 7% attrition in Toddler phase	This metric would only make sense for graduates who have received the personalised programme from enrollment. It's too early to report on this. Same as above
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate	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	100% NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	None

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
/bachelor's degree.	confirmation of professional registration. Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.		
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula % of NFP team meetings, case conferences and team education sessions are completed (against expected for time period) see comment box	100% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities % completion of team meetings, % completion of case conference and % completion of education sessions - see comment box	We are currently unable to report on team meetings, case-based meetings and team learning due to the change in the Information system. Historically this was not collected on the information system and quarterly surveys were used to ascertain this information. These surveys were suspended during the pandemic and this information will in future be collected as part of the development of the new information system. Anecdotal feedback from nurses and supervisors has reported the importance of maintaining team meetings and team learning sessions and after some initial disruption it seems that teams have maintained this albeit virtually over the course of the year.
10. NFP nurses, using professional knowledge, judgment	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/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
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.			
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% of 4-monthly Accompanied Home Visits completed (against expected).	% of 4-monthly Accompanied Home Visits completed – see comment box	Supervisors have reported that accompanied home visits have largely been suspended during the pandemic. The National Unit has made it clear that while supervisors should undertake an accompanied home visit if there are clear clinical practice reasons for doing so, the expectation to meet the 4 monthly has been suspended. We have received mixed reports regarding the success of virtual accompanied home visits and have recommended that supervisors work alongside their nurses to exercise their clinical judgment about the appropriateness of this.
12. Each NFP team has an assigned NFP Supervisor who leads	100% of NFP teams have an assigned NFP Supervisor	100 % of NFP teams have an assigned NFP Supervisor	All teams have an assigned supervisor although managing long term sickness continues to be a

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
and manages the team and provides nurses with regular clinical and reflective supervision	100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurse).	% of reflective supervision sessions conducted – see comment box	challenge on occasion. We are unable to report on the % of reflective supervision sessions conducted as previously this was not collected on the information system and quarterly surveys were used to ascertain this information. These surveys were suspended during the pandemic and this information will in future be collected as part of the development of the new information system.
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: The work of the data team in partnership with the clinical quality and implementation team.	Progress: The introduction of the new Information system has provided an opportunity to review and update data collection and data reporting. The new Turas system was launched in September 2020 and work is ongoing to finalise the management reporting which will enable the National Unit to fulfil the function described here.	The change from the previous data system to the new data system is both a challenge and an opportunity. The new system provides functionality at both site and national level to guide implementation and quality improvement of the programme. We will have improved ability to demonstrate programme fidelity and assess indicative client outcomes as well as guiding practice. In order to ensure that the implementation of the new personalised service delivery model

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			could be monitored a temporary reporting dashboard was set up to draw data from both systems during the changeover period.
14. High quality NFP implementation is developed and sustained through national and local organized support	100% of Annual Reviews or equivalents held in relation to expected 80% attendance at Advisory Boards held in relation to expected. Monitored/assured by (including other measures used to assure high quality implementation): Quality improvement and development leads who attend Annual reviews and report on a quarterly basis.	78 % of Annual reviews or equivalents took place 81% National Unit attendance at Advisory Boards	At the start of the reporting period the National Unit put a pause on Annual Reviews. This pause was lifted in June 2020 and sites who had reviews that had been due during the pause were asked to set a date before the end of the calendar year. The Annual Review paperwork was reviewed using quality improvement methodology with final testing taking place in Q4. This includes a new site self-assessment against key core model elements which supports both site fidelity and National Unit quality assurance.

Domain coverage*

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

NB: FNP England no longer collect data across the six domains – please see commentary below.

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)						

Maternal Role (My Child and Me)						
Environmental Health (My Home)						
My Family & Friends (Family & Friends)						
Life Course Development (My Life)						

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
With the introduction of the personalised service delivery model and use of the New Mum Star, this data is now being collected across the nine areas of the New Mum Star. The Turas information system collects this data on every nurse visit and by next year we will be able to report on this as part of this annual review. Findings from ADAPT and initial review of the data on the new system suggests that the focus of the work continues to be in the maternal role domain.

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. Please explain any missing data or analyses and comment on data completeness where appropriate.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous 3 year(s) (n/%)**	**Current Period (n/%)**
Age (range and mean)	<15: 211 (2.3%) 15: 565 (6.2%) 16: 1432 (15.6%) 17: 2121 (23.1%) 18: 2409 (26.2%) 19: 1845 (20.1%) 20+: 600 (6.5%)	<15: 46 (1.9%) 15: 130 (5.5 %) 16: 370 (15.5%) 17: 520 (21.8%) 18: 591 (24.8%) 19: 451 (18.9%) 20+: 275 (11.5%)
Race/ethnicity distribution	Asian/Asian British: 240 (3.0%) Black/African/Caribbean/Black British: 546 (6.7%) Mixed/multiple ethnic groups: 469 (5.8%) Other Ethnic Group: 182 (2.2%) White: 6707 (82.4%)	Asian/Asian British: 61 (3.4%) Black/African/Caribbean/Black British: 112 (6.2%) Mixed/multiple ethnic groups: 106 (5.9%) Other Ethnic Group: 32 (1.8%) White: 1489 (82.6%) Not Stated: SUPP (SUPP)
Father involvement with client	Question not asked previously	Baby's father involvement Every day: 563 (66.9%) Less often than once a month: 29 (3.4%) Less often, but at least once a month: 35 (4.2%) Less often, but at least once a week: 92 (10.9%) Never: 123 (14.6%)

		Note: data available from 21st Sep 2020 onwards
Income (please state how this is defined)	Question not asked previously	Clients receiving income benefits: No 206 (24.5%) Prefer not to say/Don't know 129 (15.3%) Yes, this accounts for all of the household's income 251 (29.8%) Yes, this accounts for some of the household's income 256 (30.4%) *Note: data available from 21st Sep 2020 onwards*
Inadequate Housing (please define)	Clients who are homeless: 377 (4.7%)	Clients who are homeless: 86 (4.8%)
Educational Achievement	Clients who have completed school: 6586 (81%) Clients who are enrolled in educational programme: 2163 (26.6%) Clients with academic or vocational qualifications: 5930 (72.9%)	Clients who have completed school: 1421 (78.8%) Clients who are enrolled in educational programme: 519 (28.8%) Clients with academic or vocational qualifications: 1159 (64.4%)
Employment	Clients in education, employment or training (EET): 3596 (44.2%)	Clients in education, employment or training (EET): 806 (44.7%) *Note: data available from 21st Sep 2020 onwards*
Food Insecurity (please define)	Not collected	
In care of the State as a child	Clients on a social care plan (CPP/ CIN) and LAC: 2144 (25.9%) *Note: data needed to be aggregated together across different social care involvement categories to be able to include data pre-migration*	Clients on a social care plan (CPP/ CIN) and LAC: 425 (23.0%)
Obesity (BMI of 30 or more)	Not collected	
Severe Obesity (BMI of 40 or more)	Not collected	

Underweight (BMI of 18.5 or less)	Not collected	
Heart Disease	Not collected	
Hypertension	Not collected	
Diabetes – T1	Not collected	
Diabetes – T2	Not collected	
Kidney disease	Not collected	
Epilepsy	Not collected	
Sickle cell Disease	Not collected	
Chronic Gastrointestinal disease	Not collected	
Asthma/other chronic pulmonary Disease	Not collected	
Chronic Urinary Tract Infections	Not collected	
Chronic Vaginal Infections (e.g., yeast infections	Not collected	
Sexually Transmitted Infections	Not collected	
Substance Use Disorder	Clients receiving substance abuse services at intake: 948 (10.8%)	Clients receiving substance abuse services at intake: 167 (8.7%)
Mental Illness	Clients receiving mental health services: 2573 (26.6%)	Clients receiving mental health services: 490 (24%)
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.

The table above shows that FNP clients continue to have high levels of vulnerability. Almost 90% of clients are teenagers. 23% of clients had some form of social care involvement such as being on a child protection plan, child in need plan or been looked after. Around 45% of clients are in education, employment or training and over 60% of clients enrolled who were active within the reporting period rely on benefits that accounts for some or even all their household's income.

Alterable Maternal Behaviour/ 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) **Anxiety in moderate/clinical range -** *combines HADs (threshold: 8+) and GAD7 (threshold 10+)*	183 (27.2%)	276 (29.6%)	116 (29.1%) at 8-12 weeks infancy	11 (35.5%)	14 (35.9%)
Depression, (n, % moderate + clinical range) **Depression in moderate/clinical range -** *combines HADs (threshold: 8+), PHQ9 (threshold 10+) and EPDS (threshold 10+)*	116 (16.9%)	140 (15.0%)	59 (14.8%) at 8-12 weeks infancy	18 (43.9%)	16 (35.9%)
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours) *Note: data available from 21st Sep 2020 onwards*	203 (55%)	130 (47.1%)	263 (34.3%)	243% (31.9%)	230 (37.6%)
	Clients who smoked at all during pregnancy - 36 weeks: 702 (44.9%)				
Alcohol, (n, % during pregnancy, units/last 7 days)	SUPP	SUPP	21 (2.3%) at 6 months	26 (3.1%)	21 (3.0%)

Note: data available from 21st Sep 2020 onwards					
Class A drugs (n, % used in pregnancy, days used last 14 ays)	SUPP	SUPP	SUPP	SUPP	SUPP
Class B drugs (n, % used in pregnancy, days used last 14 days) *Note: data available from 21st Sep 2020 onwards*	SUPP	SUPP	SUPP	SUPP	SUPP
Other street drugs - Cannabis, (n, % used in pregnancy, days used last 14 days) *Note: data available from 21st Sep 2020 onwards*	34 (1.9%)	34 (2.2%)	21 (2.3%)	26 (3.1%)	21 (3.0%)
Excessive Weight Gain from baseline BMI during pregnancy (n, %)	Not collected				
Mastery, (n, mean)	Clients with low mastery score: 395 (22.7%)	Clients with low mastery score: 319 (21.3%)	Clients with low mastery score: 197 (21.9%)	Clients with low mastery score: 167 (20.3%)	Clients with low mastery score: 127 (18.7%)
IPV disclosure, (n, %)	5-7th pregnancy visit: 403 (29%)		8-12 weeks infancy: 446 (28.4%)	12 months: 212 (31.7%)	14 - 18 months: 166 (43.3%)
	6 Months	**12 Months**	**18 months**	**24 Months**	

Reliable Birth Control use, (n, %) Clients using long-acting reversible contraception (LARC)	468 (28.4%)	579 (35.1%)	433 (33.0%)	430 (36.6%)	
Subsequent pregnancies, (n, %)	42 (5.9%)	117 (15.7%)	129 (21.6%)	137 (23.4%)	
Breast Feeding, (n, %) *Note: data available from 21st Sep 2020 onwards*	96 (13.3%)	72 (9.9%)	26 (4.5%)	10 (1.8%)	Breastfeeding - at birth: 359 (40.9%) clients breastfeeding - at 6 weeks: 262 (31.2%)
Involvement in Education, (n, %)	Clients in EET: 392 (23.9%)	Clients in EET: 482 (29.3%)	Clients in EET: 419 (32.0%)	Clients in EET: 426 (36.3%)	
Employed, (n, %)					
Housing needs, (n, %)	Not collected				
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	Not collected in this format				
Father's involvement in care of child, (n, %)	Daily: 741 (45.2%) At least once a week: 290 (17.7%) At least once every 2 weeks: 32 (2.0%) At least once a month: 130 (7.9%) Less than once a month 50 (3.1%) Never 395 (24.1%)	Daily 667 (40.8%) At least once a week 341 (20.8%) At least once every 2 weeks 28 (1.7%) At least once a month 132 (8.1%) Less than once a month 40 (2.4%) Never 429 (26.2%)	Daily 461 (35.3%) At least once a week 272 (20.8%) At least once every 2 weeks 30 (2.3%) At least once a month 119 (9.1%) Less than once a month 31 (2.4%) Never 392 (30.0%)	Daily 403 (34.5%) At least once a week 256 (21.9%) At least once every 2 weeks 25 (2.1%) At least once a month 100 (8.6%) Less than once a month 27 (2.3%) Never 357 (30.6%)	

Other (please define)					

SUPP- Numbers under and equal to 5 and associated % have been suppressed to protect confidentiality.

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)**:**

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

Which are the areas of challenge?

The summary data around maternal outcomes indicate a similar picture as last year. Around 40% of clients breastfed their babies at birth and 31% were still breastfeeding at 6 weeks after birth. The official statistic for England for the same period 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.

High levels of anxiety continue to be apparent for FNP clients across the duration of the programme, with up to 30% experiencing moderate to severe anxiety by 36 weeks in pregnancy. This continues to reflect 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 later time points need to be viewed cautiously as they reflect a very small number of clients and the pandemic may have had an impact on the family nurses' ability to screen for anxiety and depression. 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.

The apparent high levels of smoking need to be interpreted with caution as the data was only collected in this format starting with September 2020. Smoking prevalence is higher in the FNP cohort when compared to smoking prevalence in all women in England at the time of delivery which is 10%. However, no national comparable figures are available for women of similar age groups and with characteristics similar to the cohort FNP clients,

Whilst recorded levels of illegal drug use remain low and the data has only been collected in the current format since the start of the new information system in September 2021, 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.

The levels of IPV disclosure remain high with particularly concerning rates for the 14-16 month assessment point of 43.3%. The international IPV adaptation was tested in 8 FNP sites as part of the ADAPT project and the learning from that will be implemented across all teams from Autumn 2021 onwards. This implementation was delayed due to the pandemic but remains a key priority for the National Unit.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	10	0.4%
Very preterm (28-32 weeks' gestation)	32	1.4%
Moderate to late preterm (32-37 weeks' gestation)	348	15.3%
Low birthweight (please define for your context) Babies with low birth weight (<2500g)	150	8.8%
Large for Gestational Age (LGA) (please define for your context) (>4000g)	167	9.9%
Other (please define)		

Please comment below on your birth data:

Around 77 per 1,000 babies are born prematurely in England so the figures for this reporting period at 17.1% reflect a higher prevalence for a population that is at higher risk of preterm labour. Almost 9% of FNP babies had low birthweight. This is marginally higher than the national average of 7%. 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	1550 (90.8%)	1383 (87.7%)	1160 (92.1%)	1055 (94.8%)
Hospitalization for Injuries	16 (0.9%)	18 (1.1%)	9 (0.7%)	14 (1.2%)

ASQ scores requiring monitoring (grey zone) ASQ scores requiring further assessment/referral	Children with ASQ scores outside normal range at 4 months Communication: 61 (3.5%) Gross Motor: 184 (10.6%) Fine Motor: 196(11.2%) Problem Solving: 79 (4.5%) Personal Social: 73 (4.2%)	Children with ASQ scores outside normal range at 10 months Communication: 78 (4.7%) Gross Motor: 294 (17.9%) Fine Motor: 167 (10.1%) Problem Solving: 118 (7.2%) Personal Social: 100 (6.1%)	Children with ASQ scores outside normal range at 20 months Communication: 222 (19.7%) Gross Motor: 98 (8.7%) Fine Motor: 109 (9.7%) Problem Solving: 91 (8.1%) Personal Social: 108 (9.6%)	Children with ASQ scores outside normal range at 24 months Communication: 236 (20.7%) Gross Motor: 106 (9.3%) Fine Motor: 125 (11.0%) Problem Solving: 63 (5.5%) Personal Social: 154 (13.5%)
ASQ-SE scores requiring monitoring (grey zone) ASQ-SE scores requiring further assessment/referral	Children with ASQ:SE scores outside normal range 8 (0.5%)	Children with ASQ:SE scores outside normal range 19 (1.3%)	Children with ASQ:SE scores outside normal range 49 (4.3%)	Children with ASQ:SE scores outside normal range 70 (6.6%)
Child Protection (please define for your context) Children on child protection plan -	212 (21.2%)	132 (13.7%)	97 (12.8%)	80 (11.1%)
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 94.8% of babies on the programme having up to date immunisations at 24 months. Although national figures are not yet available, 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 a small proportion of children 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: 20%; England: 11%). In contrast, a slightly smaller percentage of FNP children require further monitoring or referral for problem solving skills compared to the national average (FNP: 5.5%; England: 6.1%). These comparisons need to be approached with some caution since FNP clients are assessed at 24 months whereas the window for the England cohort extends to 30 months.

Following the publication of the Building Blocks 2-6 findings attention is focused on the safeguarding measures used in that study. It is interesting to note that over this reporting period figures for hospitalisation remain low. The figures for children subject to a child protection plan reflect a higher percentage earlier in the programme decreasing over time and while these figures do not reflect tracking of individual children it will be interesting to continue to monitor this pattern. The Turas information system will enable us to collect and collate safeguarding data much more efficiently than we were able to under the old system. Safeguarding data collection is being built into the functionality of the system so it can be collected in a contemporaneous way rather than collection at specified timepoints.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts A number of additional analytical initiatives are currently in progress. A specification for a new site level dashboard has been compiled and there are plans in place to implement this in the financial year 21/22. This will provide an overview of programme activity, client characteristics, vulnerability and programme outcomes and will support local sites in preparing for FABs and ARs and evidencing impact locally and acknowledge the complexity of the client cohort. The data team is currently leading on a project exploring determinants of cognitive and social-emotional development of FNP children in toddlerhood. As part of this project we are seeking to understand if there is any evidence of inequalities in child cognitive and social-emotional development in given maternal vulnerability profiles at intake and whether elements of the FNP programme are associated with child cognitive and social-emotional development
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.

Understanding the impact of the pandemic has been a priority throughout the year and the materials below reflect something of both client and practitioner experiences.

Towards the end of the first period of lockdown July 2020) the National Unit asked clients to complete a survey to feedback on their experiences with over 200 responses received.

One of the questions asked about what was valuable about FNP during this time: below are a selection of some of the responses reflecting client's thoughts.

'Having a Family nurse and knowing she will answer the phone'

'I learn something new every session with my family nurse and it also gives me something to look forward to! All the advice and support has given me new knowledge'

'Hearing a familiar voice telling me I'm not going crazy'

'having someone to contact easily'

'My family nurse was able to support me virtually…knowing I could contact her supported my mental health too'

'the only person outside of the accommodation I have seen face to face is my family nurse. She comes in PPE which feels strange, but I prefer that than virtual video call.'

'having the support of someone I knew and was reliable and trusted'

'Being able to contact nurse directly and easily. Knowing I would be supported'

'It has been great to have any questions that I have answered. It has stopped me feeling isolated and time with the FN explaining things I should do and telling me that I'm doing well has helped me feel confident and reduced my anxiety'.

'You kept me sane. You are the only person I have seen outside my family. I look forward to your visits. Outside contact made me feel good as a parent. I was doubting myself then I saw you. We did a developmental check and my son scored highly and it made me think yes I am doing well at this parenting thing.'

'I thought the contact with the family nurse would end in the lockdown but my family nurse continued working as she would'

'It was great still having the support from my family nurse. We continued having the visits via phone, video call and home visits'

'Being able to talk to somebody about anything has helped.'

'It was great to be able to chat to M on the phone or using WhatsApp. She dropped off the information, so I was able to do reading before our calls. I had lots of information which helped me, and I felt more prepared before T was born.'

'Relationship with Family Nurse has allowed the ongoing emotional support to continue although she was redeployed to another area for a short time'

'We went for social distance walk and was nice to go out the house and not see four walls and fresh air – I have since been out for more walks and I was glad to of seen my family nurse as I feel better after'

'Having regular contact and going for walks face to face have helped me cope and to learn about my new baby'.

'good listener; easy to contact; always replies; information is easy to understand'

'Continued connection'

'I look forward to my sessions and I'm glad this could still happen as everything else seemed to stop'

'It was good to have a consistent person I could trust through a difficult and stressful time'

'Having someone to talk to and support me especially when my mental health worsened'

'she kept on texting and then visited even when I didn't respond and encouraged me'

'my FN has continued to be in contact. Thinking about my baby's development being able to think about play activities and what I can do with her has been helpful. I had someone to talk to, I wasn't on my own and had a safe space.'

'Speaking to my nurse, seeing her on Visionable and best of all when she started visiting face to face. She has helped me with domestic violence work and supported me with child protection meetings and goals.

'Gives me a bit of sanity. Domestic abuse and had to move out of home during lockdown. Would not have happened if not for family nurse.'

The second item is a blog written by a family nurse about adapting to the first pandemic lockdown

Rising to the challenges imposed by Covid-19

Susan Wilson, family nurse at FNP Gateshead describes how she and her colleagues are adapting to cope in delivering FNP during these uncertain and difficult times.

With change comes challenge, and our small team in Gateshead, on the southern side of the Tyne, has had like every FNP team, to confront and respond to sudden, huge change in a very short space of time.

Having worked as a family nurse for the last eight years, I felt off balance and disorientated, with a sense of "loss" including, fundamentally, of not being able to move around freely and I know other family nurses will be feeling the same. There's also a form of loss in being unable to deliver such a vital programme as FNP in our usual way. In helping safeguard, protect and support the most vulnerable, FNP is needed in this time of upheaval, uncertainty and isolation more than ever.

If this is what I and other family nurses are feeling, what must our clients be experiencing right now as young, first-time parents or parents-to-be?

Some of our clients already live with mental health struggles and the risk of abuse within relationships. The tension, stress and overwhelming feelings at this unprecedented time mean some people will struggle, understandably so, and we need continued 'eyes on the child' to make sure the needs of babies and children are being met.

Keeping faith, being mindful and, above all, keeping children at the centre of our focus does not change. We are doing everything we can to continue working with our existing partner agencies with a shared belief in safeguarding our most vulnerable clients – those young people and children most at risk from experiencing neglect, suffering abuse, and who struggle with day to day life.

As practitioners, it is vital that we all continue our important work by any means possible, modifying our approaches and tactics so that our clients' individual needs can continue to be met. While our hospital-based nursing colleagues work tirelessly in critical care, our community nursing role is just as important during this time.

So how have we adapted what we do?

Well, it has been a positive and thought-provoking experience, looking at how I work at a time of change, with the findings and learning of the ADAPT project in mind – a project all about doing things differently. I feel proud to have been part of ADAPT and I can vouch that a more personalised model of FNP delivery works well.

During the Covid-19 outbreak, this approach to change has involved thinking about the resources available to me and how I now need to adapt what I do to achieve the same outcomes. It has reaffirmed my passion and desire to continue to deliver the FNP programme to our most vulnerable.

On the practical side, thank heavens for technology and those providers that have responded quickly by equipping us with what we need to continue to work during these demanding times.

Thank goodness also for a supervisor who is so supportive and adaptable, offering video call supervision, and weekly and daily updates. These all help further strengthen the team, binding us together in shared knowledge and clear guidance – an antidote and balm in these far from certain times.

This past week has seen contacts and sessions delivered via video call, for example using WhatsApp and Messenger, backed up by sending the programme content out electronically (something new for all of us).

The content, structure and connection between client and nurse has been maintained. While initially this felt 'weird', by exploring threads from the most recent face-to-face visits and linking that into the core programme, electronic and online engagement soon felt much more fluid, while the discussion and sharing of insight and learning by both client and nurse once again became very meaningful and pertinent. I believe this has been particularly beneficial for some clients.

What quickly become apparent in our team is how, alongside sound clinical judgement, the depth of the therapeutic relationship between client and nurse, and the emotional intelligence and communications skills used by family nurses help both facilitate and support the video call sessions. Clients have welcomed the contact and embraced the change.

Delivery of the programme via video call, is very much helping address shared anxieties, while at the same time keeping clients and children at the centre of our care and, in the case of video calls, quite literally in our sights, too. Appreciation of how much our clients are valuing the video contact has been uplifting.

Changed times offer valuable opportunities and moments to reflect. There has been the need to radically change how visits are delivered, but without sacrificing our ability to meet the needs of our clients and their families. Active reflection as a team has been invaluable to consider how best to ensure that individual contact is maintained. Here, the therapeutic relationship that lies at the heart of FNP underpins all we do.

The weeks ahead are going to be full of change and challenge, but we have tools in the kit bag that can help. Clients and children are relying on us to adapt and meet the challenges head on, both as a team and as individuals. This knowledge only strengthens our resolve.

With the robust framework of the Family Nurse Partnership programme, support from kindred FNP teams, strong internal models of supervision, tried and tested programme content, and close support from the FNP National Unit, plus our own team spirit of can-do and resilience, we can face this challenge with confidence.

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	**2**	**Both were sudden unexpected infant deaths at 5 weeks and 8 weeks of age. In each case clients were highly vulnerable with histories of trauma and abuse. In both cases children's social care were involved and domestic abuse was a shared feature. One of the babies had been born prematurely.**
Maternal death	**0**	
Other	**5**	**Over the reporting period there were five reports of children who were harmed. There were some common features in all these cases around the level of vulnerability of the parents who had histories of multiple trauma.** **In two cases the impact of pandemic restrictions meant that babies were not as visible, and this appears to have been used to further avoid contact with professionals. Both families were open to children's social care.** **In a third case the lack of face to face contact may have contributed to a delay in presentation at ED for a baby with an undiagnosed congenital heart condition. These cases occurred early in the pandemic and concerns were escalated through appropriate channels in PHE. The recognition that face to face contacts were essential for vulnerable families and needed to be maintained using appropriate risk assessments and PPE was vital in safeguarding vulnerable children during the national lockdowns.** **The tenacity and commitment of family nurses to multiagency working was also a notable feature.**

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, 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 and Development 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 implementation of the personalised service delivery model and the introduction of the new Turas information system both mark important steps on the journey of continuous quality improvement. Both have been implemented in a period of great pressure and uncertainty and it is a testament to all those involved that early implementation has gone well.

The impact of the pandemic has meant that over the reporting period considerable focus has been on maintaining a safe, quality service in line with the national and local restrictions. The clinical quality and implementation team have provided additional means of monitoring implementation of the programme during this unprecedented time. These have included two rounds of telephone audits with individual supervisors which elicited 102 responses. 12 additional supervisor meetings to provide a space for support and sharing of good practice as well as flagging risks and issues. Individual site support in response to particular challenges and the sharing of practice guidance to support ongoing programme delivery.

- Outcomes of CQI program for the reporting period

The continuous quality improvement programme has been responsive to the pandemic and maintained momentum at a time of unprecedented challenge. The markers of quality are embedded in the programme structure and the importance of these, particularly the core model elements around team meetings and supervision, have been integral to the maintenance and delivery of the programme over this period.

The initial evaluation of personalisation indicates that nurses are engaging with the new personalised approach and we will continue to monitor this to ensure that the changes become embedded in practice.

The Turas information system has been well received and it is being well used. Engagement in the user group is high and there is a really strong sense of collaborative work to maximise the full potential of this new system.

- Lessons learned from CQI initiatives and how these will be applied in future:
  One of the lessons learnt in last years report was the importance of good implementation in achieving outcomes and a commitment to using that expertise as personalisation and the new information system were introduced. This has been a fundamental guiding principle for both these significant implementation projects and has been particularly important when assessing the most appropriate time to introduce personalisation, having paused implementation at the start of the pandemic. It has enabled the successful introduction of both these changes in the midst of a time when practitioners were managing high levels of uncertainty and pressure.

  Remaining true to core principles, holding clear expectations and using the multidisciplinary expertise of the National Unit team has enabled the anxiety associated with change to be contained and a robust process of implementation to be followed. This will continue to be central to the approach as we face the ongoing challenges of the pandemic and the restructuring of the public health system in England.

- Goals for CQI in next year:
  To use continuous quality improvement to monitor the ongoing implementation of personalisation and the new information system and to assure that they have positive impact on FNP across.
  We are also undertaking a review of the learning programme and the quality assurance framework that supports that work and we are applying a continuous quality improvement approach to that work.
  We will also be implementing the learning from the neglect and IPV adaptations which were tested as part of the ADAPT project.

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

- Program innovations tested[1]:

- Program innovations implemented:
  Personalisation
  Turas information system

- Findings and next steps:
  Initial implementation is going well and this will continue to be evaluated over the coming year.

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

Additional Approved Model Elements (AAMEs)

Please attach a summary of findings in relation to any Additional Approved Model Elements in Appendix 3 to this document

Research and evaluation

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

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

There continue to be good links with the academic community. Members of the National Unit sit on the steering Committee of a project evaluating the real-world implementation of the FNP in England. The project uses data linkage of a number of administrative datasets and is led by Katie Harron (University College London). A first paper looking at predictors of enrolment in FNP is due to be submitted for publication in May.

Data has recently been shared with Gabriella Conti (University College London) who submitted a proposal for a research project exploring the impact of the pandemic on vulnerable families and their children.

Commission for evidence:

- Keele University – a synthesis of the evidence for digital approaches. This is an academic review of the evidence for effective use of digital contact particularly for vulnerable client groups.
- Newcastle University – a rapid review of the evidence on the impact of the Covid 19 pandemic on sensitive and responsive parenting
- Oxford Brookes University – an integrative review of the evidence on intensive parenting support in England.

PART FIVE: ACTION PLANS

LAST YEAR:

Our planned priorities and objectives for last 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.

Progress against those objectives:

As detailed in this report we have made good progress against all the planned priorities and objectives that we set out for the year apart from implementing the learning from the IPV and neglect adaptations. The delay to implementation of the personalised service delivery model and our learning from ADAPT about adopting a staged approach to implementing changes to practice, meant that a decision was taken at the start of the year to delay this work until 2021/22.

Reflections on our progress:

This year has been unprecedented, and the National Unit has continued to set a highly ambitious programme of work to ensure that the needs of vulnerable families are addressed. The challenge of integrating into a new organisation virtually and engagement in preparations for further transition has required ongoing attention to team functioning and application of skills and expertise across the National Unit. When reflecting on progress the quantity and quality of the work delivered reflects a high functioning team with clear vision and values which drive purposeful work. The pandemic has shone a light on the ongoing pressing demand for this work and the expansion of the remit to develop a wider offer utilising National Unit expertise will shape our work over the coming year.

NEXT YEAR:

Our planned priorities and objectives for next year:

- To sustain and develop the FNP programme in England including ongoing evaluation of the implementation of personalisation
- To implement the learning from the IPV and neglect adaptations
- To implement the outcome of the Learning and implementation project
- To support the transition to the new public health arrangements following the restructure of PHE

• To lead on the development of a national parenting support offer as part of the Best Start in Life Programme.
Measures planned for evaluating our success: • Ongoing quality assurance of FNP programme delivery across England leveraging the benefits of the new Turas information system • Successful transition and integration into the new organisation following the public health reforms • Implementation and evaluation of the new learning programme • Delivery of the wider national offer on parenting support.
Any plans/requests for program expansion? • Initial conversations are underway in one Local Authority area that previously decommissioned FNP and may be keen to consider commissioning the service again. • The positioning of the National Unit as part of PHE and the publication of the Building Blocks 2-6 findings has opened up opportunities for FNP reach beyond those areas that currently commission it and there is continued work to leverage these opportunities.
FEEDBACK FOR UCD INTERNATIONAL TEAM:
The most helpful things we have received from the International team over the last year have been: • The international Covid-19 project • The international Clinical Advisory Group meetings and the data and analysis meetings • The work around the IPV pathway and the development of the Trauma and Violence informed working group. • Liaison on the Building Blocks 2-6 findings.
Our suggestions for how NFP could be developed and improved internationally are: Ongoing opportunities to share internationally and present more widely e.g. IPV presentation at the conference in September The sharing of the evidence for DANCE is a priority for FNP England
This what we would like from UCD through our Support Services Agreement for next year: Continued coordination of the CAG, Data and research forum and TVIC group and coordination of the international project Annual review The sharing of the evidence for DANCE is a priority for FNP England Clarification of the structure and governance of NFP as a whole to enable aligning with our national governance Discussion about how NFP developments could be applied to the current English context of integration

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:

- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- Liaison and expert guidance regarding the Building Blocks 2-6 findings.
- COVID-19 project, in which resources and learning has been rapidly shared between countries and shared principles for continued use of telehealth within NFP/FNP have been developed.
- 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 additional opportunities for international collaboration and networking, such as the data analytic and research-leads forum, the PIPE education group and the international meetings regarding DANCE implementation and use of data.
- Access to expert consultation re IPV from Dr Susan Jack and learning from other countries adapting and testing the intervention
- Facilitating the sharing of good practice between countries on particular topics.
- Sharing new NFP international research outputs from all countries via the website and through the international research seminars.
- Promoting NFP internationally as an example of a program that ensures high quality replication in all contexts and maintains its international reputation for effectiveness and quality.

Identified strengths of program:

- The commitment, talents and resourcefulness of the National Unit, resulting in continued adaptation and development of program implementation and an exemplary annual report
- The ability of the leadership and local teams to adapt to the challenging environment created by the COVID pandemic and to continue to provide a service to clients in times of great challenge, whilst at the same time continuing to undertake a wide ranging program of quality improvements
- The continued ambition of the National Unit to achieve the best results possible on behalf of the families served
- The ability of the nurses to develop and maintain purposeful relationships with clients, as exemplified by the outstanding retention rates set out in this report, and their growing ability using the New Mums Star to adapt the program to their individual needs
- The collaborative approach to program adaptation, in which learning from the frontline is developed and thoughtfully integrated into processes and program adaptations.
- The continued development of the Information system and the high-quality analysis of data evident in the annual data report

- The transition of the National Unit into PHE and the continued strategic support for NFP at a national level
Areas for further work: The following areas were discussed as part of the review; - Consideration of further work with regards to maternal health in pregnancy , especially maternal obesity - Monitoring the impact of the new approaches to smoking cessation, and whether CO measures could be captured as data to assess this - Use of Mastery scores to evidence levels of client need at intake and to enhance nurse targeting (international guidance is being developed to support this)
Agreed upon priorities for country to focus on during the coming year: As detailed in part 5, with consideration of the additional areas above
Any approved Core Model Element Variances: - CMEs 4 &7 (see below) - The ongoing evaluation of these variances is appreciated and we are pleased to see that decisions have been taken regarding the importance of work in pregnancy (CME4)
Agreed upon activities that UCD will provide through Support Services Agreement (March 21-22): - Monitoring of the license and oversight of fidelity - CME Variance monitoring - Expert input on research findings (RCT follow up) - Ad hoc additional consultation

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

Appendix 2: Evaluation of temporary CME variances

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

CME #: 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
Temporary Variance to CME agreed:
Late gestation enrolment was tested as part of the ADAPT project however following the end of the project it was agreed that we would continue with the 28 week gestation CME in recognition of the importance of the work during pregnancy. The only exceptions to this will be concealed pregnancy and clients who move into a new area which offers FNP later in pregnancy. We expect numbers to be low and the guidance makes it clear that these late recruitments will need to be reported to the FAB as exceptions on a quarterly basis.
Brief description of approach taken to testing the variance:
Testing was undertaken and monitored as part of the ADAPT project.
Methods for evaluating impact of variance:
Routinely collected data allows for monitoring gestational age at the time of enrolment in the FNP programme. The following will be included in the annual report for discussion and analysis as follows: # and % of clients enrolled by ~~before~~ 28 weeks (early gestation) – 92% of Q3 & Q4 # and % of clients enrolled after 28 weeks (late gestation), to include # and % by week from 28 weeks – # and % of clients enrolled after 28 weeks who meet the guidance criteria for late enrolment – this is not recorded nationally but monitored locally via exceptions reporting at Annual reviews. Analysis of the characteristics of clients enrolling after 28 weeks, compared to those enrolling before 28 weeks – see commentary below Over time, analysis of the dosage and attrition of clients enrolled post 28 weeks compared to those enrolled before 28 weeks -We do not yet have enough data to analyse and on the basis that following the testing in the ADAPT project we have returned to the 28 weeks gestation CME with only concealed/ late presentation as an exception we are unlikely to have large enough numbers to enable robust analysis. # = numbers, % = percentages To ensure appropriate ongoing reporting of programme outcomes, especially for outcomes reported in pregnancy, the site and national-level reports will be adapted to allow for comparisons between clients recruited in early and late gestation. This process will begin as soon as a new information system is in place in 2020/21.
Findings of evaluation to date:
Preliminary analysis covering the last financial year comparing characteristics of clients enrolled in late gestation (after 28 weeks) compared to those enrolled earlier shows that when looking at each characteristic separately, no statistical significant differences could be detected. However, when taking into account cumulative vulnerabilities, clients recruited in late gestation appear to

be on average more disadvantaged compared to those recruited in early gestation. This difference was of borderline statistical significance ($p<0.05$).
Characteristics taken into account: relationship status, ever lived away from home, whether client completed school, NEET, age (under 16), receiving benefits, historical social care involvement, whether baby had a pre-birth assessment, smoking status, learning difficulties, housing tenure and mental health.

These findings need to be interpreted with caution as we are still undergoing some checks following the data migration to reconcile some records and therefore, this analysis should be regarded as provisional.

Please note that due to some discrepancies identified in the data collected in the old system, this analysis includes Q3 and Q4 data only. To assess the impact of excluding a selection of data, the analysis was also carried out on the full dataset which produced very similar results. This shows minimal impact of the data discrepancies on analysis results.

CME #: 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

Temporary Variance to CME agreed:

Graduation of clients when their babies are between the age of 1 and 2 years

Brief description of approach taken to testing the variance:

As part of the ADAPT project we tested early graduation. Early graduation enabled clients to graduate from the programme when their child was between 1 and 2 years of age. The reasons for testing this were:
1. All FNP teams across the country keep a 'waiting list' for places, some are longer than others with many teams unable to fully meet the need.
2. There was growing anecdotal evidence of clients doing very well in late infancy/early toddlerhood, so much so that they disengage from the programme.
3. Family nurses told us there are some clients who in their clinical judgement no longer need the support the programme offers, or do not need it as much as others may.
4. Early graduation gives the opportunity to celebrate clients' successes and to offer a much needed place to another client.
5. In this time of austerity and funding cuts we have to continue to consider ways of targeting FNP at those most in need and therefore making FNP more cost effective.

Methods for evaluating impact of variance:

Routinely collected data allows for monitoring, a range of client characteristics, the age of the child at the time of graduation from the FNP programme and a range of developmental outcomes. The following will be reported to UCD on an annual basis:

1. Graduation overview	# and % of clients who graduated when their child was between 12 months and 22 months of age (out of all clients who graduated during the period). Distribution of child's age at graduation during the period
2. Evidence of the use of the New Mum Star to support collaborative decision-making between Family Nurse and client	# and % of clients who graduated when their child was between 12 months and 22 months of age, with at least two collaborative New Mum Star assessments completed in pregnancy and infancy (out of all clients who graduated during the period)
3. Characteristics and developmental outcomes of children whose parents graduated between 12 and 22 months compared to their counterparts who graduate at the end of the programme.	For each of the two groups of graduates: # and % of children with physical development within normal range as indicated by the most recent ASQ-3 score

and % of children with social-emotional development within normal range as indicated by the most recent ASQ-SE score

ASQ3 can be broken down by communication, gross motor, fine motor, problem solving and personal social in order to gain insight into language development and behavioural issues between those who graduate before two years and those who graduate at two years with the aim of identifying any developmental differences for those graduating before two years.

1. Life circumstances of clients who have graduated before 24 months compared with those that complete the program	For each of the two groups at point of program graduation: # and % of clients in employment or education # and % of clients living alone

Numbers less than 10 will be suppressed as well as derived percentages in line with existing data protection codes of practices.

 # = numbers, % = percentages

Findings of evaluation to date:

Analysis with respect to this CME cannot be completed at the moment. There were only 13 graduates within the reporting period. More time has to pass to allow clients to complete the programme under personalisation.

Appendix 3: Additional Approved Model Element (AAME)

AAME agreed:
Reflections and findings in relation to use of the AAME