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International Nurse-Family Partnership® (NFP)

Phase Four Annual Report

Phase Four - Continued Refinement and Expansion

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

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data is reported, analysed and reviewed, to guide discussion of the country's implementation successes and challenges, as well as emergent outcome variations. The annual report forms the basis of the Prevention Research Centre, University of Colorado's (UCD) annual review of NFP implementation and fidelity in licensed partner countries and for discussing quality improvement plans. By using quantitative and qualitative data, the annual report creates an opportunity for each country's leadership team to reflect on progress and develop quality Improvement plans for the following year.

Completing the report:
The country license holder is requested to coordinate the completion of this report, with contributions from the national implementing body, and others, as required.

Please note: If you are unable to complete any items in the report template, please indicate whether this data is not collected in your country or is not able to be analysed at this time. Where terms used in the report template are generic, please specify how items are measured in your country. Where you have adapted your data collection schedule/timings or approach to accommodate local systems, please adapt the document as necessary to take account of this.

The report should be sent to Dr David Olds, Ben Jutson and the country's International Consultant at least three weeks prior to the Annual Review meeting.
If you have any questions regarding the content of this document, please do not hesitate to get in touch with your NFP International Consultant.

PART ONE: PROGRAM OVERVIEW

Name of country:	Scotland	Dates report covers (reporting period):	1 April 2021-31 Mar 2022
Report completed by:	Carolyn Wilson	Date submitted:	29.9.22

The size of our program:

	Number
Fulltime NFP Nurses	179.5
Part time NFP Nurses	See below
Fulltime NFP Supervisors	31.9
Part time NFP Supervisors	See below
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	211.4

- We have 33 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1/6

- Current number of implementing agencies/sites delivering NFP: 11
- Number of new sites over reporting period 0
- Number of new teams over the reporting period 0
- Number of sites that have decommissioned NFP over the reporting period 0
- Successes/challenges with delivery of NFP through our implementing agencies/sites:
  - We have achieved a fully sustained, universally offered service to all eligible clients.
  - We hope to continue to learn the lessons from the COVID pandemic including the use of technology
  - There have been significant support mechanisms in place for sites where there have been some ongoing challenges.
  - Support from Scottish Government, leadership team and the education is tailored to meet the needs of the sites and those individuals working there.

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

License holder name:
The Scottish Ministers devolved to the Scottish Government.

Role and Organisation:
NHS Boards sign up to a Service Level Agreement as part of the process of delivery and assurance. In terms of decision making related to the programme model, materials and adaptations, this is generally taken forward through a distributed leadership model, engaging with senior nursing leaders within NHS Boards and through the National FNP Leadership team.

Description of our National implementing capacity and roles:

1. **Clinical Leadership:**

FNP Scotland continues with a distributed leadership model which works well. Support is provided to sites by the Scottish Government FNP Leadership Team, inclusive of a national clinical lead alongside the FNP Education team in NHS Education for Scotland.
The accountability for professional leadership and clinical governance is the responsibility of sites via the FNP Sponsor, Lead and the Supervisors.

2. **Data analysis, reporting and evaluation:**

Access to the TURAS FNP data system is provided to sites to support clinical delivery of the programme for the entering, collation, extraction and reporting to support data analysis and to help inform practice and learning for Family Nurses and Supervisors.
Cumulative monthly reports are provide by sites to the FNP Leadership Team which are reviewed by the team for:

- Site progress with FNP delivery
- Challenges with implementation and delivery of the programme
- Quality and fidelity measures
- Active client recruitment
- Recruitment and client retention
- License breaches
- Workforce establishment and availability

An annual cycle of FNP site self-assessment is reported to the FNP Leadership Team for analysis and review and to provide assurance on the quality of programme delivery and areas of strength and improvement. This review enables discussion with individual sites on a local and national level for sharing learning, new developments and future improvements.

3. **Service development/site support:**

Service development is an integral and dynamic area of enabling continuous improvement to ensure high quality services. Family Nurses and Supervisors contribute to new developments as part of their roles to ensure safe, effective and person- centred care. The challenges presented by the Covid-19 pandemic has been significant resulting in changes in the way FNP programme could be delivered, leading to re-prioritisation of work and "standing down" of non-essential work and planned developments.
Site support is provided by the Scottish Government FNP Leadership team and the FNP Education Team in NHS Education for Scotland.

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

This work is further supported by the National Analytical Programme Lead, based in Scottish Government.

4. Quality improvement:

FNP Scotland is committed to quality improvement by working to ensure our clients and workforce have the best possible experience through an inherent model of continuous improvement and engagement with sites.

National QI – Research and Improvement Advisory Group (RIAG)

In November 2021, we set up a broad stakeholder group, with an independent chair to consider next steps around research and improvement, using national data for the FNP programme in Scotland. The Terms of Reference (ToR) for the group is attached.

Family Nurse Partnership - Researcl

5. NFP Educators:

See section on NFP Education

6. Other (please describe)

Description of our local and national NFP funding arrangements:

The Scottish Government has fully funded the programme for the past 11 years and this commitment remains. Locally, the funding sites receive is protected to ensure that programme continues to be delivered.

Current policy/government support for NFP:

The First Minister for Scotland continues to provide personal and political support for the programme. The strategic development and direction of the programme is led by the National Strategic and Programme Lead within the Scottish Government. This provides clear opportunity to engage with wider cross-cutting policy, within Scottish Government, to ensure the currency of FNP within the Scottish context. The programme is strongly supported by the Chief Nursing Office for Scotland as an important aspect of the nursing family in this country.

With a focus on reducing current and future inequalities, early years, prevention and early intervention, the FNP programme remains at the forefront of making a difference for young first time mothers and their children.

Organisation responsible for NFP education:
NHS Education Scotland, commissioned by the Scottish Government since 2015 provide the FNP education and learning programme.

Description of any partner agencies and their role in support of the NFP program:
Partnership and collaborative working with FNP England

Integration and connections within the Scottish Government Chief Nursing Office Directorate and the wider Nursing, Midwifery and Allied Health Professionals Networks

Other relevant/important information regarding our NFP program:

PART TWO: PROGRAM IMPLEMENTATION

Clients

NFP clients participating in the program at any point over the last year: 4023

No of clients participating on the 31st March 2022 2653

- Current clients: Pregnancy phase (n/%): 475/17.9% at March 2022
- Current clients: Infancy phase (n/%): 1017/38.3% at March 2022
- Current clients: Toddler phase (n/%): 1161/43.8% at March 2022

Nursing Workforce

- Average nurse caseload: 18 (range from 14 to 25)

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	172.5	32.90	-	205.4
# of staff who left during reporting period	28	7	-	35
% annual turnover	5%	3%	-	4%
# of replacement staff hired during reporting period	19	8	-	27
# of staff at end of reporting period:	163.45	33.9		197.4
# of vacant positions	11	2	-	13

- Reflections on NFP nurse/supervisor turnover/retention during reporting year:
- Nursing turnover is a fraction higher in this year compared to last with a more notable increase in turnover of Supervisors. This has been mainly due to retirement or moving to promoted posts. Anecdotally those working in FNP feel that staff recruitment and retention is worsening. It is challenging to understand patterns or trends as previously FNP in Scotland was still scaling up therefore numbers were constantly changing. To enable patterns and trends to be more readily visible, data has been recorded differently over the past 2 years, and we will continue to monitor it closely going forward.

- Successes/challenges with NFP nurse/supervisor recruitment:
- Innovative recruitment drives have proved fruitful such as virtual drop in information sharing sessions and advertising via social media. The learning from these initiatives have been shared nationally.
- Hosting students has also proved to be a good source of information sharing. We have now had a few applications from nurses that had previously had placements in FNP as student nurses.
- It is hoped that the new Professional Diploma in FNP starting in Sept 2022 may increase the attractiveness of FNP as a career choice.

- Any plans to address workforce issues:

- Discussions have begun to try to better understand this in the context of the overall workforce challenges in the NHS.
- Work is underway to pilot an alternative model of dual roles that may improve the recruitment and retention of nurses in rural areas.
- Further consideration of career pathways in FNP with more consideration for succession planning.
- The data collected on staffing is mostly through the monthly reporting template and the annual review process. A new data form is complete, it is anticipated that it will be fully operational on the Turas FNP system by the end of the year. This will add to the richness of the data already collected; it will be useful to have more information relating to where staff are recruited from and their onwards journey when they leave.
- Work is under way to understand staff recruitment and retention, to hear from those working in the service regarding their perceptions of the strengths and challenges and to consider what improvements can be made.
- It is also important to recognise that there is some evidence of an increasing experience complexity gap, which requires action across the whole system and over time.

NFP education

The Education Team Annual Report is attached to provide an update on progress.

FNP (Scotland)
Education Team Annu

We particularly direct you to page 4, which provides an update on our progress towards a Scottish Qualifications Authority Diploma.

Achievements

The development of the Professional Diploma in Family Nursing has provided an additional opportunity for quality assurance and quality improvement of the Education Programme. The Scottish Qualifications Authority (SQA) have reviewed and approved the learning outcomes and performance criteria for the core Family Nurse education programme. This recognised that what is being taught is relevant, contemporary, and provided in a way that supports synthesis to practice. The formalisation of assessment processes will enable Family Nurses to evidence their achievement of the learning outcomes. The SQA recognises that the planned assessments are valid, reliable, and practicable.

The monthly SQA Standardisation meetings provide the team of Assessors and Internal Verifiers the safe space to ensure the operationalising of these assessments will be equitable and fair and will continue to support a contemporary curriculum and effective pedagogies as the Diploma is implemented.

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:

  Reflective supervision is the bedrock of FNP in Scotland, it provides a platform from which nurses are able to safely learn and develop their practice and enables good quality assurance and quality improvement processes.

  Much of the supervision processes were moved on line during the COVID pandemic which enable this valuable support to continue. As we slowly recover from the effects of the pandemic face to face supervision is being reinstated as the norm. The relational nature of the FNP work has been highlighted, supervision offers holistic support to nurses, face to face supervision enables connection and understanding to surface more effectively. However, it is essential that we learn the lessons from what worked well during the pandemic and are able to flex to work virtually when required and suitable.

  We were delighted to launch the new Supervision guidance document in August 2021. This helped to build understanding of the purpose of supervision and to standardise the process but also allow for flexibility to suit individual and regional differences.

  
  Supervision in Family Nurse Partnership.doc

- Successes/challenges with reflective supervision to our supervisors:

  The supervisor role in FNP is pivotal to the delivery of a caring and compassionate service which is also dynamic; good leadership is required to create a responsive learning environment. It is therefore essential that our supervisors have a safe reflective space of the own; supervision of the supervisors is multifaceted and includes:
  - Child Protection Supervision for client cases
  - Monthly support from the Child Protection Lead relating to organisational systems/management
  - Support from the FNP Lead including 1-1, Personal Development Plans, Nursing and Midwifery Council revalidation
  - Monthly 1-1 psychology support

  Please find attached the findings of the psychology annual review process

  
  Annual Review of Psychology Consultat

  It is lovely to see that the feedback for this is very positive and that staff value the input from their psychology colleagues. However, the return rate for this was less than expected and is something that we hope to improve on next year. The consultant psychologists are supported in a national forum which meets quarterly to enhance their understanding and share learning relating to FNP.

  Supervisor partnership arrangements are in place. Supervisors are paired up following the completion of the learning programme. This is peer support with reflective appreciative feedback which allows for the embedding of strengths and consideration of challenges and areas for growth. The SVs report that this is valuable as a learning tool

and also helps with role modelling good practice with nurses, as they see that SVs also have accompanied visits.

- 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 programme and the environment in which it is delivered is very complex; the use of qualitative and quantitative data sets in combination is fundamental to developing understanding, to achieve successful programme implementation and beneficial outcomes for clients and their children.

  FNP is a data driven service, where the data is much more than management information, it is core clinical tool used to inform the engagement between the client and the nurse and aids assessment of needs. It also provides key insights on areas for local and national improvement, in both processes and outcomes, and continues to shape the FNP model delivery in the Scottish context over time.

  The bespoke data system, Turas FNP has been designed to both reduce the data burden on nurses and enhance the utility of the data at all levels of the programme. It is an online based platform which can be accessed using any device that has internet connectivity and an up to date web browser. Guidance relating to data collection and entry is provided via the attached document.

  FNP Data Forms - 2022 - Clinical Data I

  <u>Move to direct data entry</u>
  The data is collected by nurses and supervisors on bespoke data forms. Data entry onto the system is via the site Data Manager following a data quality assurance checking process by the Supervisors. However, following a trial period of SVs adding forms directly on the system and preparation in teams, direct entry on the Turas FNP system by nurses will commence on the 1st of Dec 2022.

- Commentary on data completeness and/ or accuracy:

  We recognise that data completeness and accuracy is fundamental to the ability to analyse, interpret and make changes in the best interests of the clients. A review of 10 years of data and working with the Data Users Group (DUG) helped us to understand where there were challenges in the data collection processes and enabled changes to be applied to the system to improve the consistency and validity of data entered on to the system.

  All data must be accounted for, a reason for any missing data must be entered onto the system by a supervisor i.e. client declined to answer or nurse unable to present the form in the correct time frame.

The system informs the nurse or supervisor when forms are due to be completed. However, there are set timeframes that data is to be collected within i.e. most forms are required to be completed no earlier than 2 weeks before they are due and no more than 60 days after the date that they are due. Clients are prevented from leaving the system i.e. graduating or transferring if there are any missing or incomplete forms.

The validations in the system have been an ongoing improvement journey which has taken significant steps forward over the last year. This work has given us considerable confidence that the nurses and supervisors will now be able to move to inputting data directly onto the system with accuracy. There are numerous hard and soft validations in the system i.e.

- hard validation - not able to enter a form if the date is on a Saturday or Sunday
- Soft validation – warning given and nurse asked to check if a pregnancy intake form is entered prior to 8 weeks gestation

However, completion of data relating to IPV remains a challenge and will require further curious questions to be asked as the data is not consistent enough to make it reliable for analysis.

- Reports that are generated, how often, and for whom:
  There are 10 'live' reports available on the system to all users, the level of detail viewed is dependent on the user's role within FNP. The system allows the user to filter on a number of different areas such as phase of the programme or dates.

  Adhoc reports can be requested from the NES team via the ticket system (as attached).


FNP Turas System - Ticket Log - Template.


FNP TURAS Ticket Guidance Document.c

  The ticket process is also a fundamental process in understanding themes around data capture and analysis challenges. These are collated and discussed regularly to support the implementation of changes to enable the system to be as effective and efficient as possible.

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

  To enhance the systems usability over time we work closely with the FNP teams across Scotland in combination with the expertise of the SG analytical team enabling clinical experience and analysis of data to inform any adaptions.

  We have ongoing work to continuously review the existing data forms to ensure that they remain fit for current practice and to consider what further information we require. The new Supervision data form successfully went live in September 2021. We have a number of new forms in draft including visit child and workforce forms which are now ready for the system build and testing. We hope that these will go live throughout 2022. Consideration needs to be given to language relating to equality around gender; we hope to commence this work at the end of 2022.

The user experience of the reports requires to be enhanced as the level of detail can create difficulties around interpretation or analysis. This work has been delayed whilst improvements were firstly made to the data consistency and quality as this impacts on the validity of the reports.

Work has begun to establish a suite of dashboards that will complement the reports. These will be based on the requirements for the national and international annual reports and the monthly reports required from sites. It is also hoped that sites will be able to view national level data in order to make local comparisons.

We work closely with our colleagues in NHS Education for Scotland who develop and maintain the tool. There have been a number of challenges relating to staff capacity which has had an impact on the implementation of changes and development.

Continuous Quality Improvement (CQI) Program

- Brief description of CQI processes:

  For the FNP service to remain current and evidence based it is essential that we have a robust quality improvement process in place. It is imperative that we are responsive to the changing needs of clients, the workforce and the policy landscape of the Scottish Government.

  We now have well-established mechanisms that contribute to continuous feedback loops throughout the FNP system.

  - Nationally:
    - **R**equest, **I**ssue, **C**hange, **E**xception (**RICE**) logs are completed to inform Scottish Government of any important changes, requests, breaches in fidelity, CME variance, decision making, to update SG on decisions made locally.
    - Incident reports are completed which inform SG and the leadership team of anything potential media coverage for FNP
    - Annual site FNP self-assessment process
    - We have developed very close links with other stakeholders in relation to sharing learning and linking together to support the development of policy areas such as Perinatal and Infant Mental Health and Tackling Child Poverty
    - National Annual Report to UCD
    - Analytical team – analysis of data
    - Research projects
    - FNP newsletter – quarterly
    - Core education programme
    - CPD

  - Locally – NHS Board area:
    - FNP Advisory Boards
    - Supervision
    - Monthly reporting template to Scottish Government
    - Local governance procedures and processes
    - Mandatory training
    - Client feedback

  - Robust feedback and decision making relating to programme improvements is also gathered via a range of meetings:

- Research and Improvement Advisory Group (RIAG) (national)
- Leads meeting (national)
- Leadership meeting (national)
- Supervisor support calls (national)
- Supervisor National Forum
- Supervisor Learning Forum (national)
- Data Manager support calls (national)
- Data Users Group (DUG) (national)
- Psychology National Forum (national)
- Annual Review meeting (local)
- International Clinical Advisors Group
- Scottish Clinical and Education Leads meeting
- International consultation with Clinical and Education Leads
- National Clinical Lead meetings with Chief Medical Officers Professional Advisors group
- National Clinical Lead meetings with Chief Nursing Officers Professional Advisors group
- National Clinical Lead meetings with Chief Midwifery Officer for Scotland

- Working groups are established when required to coproduce quality improvement projects such as:
  - Facilitators review group has been set up to review the Infancy and Toddler packs. Further consideration will need to be given to possible on line methods of sharing facilitators where appropriate for the needs of clients due to a number of factors including environmental and cost implications
  - Sensitive Enquiry and Response group relating to the implementation of Trauma and Violence Informed Care in line with national policy

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

  FNP in Scotland is now fully established and embedded into NHS service delivery, has been in part due to the ability to continuously build upon what has gone well and to learn and adapt from approaches that have not been successful.

  The environment in which we are delivering the programme is ever changing and we must adapt to ensure that we meet the needs of the whole system. However, it essential that this happens in a methodical way in order that any change implemented is necessary and evidence based. FNP is rich with both qualitative and quantitative information that helps inform decision making in relation to change and supports understanding if the change has achieved the outcomes that were desired.

  The Scottish Government is committed to enabling a systematic approach to quality improvement throughout health and social care using specific techniques to support a cycle of improvement; we encourage all staff to complete training in quality improvement methodologies provided by NES. This helps ensure that we have consistent language and approach nationally and allows for adaptations that are required for local need.

- Successes/challenges with our CQI approach:

  The COVID pandemic has been tough for everyone and many adaptations were required to support the continued implementation of the programme to our clients. Many new nurses were recruited in this time period and have only known learning and delivery of the programme via hybrid models of face to face and virtual. Therefore, as we emerge and recover we wish to focus on “getting back to basics” to ensure we are able to

implement the programme as intended via the licence and CME's and yet learn from the successes of new ways of working during the pandemic.

We have been able to use the learning from the research into the delivery of the programme during the COVID pandemic; this has enabled consideration of when telehealth may or may not be appropriate in the context of FNP programme delivery.

(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.

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) In SV process	100% voluntary participation	All clients are given an information leaflet and have the opportunity to discuss the programme prior to agreeing to take part.
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Referral and recruitment processes FNP Lead Supervision process RICE logs Monthly reporting template Annual self-assessment	____>99_____% first time mothers	X1 mother recruited within the accepted exception criteria
3. Client meets socioeconomic disadvantage criteria at intake	The socioeconomic disadvantage inclusion criteria for our country are: Application of these criteria are assured and monitored by:	___100_____% clients enrolled who meet the country's socioeconomic disadvantage criteria	See end of section three for narrative regarding teenage pregnancy rates and deprivation. There are a small number of NHS Boards that offer the

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	National data sets FNP national data analysis Annual Review Self-assessments		service to 20 -24 year old mothers who meet certain vulnerability criteria such as mental health concerns, poverty, child protection and IPV. The development of the new Sensitive Enquiry data form should enable further quality assurance round this in the future.
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 85% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 70% of pregnant women are enrolled by 16+6 weeks' gestation or earlier	a) 95.6% of FNP clients receive their first home visit no later than the 28th week of pregnancy b) Eligible referrals who are intended to be recruited to NFP are enrolled in the program Clients under 19 years at LMP = 79.9% Clients over 19 years at LMP = 87.3% c) 60.7% of pregnant women are enrolled by 16+6 weeks' gestation or earlier	Those who enroll beyond 28+6 meet the agreed eligibility criteria set out in the CME#4 exception. 3.9% (N=44) are enrolled at more than 28 weeks and 6 days of these 0.7% (N=7) – presented and enrolled post-delivery

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
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 • Percentage who had only one family nurse or supervisor assigned to them = 2742 - 68.1% • Percentage who had a change of family nurse or supervisor (Including transfers) = 1283 - 31.9% • Percentage who had more than one change of family nurse or supervisor =1180 - 29.3%	All clients are assigned a single family nurse however, there are times when a new family nurse is required to take over the care i.e. when a nurse leaves the service. There is a robust handover process in place which includes a joint visit as a way of introduction. Going forward there is a need to consider the number of clients that attrition from the programme following a change of nurse and to consider if there are quality improvements we could make to reduce the risk of this.
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.	National/ Country benchmark set is: __100__% visits take place in the home	77.8% visits take place in the home % breakdown of where visits are being conducted other than in the client's home: • Telephone: 11% • Other face to face: 5.4% • Video call/Near Me: 6%	CME has accepted exceptions where visits may take place via telehealth i.e. Adverse weather conditions or Pandemic such as COVID As we emerge from the COVID pandemic it is expected that clients will be visited face to face. The use of telehealth is for exceptional circumstances only. NHS Boards are expected to complete a RICE log if there are any circumstances where

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			telehealth may be required that is not for very short term exceptional circumstances only.
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	National/Country benchmarks for : a) Length of visits by phase benchmarks: • Pregnancy phase: 60 mins • Infancy phase: 60 mins • Toddler phase: 60 mins b) Client attrition by program phase benchmarks: ___5__% attrition in Pregnancy phase __10___% attrition in Infancy phase __5___% attrition in Toddler phase • 20% or less for cumulative programme attrition – through to the child's second birthday	• 100% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is ○ Pregnancy: 8 ○ Infancy: 19 ○ Toddlerhood: 14 • 0% of clients being visited on alternate visit schedule • Average number of visits by program phase for clients on alternate visit schedule is N/A • Length of visits by phase (average and range): • Pregnancy phase: 62 mins • Infancy phase: 59 mins • Toddler phase: 58 mins Client attrition by phase and reasons: 4.7% attrition in Pregnancy phase 5.6% attrition in Infancy phase 5.6% attrition in Toddler phase	The visiting schedule for FNP client in Scotland remains as per the standard. • 100% of clients should receive 80% or more of expected visits during pregnancy • 100% of clients should receive 65% or more of expected visits during infancy • 100% of clients should receive 60% or more of expected visits during toddlerhood The visits are tailored to meet individual needs (agenda matched). For professionals working within the early year's agenda in Scotland national policy promotes the use of the National Practice Model , National Risk Assessment Framework and Child Protection Guidelines to enable practitioners to support families

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			using a consistent and balanced approach whilst taking into account the inevitability of changing circumstances. These tools are used in supervision to support the nurses to consider the visiting schedule according to needs of individual clients. Attrition is calculated using all clients that left the programme in 2021/22 including graduates. Phase has been determined by the point at which the client last had contact with the programme rather than the point at which the 6 months elapsed for those that lost contact with the programme.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by (eg standardized job description); FNP Leads FNP SV National Clinical Lead Education Leads We have standardized National job descriptions and person specifications	__100__% NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	 Final FN National evaluation updated Au  Person Specification - Family Nurse Updated  Final up-date SV National JD updated A

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	for Family Nurses and Supervisors Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.		 Person Specification - Family Nurse Updatec These have recently been updated. The development of the new workforce data form will enable further analysis of other nurse variables/demographics and also their destination when they move on from FNP.
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula __100___% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	___100___% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities _100_____% completion of team meetings, _100_____% completion of case conference and __100____% completion of education sessions	The FNP leads and SVs state on the annual self-assessments that all of this occurs 100% of the time unless there is Annual Leave or Illness. The implementation of this has been via hybrid models of face to face and virtual (normally MS Teams). The relational nature of the FNP programme means that face to face meetings are the preferred option however, completion virtually is useful under exceptional circumstances. The development and

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			implementation of the new SV data form will enable quality assurance around this in the future.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table.
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, 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).	_100_____% of 4-monthly Accompanied Home Visits completed	The FNP leads and SVs state on the annual self-assessments that all of this occurs 100% of the time unless there is Annual Leave, Illness or clients cancel. The FNP Leads and SVs have stated that accompanied home visits have were very challenging during the COVID period. However, many successfully completed accompanied visits online. This has enabled reflective discussion relating to

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			practice via telehealth. As we emerge from the COVID pandemic there is a move back to 100% face to face accompanied home visits. The development and implementation of the new SV data form will enable quality assurance around this in the future. The SV form has gone live on the Turas FNP system and should give the ability to report on this from the data system next year.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurse).	_100_____% of NFP teams have an assigned NFP Supervisor _100____% of reflective supervision sessions conducted	The data in relation to these measures during this reporting period are via self-reporting from the supervisors and FNP Leads. They state that 100% have taken place. This has been via mixed methods of face to face and virtual. The development and implementation of the new SV data form will enable quality assurance around this in the future. The SV form has gone live on the Turas FNP system and should give the ability to report on this from the data

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			system next year.
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: FNP Scotland has a distributed model of leadership, each board area has an FNP Lead through whom clinical governance and quality is assured. The gathering of information, analysis and learning is conducted through various means including: • Core education programme • CPD education • FNP national leads meeting • FNP leadership group • National supervisors meeting • Supervisor learning forum • Supervisor support calls • Data system • Supervision with nurses • From client feedback • Annual review process • Annual conference • FNP newsletter • Data managers forums • Data managers support calls • Psychology biannual meeting • FNP Advisory Boards • Research	Progress: TURAS FNP system is being refined and adapted on an ongoing basis to meet the needs of all users. The governance structures have been established over many years and have been continuously adapting to meet the needs of the whole organization as we have moved from implementation of the service to one of sustainability.	See previous information relating to CQI, data system, supervision and education.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
14. High quality NFP implementation is developed and sustained through national and local organized support	100____% of Advisory Boards or equivalents held in relation to expected __100___% attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation): FNP Sponsor – Normally a Nurse Director FNP Lead SV Annual review self –assessment Through the distributed leadership model the FNP Advisory Board (FAB) links with local stakeholders that are relevant to local area needs. The FNP leads link into Scottish Government via the FNP Leads meetings and various reporting mechanisms.	_100____% of Advisory Boards or equivalents 100_____% attendance at Advisory Boards	The data in relation to these measures during this reporting period are via self-reporting from the supervisors and FNP Leads. They state that 100% have taken place. This has been via mixed methods of face to face and virtual.

Domain coverage*

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35-40%	32%	14-20%	20%	10-15%	18%
Maternal Role (My Child and Me)	23-25%	28%	45-50%	42%	40-45%	40%
Environmental Health (My Home)	5-7%	11%	7-10%	11%	7-10%	11%
My Family & Friends (Family & Friends)	10-15%	14%	10-15%	13%	10-15%	13%
Life Course Development (My Life)	10-15%	12%	10-15%	12%	18-20%	15%

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

It is to the credit of the FNP workforce that the percentage of domains covered has remained consistent over the years. The Family Nurses and Supervisors have shown immense dedication and creativity to ensure replication of the programme given the enormous challenges thrown at them during the COVID pandemic.

It was reported that the delivery of the programme was impacted by the reduction in other services which meant that additional time was spent supporting clients to access relevant services. Family nurses and supervisors have stated an understanding of the importance in the maternal role domain which supports the building of attachment and responsive parenting techniques, this helps build confidence and strengths that can be tapped into to enhance learning in the other domains.

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.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) 2020/21 (n/%)**	**Current Period 2021/22 (n/%)**
Age (range and mean)	Average Age at LMP – 19.1 years Range at LMP – 14.5 years – 25.1 years	Average Age at LMP – 18 years Range at LMP – 12 years – 24 years

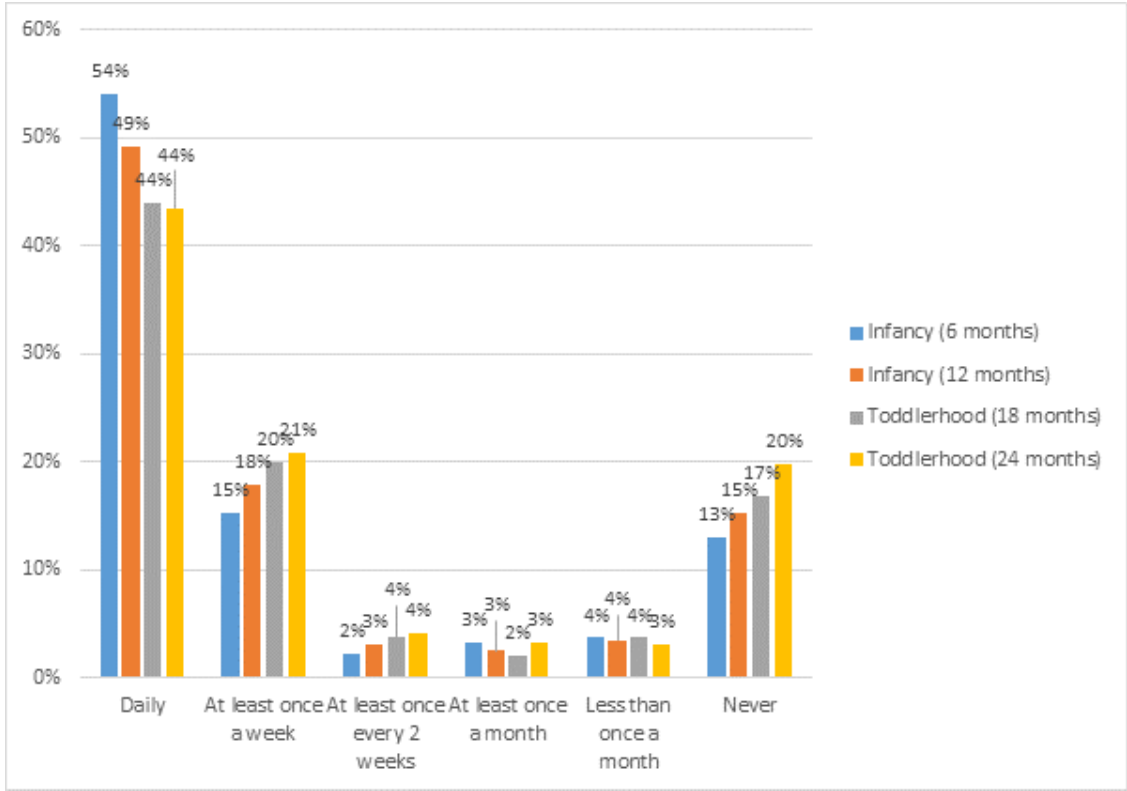
Race/ethnicity distribution

	2020/21	2021/22
White	94.5%	94.8%
Other ethnic group	2.8%	2.1%
Asian, Asian Scottish or Asian British	1.9%	2%
African, African Scottish or African British	0.4%	0.8%
Caribbean or Black	0.3%	0.1%
Prefer not to say	0.1%	0.1%
Don't know	-	0.1%

Home visits where father/partner is present

Frequency of communication with the child's biological father	2020/21
Daily – live with father	43.1%
Daily – do not live with father	36.0%
At least once a week	7.5%
At least once every two weeks	1.6%
At least once a month	0.9%
Less than once a month	1.8%
Never	7.6%
Not applicable	0.9%

In 2021/22 with better access to data using our new FNP Turas IT system we have looked at frequency of contact with father by phase. This is shown in the graph below where there is a drop of in the frequency of contact over time. During infancy over half (54%) of mothers have daily communication with the biological father, this drops to below half (44%) by 24 months, while there is an increase in those that never have communication with the child's biological father over the same time period there is also an increase in those that have communication at least once a week.



		Present in visits Father of Child or clients partner • Pregnancy 5.4% • Infancy 12.3% • Toddler 7.3%

Home visits where other family members are present

Visit Participant	Percentage of Completed visits (2020/21)	Percentage of Completed visits (2021/22)
Client's mother	8.6%	14%
Other family member	4.5%	8%
Other	3.7%	3%
Client's father	1.7%	3%
Friend	0.8%	2%
Foster parent/guardian	0.4%	0.3%

Income

Able to provide for myself and my child	Intake (2021/22)	24 Months (2021/22)
Strongly agree	43.1%	59.4%
Agree	29.0%	32.2%
Neither agree nor disagree	6.3%	2.6%
Disagree	2.8%	0.9%
Strongly disagree	1.8%	0.2%

<table>
<tr>
<td>Inadequate Housing (please define)</td>
<td>
Of the housing tenure types, the following may be considered ‘Inadequate Housing’: temporary accommodation; all forms of no fixed accommodation; safe housing.

There are two further questions asked at enrolment about accommodation both relating to clients’ experience of homelessness. The figures are shown below;

In 2020/21 and 2021/22 the following was true for clients when they joined the programme.

<table>
<tr><td>Tenure</td><td>(2020/21)</td><td>(2021/22)</td></tr>
<tr><td>Temporary Accommodation</td><td>3.1%</td><td>4.5%</td></tr>
<tr><td>No fixed accommodation</td><td>1.1%</td><td>1.7%</td></tr>
<tr><td>Safe House</td><td>-</td><td>0.1%</td></tr>
<tr><td>Registered homeless</td><td>8.3%</td><td>8.3%</td></tr>
<tr><td>Considered self - homeless</td><td>2.9%</td><td>3%</td></tr>
</table>
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Educational Achievement

Educational Qualification	2020/21	2021/22
First Degree, Higher Degree, SVQ Level 5 or equivalent	1.0%	1.2%
Professional Qualifications (e.g. teaching, accountancy)	0.2%	0.4%
HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent	6.0%	6.0%
Other higher education qualifications	1.3%	0.8%
Other post-school, but pre-higher education qualifications	2.6%	1.2%
Higher Grade, Advanced Higher, SCQF Level 6 and 7 Freestanding Units, Scottish Baccalaureate, A Level, National Certificate, Higher National Certificate	16.8%	14.1%
National 5, Standard Grade, GCSE or equivalent	47.5%	43.5%
National 3, National 4, Access 3, Intermediate 1, Intermediate 2	47.4%	40.6%
SVQ Level 1, SVQ Level 2, National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent	9.0%	8.7%
SVQ Level 3, ONC, OND, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent	4.0%	4.8%
Foundation Apprenticeship, Modern Apprenticeship	3.6%	2.8%
National 1, National 2, Access 1, Access 2 or equivalent	7.0%	5.3%
Employability, Enterprise and Employability, D of E Leadership, Employability and Personal Development, Skills	6.3%	4.0%

	for Work, Certificate of Work Readiness, National Progression Awards or equivalent		
	Other school qualifications	3.9%	2.9%
	No Qualifications	10.1%	13.3%
	Don't know	3.5%	1.8%

Employment

Employment Status – At Intake	**2020/21**	**2021/22**
Working full time	16.6%	19.0%
Working part-time	12.0%	12.3%
In full time education	12.9%	11.2%
In part-time education	2.7%	3.8%
Full-time carer	0.9%	0.9%
Part-time carer	0.4%	0.1%
Volunteering full-time	0.1%	0.0%

Volunteering part-time	0.2%	0.1%
Actively looking for work	4.0%	2.9%
Unemployed	38.0%	29.2%
Unable to work due to illness	0.8%	3.7%
Other	4.7%	1.4%
None of the above	2.0%	0.0%

Employment Status – At Graduation	**2020/21**	**2021/22**
Working full time	5.8%	6.6%
Working part-time	21.6%	21.5%
In full time education	9.2%	10.0%
In part-time education	3.9%	4.9%
Full-time carer	1.0%	3.6%
Full-Time parent	49.0%	20.1%
Part-time carer	0.6%	0.7%
Volunteering full-time	0.1%	0.0%
Volunteering part-time	0.4%	0.5%

	Actively looking for work	5.2%	6.7%
	Unemployed	12.7%	33.6%
	Unable to work due to illness	0.8%	2.9%
	Other	3.0%	4.2%
	None of the above	0.7%	0.0%

Food Insecurity (please define)

Clients with Support to obtain food	**% Clients**
182	4.5%

In care of the State as a child

Has the client ever (at the point of enrolment):	**Number of Clients**	**% of Clients**
Been a Looked After Child (At Home)	163	4.0%
Been a Looked After Child (In Kinship Care)	379	9.4%
Been a Looked After Child (In Residential Accommodation)	390	9.7%

Obesity (BMI of 30 or more)	There is a visit form that has been designed to start collecting this information and data should be available from next year.
Severe Obesity (BMI of 40 or more)	There is a visit form that has been designed to start collecting this information and data should be available from next year.
Underweight (BMI of 18.5 or less)	There is a visit form that has been designed to start collecting this information and data should be available from next year.
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	Not collected

Question asked on pregnancy intake data form. These questions are the same as nationally collected data to allow for comparison.
Do you have any physical or mental health condition or illness lasting or expected to last 12 months or more?

Physical or Mental Conditions	Clients	% Clients
A speech impairment	1	0.0%
Arthritis	7	0.2%
Chest or breathing problems (asthma/ bronchitis)	65	1.6%
Diabetes	7	0.2%
Difficulty hearing	20	0.5%
Difficulty seeing (even when wearing spectacles/ contact lenses)	22	0.5%
Difficulty understanding spoken and/or written word	26	0.6%
Dyslexia	114	2.8%
Epilepsy	10	0.2%
Heart, blood pressure or circulation problems	16	0.4%
Learning or behavioural problems (e.g. autism, Down's Syndrome)	28	0.7%
Mental health problems	322	8.0%
Prefer not to say	1	0.0%

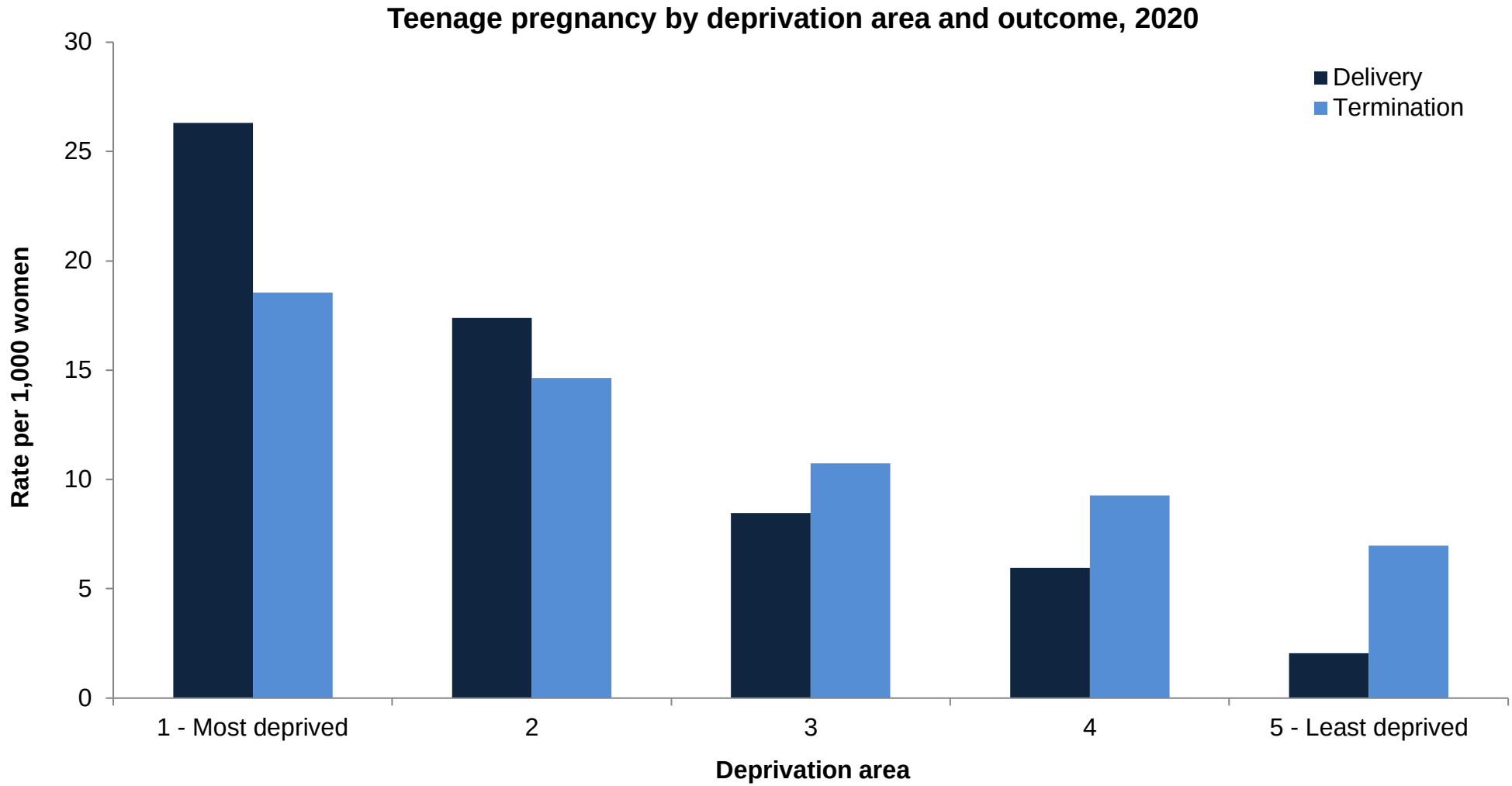
Infections (e.g., yeast infecions		Problems or disabilities related to arms or hands	5	0.1%
Sexually Transmitted Infections	Not collected	Problems or disabilities related to back or neck	20	0.5%
Substance Use Disorder	See substance use data below	Problems or disabilities related to legs or feet	19	0.5%
Mental Illness	See below (anxiety depression)	Severe disfigurement, skin condition or allergies	27	0.7%
Other (please define)		Severe stomach, liver, kidney or digestive problem	16	0.4%
		Some other health problem or disability	36	0.9%
		Some other progressive disability or illness	3	0.1%
		Total Active Clients	4,023	

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

- The Teenage pregnancy rate in Scotland is at its lowest level since reporting began.
- Rates fell for a thirteenth consecutive year to 23.9 per 1,000 women in 2020 (equivalent to 3,300 teenage pregnancies).
- Total number of teenage pregnancies - 9,362 in 2007 compared to 3,300 in 2020. Of the 3,300 pregnancies, 165 were in the under 16 age group (5%) and 1,024 were in the under 18 age group (31%) and the majority (69%) were to those aged 18 and 19 years old at conception.
- Termination rates have remained higher than delivery rates since 2002 for the under 16 age group and since 2018 for the under 18 age group. For the first time in 2019 teenage women in all age groups (under 16, under 18 and under 20) were more likely to have a termination than a delivery and this continued in 2020 as those aged under 20 saw slightly higher termination rates for the second year running.
- In 2020 the delivery rate in Scotland for under 20s was 11.9 and the termination rate was 12 per 1,000 women. In line with decreasing numbers of teenage pregnancies, both rates dropped slightly from the previous year when they were 13.8 and 13.9 per 1,000 respectively.

Across Scotland there continues to be a drop in the teenage birth rate. However, those who continue on with pregnancy to give birth in Scotland are those that live in the areas with the highest levels of deprivation as measured by Scottish Index of Multi Deprivation. The most deprived areas had almost 13 times the rate of delivery compared to the least deprived areas (26.3 compared to 2 per 1,000) and over double the rate of

termination of pregnancy (18.6 compared to 7). These young women are those that we need to reach the most. The level of complexities in the family nurse caseloads has risen and yet we have continued to have very high uptake rates for the programme in Scotland.



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

Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is collected)					
	Intake	**24 months**			
SWEMWBS - Percentage scoring 20 or below (indicating low wellbeing)	6.7%	10.1%			
GAD7 - score above 10 (moderate to high anxiety)	16.6%	19.8%			
GSE Average Score (Self –efficacy)	32	33			
EPDS – percentage scoring above 10 (indicating possible depression)	14.5%	10.0%			
Social-Isolation Score - Average		**4**			
	Intake	**6 weeks**	**6 months**	**12 months**	**18 months**
Cigarette Smoking, (% of clients currently smoking cigarettes or e-cigarettes)	30.2%	31.7%	33.7%	34.5%	34.5%
Alcohol (in last 7 days)	18.4% (had consumed alcohol at all during pregnancy)	7.8%	8.3%	7.1%	14.4%
Drug use	6.7% (had any drug use in pregnancy)	1.7%	3.3%	3.2%	4.3%
Marijuana		1.7%	3.3%	2.9%	4.2%
Cocaine		0.0%	0.1%	0.3%	0.3%
Other street drugs		0.0%	0.0%	0.0%	0.3%
Excessive Weight Gain from baseline BMI during pregnancy (n, %)	Not collected				
Mastery, (n, mean)	See self - efficacy				
IPV disclosure, (n, %)	Data form completion rates for the IPV forms are low therefore the figures are not reliable. Improvement work regarding this will form part of the ongoing Sensitive Enquiry and Response journey.				

	6 Weeks	6 Months	12 Months	18 months	24 Months
Reliable Birth Control use, (n, %)	1139, 47.3%	1783, 74.0%	1600, 66.4%	725, 62.5%	728, 62.8%
Subsequent pregnancies, (n, %)	8, 0.3%	120, 5.0%	344, 13.3%	289, 24.9%	398, 29.8%
Breast Feeding, (n, %)	569, 15.9%				31, 2.7%
Involvement in Education, (n, %)	Intake – 229, 20.4%	488, 13.7%	461, 12.7%	356, 14.7%	329, 13.6%
Employed, (n, %)	Intake Data Available				325, 28.1%%
Housing needs, (n, %)	See above				
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	Not collected				
Father's involvement in care of child, (n, %)		Never – 313, 13.0%	Never – 369, 15.3%	Never – 196, 16.9%	Never – 230, 19.8%
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g. to previous years, to rates achieved in RCT, to equivalent populations etc)**:**

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

The relational nature of the programme to support an increase in clients confidence and ability to navigate broader systems and to access services was highlighted in a recent paper by Professor Steven Buchanan, it was reiterated in our research into the impact of the COVID pandemic on the service and is also evident in our high uptake rates and low attrition rates. Engagement with support networks can be very difficult for a client group that have had significant trauma in their lives. The ability of family nurses to engage clients and maintain a therapeutic relationship is the building block from which to role model and offer different life choices.

Which are the areas of challenge?

As we emerge and begin to recover from the COVID pandemic we are aware that those most in need are those that being most adversely effected. It is therefore crucially important that we continue to empower our clients to seek out what they need for themselves and their children.

There is considerable challenges ahead to support clients to become economically self-sufficient in a time of global and local uncertainties and a cost of living crisis.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	10	0.3%
Very preterm (28-32 weeks' gestation)	33	0.9%
Moderate to late preterm (32-37 weeks' gestation)[1]	243	6.8%
Low birthweight (less than 2.5kg)	Less than 37 weeks gestation and less than 2.5kg: 174 37+ weeks gestation and less than 2.5kg: 112	Less than 37 weeks gestation and less than 2.5kg: 4.9% 37+ weeks gestation and less than 2.5kg: 3.1%
Large for Gestational Age (LGA) (equal to or more than 4.2kg)	116	3.2%
Other (please define)		

Please comment below on your birth data:
The figures above are calculated for all active clients between 1st April 2021 - 31st March 2022 that had completed the pregnancy phase at any time point.

Evidence in a recent Public Health Scotland report states that living in an area of deprivation and being a young mother increases the risks of their child being born prematurely and/or with low birth weight, this can have consequences on health and development over the course of the individuals life.

The number of premature births do appear to have dropped in the FNP client group over the last year, the figures are small and would need to be tracked over a longer period of time.

In Scotland, 7% of all live singleton babies were born pre-term in 2016/17, and 5% had low birthweight (National Records of Scotland, 2021).

[1] https://www.who.int/news-room/fact-sheets/detail/preterm-birth

Child Health/Development				
	6 months (Number, % of total)	**12 months (Number, % of total)**	**18 months (Number, % of total)**	**24 months (Number, % of total)**
Immunizations Up to Date	999, 86.1%	1022, 88.1%	1017, 87.7%	1087, 93.7%
Hospitalization for Injuries	15, 1.3%	17, 1.5%	8, 0.7%	10, 0.9%
ASQ scores requiring monitoring (grey zone)	(4 months) 173, 4.9%	(8 months) 236, 6.7%	(14 months) 204, 5.8%	(20 months) 209, 6.0%
ASQ scores requiring further assessment/referral	(4 months) 61, 1.7%	(8 months), 117, 3.3%	(14 months) 160, 4.6%	(20 months) 183, 5.2%
ASQ-SE scores requiring monitoring (grey zone)	69, 2.0%	70, 2.0%	72, 2.1%	58, 1.7%
ASQ-SE scores requiring further assessment/referral	31,0.9%	47, 1.3%	94, 2.7%	86, 2.5%

Child Protection

At Birth

Child had Assigned Social Worker	**Clients**	**% Clients**
Don't know	114	3.3%
No	2768	79.0%
Yes	623	17.8%

Child placed On Child Protection Register	Clients	% Clients
Don't know	119	3.4%
No	3136	89.5%
Yes	248	7.1%

By Graduation

	Added Social Work intervention		Removed Social Work intervention	
	Clients	% Clients	Clients	% Clients
Child assigned a social worker	126	10.9%	42	3.6%
Child became Looked After Child - Accommodated	18	1.6%	7	0.6%
Child became Looked After Child - At Home	*not disclosed due to small numbers		*not disclosed due to small numbers	
Child became Looked After Child - Kinship Care	27	2.3%	7	0.6%

Child subject to Child Protection Order	12	1.0%	*not disclosed due to small numbers	
Child subject to Supervision Order	18	1.6%	*not disclosed due to small numbers	
Child's name placed on Child Protection Register	79	6.8%	53	4.6%
Other	6	0.5%	3	0.3%

Please comment below on your child health/development data:

At service user events the children demonstrate attachment to their care givers, they have excellent emotional containment and ability to cope in such strange and busy environments.

Given that the FNP client group generally have complex and challenging lives we are delighted that the immunisation rates for FNP children appear to be comparable to the national rates.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts We await the publication of the data linkage study. The 10 year analysis was carried out and is available below.. Family Nurse Partnership: 10 year analysis - gov.scot (www.gov.scot)
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program. This can include collated client feedback, a case study or by clients providing video evidence etc. We endeavour to include our client voice in all aspects of the programme. • They are involved from the beginning with nurse and supervisor recruitment

- Their voices are heard in the classroom during the education sessions
- Are part of our CQI local projects such as working with the Dolly Parton Imagination Library
- The evaluation of projects such as bookbug
- Involved in development of new facilitators
- Many sites have ask clients to complete evaluations at graduation
- Nurses encourage the clients to take part in national research or surveys regarding health and social care
- We have a number of social media pages nationally and locally in different board areas to share information
- Client events are once again beginning to place

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	<5 Neonatal deaths <5 Infant death	**Unable to comment due the risk of confidentiality breech**
Maternal death	<5	**Unable to comment due the risk of confidentiality breech**
Other		

Any other relevant information or other events to report:

All incidents of these types are investigated in the local NHS board area with FNP learning share via the methods described in the CQI sections if appropriate.

Boards follow the guidelines and reporting mechanisms that appropriate for the events described such as SUDI Scotland Toolkit - providing information to professionals involved in the Sudden Unexpected Death of an Infant.

There are also a number of different mechanisms for sharing learning nationally such as MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf (ox.ac.uk)

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- Briefly describe your system for monitoring implementation quality;

A service level agreement between the Scottish Government and FNP sites details the responsibilities FNP sites have for delivering the FNP programme and for providing safe, effective, high quality person-centred care in line with the license requirements. A monitoring and assurance programme is in place within NHS Boards and between NHS Boards and Scottish Government. This includes monthly reporting to the national leadership team to enable monitoring of the quality of programme implementation against the core fidelity measures, along with an annual cycle of self-assessment reporting and quarterly budget monitoring. This supports the monitoring and identification of areas for continuous quality improvement (CQI) from the information provided to assess the quality of programme delivery across Scotland.

To support CQI towards the new fidelity minimum standards all sites have submitted QI plans to the national leadership team and their progress towards their QI plans are reviewed as part of the annual quality assurance cycle.

Wrap around support is provided by the national leadership team for all sites where identified via supportive visits to review and discuss areas of challenge and/or improvements and in addition by attending local advisory board meetings.

- **Goals and Objectives for CQI program during the reporting period:**

The goals and objectives for reporting period 2021/22 were:

- FNP teams to collaborate with local authority partners to enable FNP children an early learning child care place at 2 years of age
- Commence a review the Infancy and Toddlerhood facilitators
- Commence a knowledge and skills exchange project
- Commission a review of the older (20-24 year olds) extended eligibility criteria
- Implement an ASQ at 2 years of age
- Implement a refreshed communication strategy
- Sustainability of FNP funding and future hosting of FNP in Scotland
- Report on the 10 year analysis and data linkage study
- C/F expand to offer the programme in the remote and rural boards
- C/F systematic review of the clients voice within the programme
- C/F workforce challenges

- **Outcomes of CQI program for the reporting period**

The planned goals and objectives for 2021/22 have been recognised by the national leadership team as being over ambitious and unrealistic to fulfil within a year and at a time of unprecedented challenge with the Covid-19 pandemic These objectives and goals many of which are significant and ongoing will be reprioritised as we learn and progress forward our plans and identified improvements.

1. The majority of FNP sites are working with their local authority partners to ensure the children of all clients graduating from the FNP programme are supported in obtaining and /or offered a discretionary eligible 2's Early Learning and Child care placement.
2. Badgernet – This work have been put on hold nationally
3. The planned review of the Infancy and Toddlerhood facilitators was put on hold at the end of 2021 due to covid restrictions, winter pressures and workforce challenges. It is recognised that undertaking this review is a significant piece of work. This review is now being progressed with infancy and toddler subgroups of Family Nurses and Supervisors from all sites across Scotland since June 2022.
4. Commence knowledge and skills exchange project (not commenced).
5. Commission a review of the older (20-24 year olds) extended eligibility criteria (not commenced). However, plans are being progressed to extend the programme to support all first time mothers aged 21 and under by the end of 2024 and where capacity allow, target first time mother under the age of 25 who are care experienced or from the most deprived communities as part of the Scottish Government tackling child poverty plan to reduce health inequalities and improve outcomes for children and young people.
6. Implement an ASQ at 2 years of age (not commenced).
7. Implement a refreshed communication strategy – in progress
8. Sustainability of FNP funding and future hosting of FNP in Scotland – FNP funding sustainability aim is to baseline funding during 2023/24 financial year subject to any further negotiations that may be required. Early discussions are being considered relating to the future hosting arrangements for FNP in Scotland.
9. We are delighted that the 10 year analysis of the FNP data Report was published in May 2022 10 Year Analysis of Family Nurse Partnership data. The findings from this study provides an improved understanding of the programme as a whole in Scotland, helps us understand who has received the programme, the changes over the 10 years of operation, and the areas of achievement and where we would like to make improvements.

   The publication of the data linkage study has been delayed and not due to report now until Winter 2022. An FNP Research and Improvement Advisory Group (RIAG) has been reinstated to ensure all research commissioning, improvement and evaluation work undertaken will add value to FNP programme for Scotland. The group will also contribute to shaping an overarching FNP Scotland improvement plan following publication of the data linkage study.

10. To expand to offer the programme in the remote and rural boards – This work is being trialled in one FNP site (Highland) with a model in development to both test out a dual role (initially an FN and Health Visitor) and the use of Telehealth. We hope to learn from this work for scale and spread to other areas of Scotland. eg. Island Boards.
11. C/F systematic review of the clients voice within the programme – This remains an outstanding piece of work
12. C/F workforce challenges – workforce challenges are ongoing and not unique to FNP. There is a national shortage of nurses and the FNP leadership team are involved in the national discussions to address this for all nursing disciplines and midwifery.

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

FNP staff worked considerably hard during a critical and challenging time. A key lesson is the fast pace of change and to set realistic goals and objectives. Despite challenges there has been some incremental progress towards the CQI for sites albeit not at the pace anticipated, however cognisance is needed towards implementing changes and supporting sites as they remobilised and the covid recovery stage impacts as we learn to now live with covid and adapt.

- **Goals for CQI in next year:**
  - Progress the infancy and Toddler facilitator review
  - C/F knowledge and skills exchange project
  - Test out ASQ at 2 years of age
  - Report on the data linkage study and develop a national FNP improvement plan
  - Test out a new model for remote and rural delivery of FNP programme to inform learning for further expansion
  - C/F systematic review of clients voice within the programme
  - Support sites modelling to expand the universal offer to 20 years and under and planning towards 21 years and under

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

- Program innovations tested[2]:

As reported last year, 2021/22 continued to be a challenging time particularly related to workforce which impacted on CQI projects and test of change. Additional projects not already discussed are:

  - FNP Bookbug before birth pilot to encourage signing, rhyming and reading in pregnancy evaluation publication October 2021. A client survey is in progress. There are ongoing discussions to enable this to be sustained.

- Program innovations implemented:
  - FNP Scotland CME benchmark
  - Additional CME 4 exception criteria – ***"a client who initially refuses, reflects and reconsiders and actively seeks to engage (either personally or through another professional), beyond 28+6 weeks and before transfer to health visiting services following birth, can now be enrolled"***

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

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

We await the outcome of the data linkage study, being carried out by Cardiff University. No new research or evaluation is planned at this stage.

Evaluation of the Family Nurse Partnership (FNP) Scotland: A Natural Experiment Approach - Centre for Trials Research - Cardiff University

PART FIVE: ACTION PLANS

LAST YEAR:

Our planned objectives for last year:

- FNP teams to collaborate with local authority partners to enable FNP children an early learning child care place at 2 years of age
- Commence a review the Infancy and Toddlerhood facilitators
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- C/F expand to offer the programme in the remote and rural boards
- C/F systematic review of the clients voice within the programme
- C/F workforce challenges

Progress against those objectives

1. The majority of FNP sites are working with their local authority partners to ensure the children of all clients graduating from the FNP programme are supported in obtaining and /or offered a discretionary eligible 2's Early Learning and Child care placement.
2. The planned review of the Infancy and Toddlerhood facilitators was put on hold at the end of 2021 due to covid restrictions, winter pressures and workforce challenges. It is recognised that undertaking this review is a significant piece of work. This review is now being progressed with infancy and toddler subgroups of Family Nurses and Supervisors from all sites across Scotland since June 2022.
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Reflections on our progress:

We continue to build a sustainable model to support FNP in Scotland. Despite the many challenges, some not unique to FNP, the service continues to improve with high levels of client recruitment and low attrition. We would again like to thank all those involved in delivery a high quality service to families who are most likely to benefit from this intervention, and continue

NEXT YEAR:

Our planned objectives for next year:

- Sustainability model for leadership of FNP in Scotland
- Work is underway to pilot an alternative model of dual roles that may improve the recruitment of nurses in rural areas.
- We continue to work closely with the FNP teams across Scotland, to use their clinical experiences to inform and enhance the usability and effectiveness of the Turas FNP system over time including:
  - Further refinement of the validations
  - Additional data forms – Visit child, Workforce and Sensitive Enquiry
  - Dashboard implementation
  - Family Nurses to enter data directly onto the system
- Review of infancy and toddler facilitators
- Continue with the work relating to Sensitive Enquiry and Response
- The delivery of Trauma informed care training to data managers and admin staff

- Our attrition rate is small and to be celebrated however there is to be a QI project to consider how we can further reduce avoidable attrition.
- Review of the data managers job description and job specification
- Consideration is being given to a research project to support an increase in fathers involvement in the service – this will be long term project.
- Set up a working group to review workforce recruitment and retention strengths and challenges and develop a workforce strategy linked to national plans

Measures planned for evaluating our success:

- Publication of the 10 year analysis
- Publication of the data linkage study

Any plans/requests for program expansion?

- Plans are in progress for implementation of the Tackling Child Poverty Plan which states that FNP will increase the age range to include all first time mother under the age of 21 at LMP by the end of 2025

FEEDBACK FOR UCD INTERNATIONAL TEAM:

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

• Sharing of early learning internationally regarding COVID

• International research meetings - sharing presentations

• Discussions at CAG meetings

• International website for sharing of documents

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

• International online conference for all FNP colleagues

• Regular international newsletter which might include

- blogs from staff and stakeholders
- shared learning

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

- Move to a biannual cycle of review on the basis that FNP in Scotland has remained relatively stable over the past few years, and quality levels have been retained

Please note: with permission, all completed annual reports are uploaded to the restricted pages of the international website so that every implementing country can mutually benefit in sharing their progress and achievements.

Please indicate your country's willingness to share this report in this way by checking one of the boxes below:

I agree to this report being uploaded onto the restricted pages of the international website	x
I do not agree to this report being uploaded onto the international website	

PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

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

- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- Provision of clinical and education leads quarterly meetings to explore clinical quality and new developments
- Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
- Provision of a range of international themed meetings including the international Clinical Leads' Advisory Group, the data analytic and research-leads forum, the PIPE education group (now the education group) and the strategic leads group.
- Sharing new program innovations developed and researched by PRC and all implementing countries
- 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:

- Scottish implementation of FNP at a very mature stage, with continued committed and collaborative leadership, both nationally and in local sites.
- The quality of the FNP workforce, whose work is highlighted by the findings presented in this report and the work being done to ensure that the workforce is sustained in future
- The continued progress towards full integration of FNP within local systems, enabling sustainability for the program and good access for families
- The extremely high quality of the education program, which has achieved academic accreditation and is rated very highly by FNP practitioners
- The continued development of the Information system and the high-quality analysis of data evident in the annual data report
- The scale of ambition for the program – as evidenced by the planned QI projects and new developments
- The continued political and policy support for the program and the enduring commitment to provide the best service possible to FNP families

Areas for further work:
The following were discussed during the annual review meeting, in addition to the plans already outlined in part 5 of this report

- Further work to ensure that the program is reaching clients with overlapping needs as the eligibility criteria are expanded. This includes any possibility of understanding the needs of the approx. 20% who decline to enrol on the program

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

- As in part 5, plus the area above

Any approved Core Model Element Variances: CME 4 – data collection for evaluation is ongoing
Agreed upon activities that UCD will provide through Support Services Agreement: • Monitoring of the license and oversight of fidelity • Meetings with clinical and education leads • Review of data linkage Study findings and provision of commentary as needed • Support for embedding system changes and site quality improvement approaches It was agreed that a follow up meeting would be arranged to further explore Scottish approaches to site collaboration and quality improvement.

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
 Request for Variance - Core Model Element
Temporary Variance to CME agreed:
yes
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

Appendix 3: Additional Approved Model Element (AAME)

AAME agreed:
 Core Model Element - AAME - Scotland Ch
Reflections and findings in relation to use of the AAME
This AAME is part of the core offer for all children from birth to school entry. Ensuring that the FNP service delivers this content alongside the FNP programme is vital for individual and population level data recording. It provides a sense of clarity to FNP teams on the cross over between the work they carry out and that of health visiting, but continues to help differentiate the FNP programme as more than just HV+.