HSC Public Health Agency

AGENDA

69th Meeting of the Public Health Agency board to be held on Thursday 16 October 2014, at 1:30pm, East Belfast Network Centre, 55 Templemore Avenue, Belfast, BT5 4FP

No	Time	Item	Paper	Sponsor
1.	1:30	Welcome and Apologies		Chair
2.	1:30	Declaration of Interests		Chair
3.	1:30	Minutes of the PHA board Meeting held on 18 September 2014		Chair
4.	1:35	Matters Arising		Chair
5.	1:40	Chair's Business		Chair
6.	1:45	Chief Executive's Business		Chief Executive
7.	1:50	Finance Update • PHA Financial Performance Report	**PHA/01/10/14 (for Noting)**	Mr Cummings
8.	2:00	Governance and Audit Committee Update • Minutes of previous meeting • Verbal update from Chair	**PHA/02/10/14 (for Noting)**	Mr Coulter
9.	2:15	PHA Mid-Year Assurance Statement	**PHA/03/10/14 (for Approval)**	Chief Executive
10.	2:25	Second Annual International Family Nurse Partnership Report	**PHA/04/10/14 (for Noting)**	Mrs Cullen
11.	2:45	Any Other Business		

12. **Date, Time and Venue of Next Meeting**
    Thursday 20 November 2014
    1:30pm
    Conference Rooms
    12/22 Linenhall Street
    Belfast
    BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 68th Meeting of the Public Health Agency board held on Thursday 18 September 2014 at 1:30pm, in Public Health Agency, Conference Rooms, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Ms Mary McMahon	-	Chair
Dr Eddie Rooney	-	Chief Executive
Ms Oriel Brown	-	Nurse Consultant (*on behalf of Mrs Cullen*)
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mr Edmond McClean	-	Director of Operations
Alderman William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Mrs Julie Erskine	-	Non-Executive Director
Dr Jeremy Harbison	-	Non-Executive Director
Mrs Miriam Karp	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director

IN ATTENDANCE:

Mr Paul Cummings	-	Director of Finance, HSCB
Mr Robert Graham	-	Secretariat

APOLOGIES:

Mrs Pat Cullen	-	Director of Nursing and Allied Health Professionals
Alderman Paul Porter	-	Non-Executive Director
Mrs Fionnuala McAndrew	-	Director of Social Services, HSCB
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

		Action
117/14	**Item 1 – Welcome and Apologies**	
117/14.1	The Chair welcomed everyone to the meeting and noted apologies from Mrs Pat Cullen, Mrs Fionnuala McAndrew and Mrs Joanne McKissick.	
117/14.2	The Chair expressed her apologies to members for not providing an update on accommodation at the last meeting. Members were advised via e-mail after the meeting that the proposed	

	move had fallen through. Mr McClean said that PHA was continuing to work with HSCB and BSO to seek to resolve accommodation issues affecting all three organisations.
118/14	**Item 2 - Declaration of Interests**
118/14.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
119/14	**Item 3 – Minutes of the PHA Board Meeting held on 21 August 2014**
119/14.1	The minutes of the previous meeting, held on 21 August 2014, were approved as an accurate record of the meeting.
120/14	**Item 4 – Matters Arising**
	101/14.2 Inter-sectoral Programme Boards
120/14.1	The Chair advised that the meeting of the Older People's Group has been changed to 7 November, due to the Donaldson Review.
	110/14.9 Use of IT
120/14.2	Mr McClean advised that he would be e-mailing non-executive members shortly regarding future IT requirements. He cautioned that the procurement process may take time to be completed.
121/14	**Item 5 – Chair's Business**
121/14.1	The Chair advised members that she had attended the launch of the first year report of Together for You, a Big Lottery funded initiative promoting mental and emotional well-being programme. She said that there has been an emphasis on counsellors getting trained, but she expressed concern as to what will happen when funding expires.
121/14.2	The Chair said that she had attended two governance events run by CIPFA and that she would be meeting with some of the non-executives to consider the new CIPFA governance standard.
121/14.3	The Chair informed members that she had attended a Patient

	Safety Forum event and noted the excellent work that is undertaken but which does not make its way into the public domain.
121/14.4	The Chair i members that the agenda for the PHA Board Away Day is currently being finalised and will be distributed to members once it is available.
122/14	**Item 6 – Chief Executive's Business**
122/14.1	The Chief Executive informed members that he, along with the Director of Nursing, had attended the Human Rights Commission public inquiry reviewing emergency departments. He said that the Commission was very interested in the 10,000 Voices project. He added that part of the enquiry will try to establish if there is a link between human rights legislation and health policies and priorities.
122/14.2	The Chief Executive advised that he had met with Pat Ramsey, MLA and parents regarding Trisomy 18 and Trisomy 13, diseases which have a very low survival rate. He agreed to pass on information from that meeting to HSC Trusts.
122/14.3	The Chief Executive said that he had visited the ARC Healthy Living Centre in Irvinestown, and suggested that the PHA Board should visit this facility. It was agreed that this would be organised in early 2015.
123/14	**Item 7 – Presentation on MARA**
123/14.1	Colette Brolly joined the meeting and gave members an overview of the MARA Programme which supports people living in rural areas. She invited Jacinta Linton from the South Down Family Initiative to talk about how the work of MARA has made a difference to people living in the south Down area. Finally, Ruth Liggett, who is an enabler visiting people's homes, gave members an insight into her role and gave examples of cases where the work of MARA has made a tremendous difference to people's lives.
123/14.2	The Chair said that the presentation showed the importance of a human approach in helping people and making them aware of all of the services that are available to them. Ms Brolly said that are

	people who are still unaware of the project.
123/14.3	Mr Coulter asked about the role of the enablers, what training they receive and whether the post is remunerated. Ms Brolly explained that enablers are trained in areas such as safeguarding and vulnerable adults, but that they are not expected to have a full knowledge of all of the different types of benefits available. She added that the questionnaire which enablers go through at home visits allows them to obtain the information they require to determine what further assistance can be made available.
123/14.4	Mr Coulter asked about lessons learnt. Ms Brolly said that an evaluation will be done of the MARA programme. She said that the success of the programme is the work with other organisations and she added that there is an inter-departmental forum.
123/14.5	Dr Harper suggested that there should be liaison with either Integrated Care Partnerships or GP practices in order to increase the connectivity of the programme.
123/14.6	Members noted the presentation on MARA.
124/14	**Item 8 – Finance Update** • **PHA Financial Performance Report (PHA/01/09/14)**
124/14.1	Mr Cummings presented the Finance Report to members. He advised members that there is currently a deficit to date of £232k, due to a slight overspend in programme expenditure offset by an underspend in management and administration.
124/14.2	Mr Cummings gave an overview of the general financial situation within health and social care. He said that the Minister was unlikely to get any additional funding towards the £160m deficit in the Commissioning Plan, the impact on this for PHA would be a reduction of 2.5% of its budget, namely £465k.
124/14.3	The Chief Executive confirmed that PHA has been asked to find non-recurrent saving of £465k within its management and administration budget, and that he was confident that this could be found for 2014/15. However, he was uncertain as to whether PHA would be asked to find savings within its programme

	budget. He advised that PHA was considering various options to minimise the risk of not completing mainstream programmes.
124/14.4	Mr Cummings said that the time delay in confirming the final financial position will make a bigger impact. He said that he was concerned about the recurrent financial position.
124/14.5	Mr Coulter noted the tight timescale for responding to the correspondence from DHSSPS. He asked whether the capital budget was at risk, particularly with regard to PHA's attempts to secure new accommodation. Mr Cummings advised that accommodation costs will have a revenue aspect, and he acknowledged that PHA's options were now reduced.
124/14.6	The Chief Executive advised that DHSSPS will wish to see that PHA has a high level plan in place. He said that he was confident that PHA could meet its targets non-recurrently.
124/14.7	Mrs Erskine asked about the current overspend on the Lifeline budget. Mr Cummings said that over the last few months, Lifeline expenditure has begun to reduce to within budget.
124/14.8	Dr Harbison expressed his view that while the correspondence from DHSSPS states that the reduction is non-recurrent, he expects that it will be recurrent, and that PHA should plan for a recurrent reduction. The Chief Executive acknowledged the concern and said that he anticipates further correspondence from DHSSPS shortly.
124/14.9	Dr Harper said that there is another element which should be considered, which is that the HSC should consider whether the service can be run more sustainably, and at less cost.
124/14.10	The Chief Executive said that it is difficult to know how DHSSPS will allocate the deficit, and whether this will be done proportionately between organisations.
124/14.11	Mr Mahaffy asked if the financial outlook would have an impact on the implementation of Making Life Better. The Chief Executive advised that there is no budget for Making Life Better, but that it is a key priority for PHA to take it forward. He added that the first meeting of the Regional Project Board is taking place on 24 October and that the first meeting of the Officials Group is taking place in early December.

124/14.12	Members noted the financial report. *At this point Mr Cummings left the meeting.*
125/14	**Item 9 – Programme Report – Service Development and Screening**
125/14.1	Dr Janet Little joined the meeting and gave members an overview of recent work within Service Development and Screening. She started by outlining its role within the public health directorate and its links with the commissioning process. Dr Little gave an overview of all of the screening programmes undertaken and some of the key findings emanating from those.
125/14.2	Dr Little advised that PHA is responsible for delivering the training programme for public health and that this was rated excellent following a visit by NIMDTA. She added that PHA also has a role in terms of revalidation.
125/14.3	Dr Little finished her presentation by giving an overview of future plans and challenges for the directorate.
125/14.4	Mrs Karp asked if there were any plans to introduce a non-invasive test as part of the bowel cancer screening programme. Dr Little said that there was an ongoing pilot in England, but that this new approach would carry a significant additional cost, and there was no evidence that it was more beneficial in terms of the number of lives saved.
125/14.5	Mrs Karp asked if there was any intention to reduce the age for cervical screening, but Dr Little advised that this was not the case.
125/14.6	Mr Coulter asked if there were any plans to introduce further screening programmes. Dr Little advised that there is a quarterly meeting of the Screening Committee to review programmes and that new programmes would be introduced on a risk-based approach.
125/14.7	Members noted the update on Service Development and Screening.

126/14	**Item 10 – Overview of Quality 2020 (PHA/02/09/14)**
126/14.1	Dr Harper introduced Lisa Moore, Quality 2020 Project Manager, to the meeting and invited her to give an update on Quality 2020.
126/14.2	Ms Moore outlined to members the aims of Quality 2020, and how it hopes to achieve its vision through five strategic goals – transforming the culture, strengthening the workforce, measuring the improvement, raising the standards and integrating the care. She explained how each of the task groups are aligned to the five goals and gave an overview of the achievements to date against each task, as well as an outline of the key priorities for 2014/15.
126/14.3	Ms Moore explained to members the links between the Quality 2020 work and the different regional HSC strategies. She said that Quality 2020 is about embedding the systems and process to support good practice. She finished her presentation by outlining her own role in terms of service delivery, collaborative working and communication and information management.
126/14.4	Mr Mahaffy asked how seriously the Quality 2020 project is taken by DHSSPS in terms of resources being allocated. Ms Moore said that the Minister is very interested in this project and that PHA is working with DHSSPS to ensure that the project receives an increased profile.
126/14.5	Ms Karp asked whether the e-learning system would be rolled out to healthcare assistants. Dr Harper said that in time, it would be envisaged that the training would be rolled out to all areas. Ms Moore added that the launch of the Leadership Framework will take place as part of World Quality Day on 13 November. Ms Brown said that Trusts are ensuring that all staff are undertaking mandatory training, and cited nutrition as an example.
126/14.6	Dr Harper said that as well as training, there is a need to reinforce all of the other aspects of Quality 2020 as there is not currently a systematic approach. She said that this would be picked up by the ward level review group.
126/14.7	The Chair noted that Quality 2020 has come a long way since 2011. The Chief Executive added that everything that impacts on quality and safety will have implications for Quality 2020 and

	that Quality 2020 is a good vehicle for getting messages out across the whole of the health system.
126/14.8	Members noted the update on Quality 2020.
127/14	**Item 11 – 10,000 Voices Phase One Summary Report and Annual Report (PHA/03/09/14)**
127/14.1	Ms Brown advised members that two reports were being brought to the meeting today, the first of which was the full report, and a second summary report.
127/14.2	Ms Brown explained that the first phase of the 10,000 Voices project focused on unscheduled care, emergency departments, GP out of hours, minor injuries units and the Northern Ireland Ambulance Service. She said that information had been obtained from across a range of settings, with the aim of making the survey as accessible as possible. She assured members that in cases where patient stories had highlighted bad practice, these would be escalated immediately.
127/14.3	Ms Brown told members that the majority of the patient stories received had been positive and she outlined to members an example of how feedback from the patient stories had resulted in the recent launch of a PHA initiative, “Hello, my name is…”
127/14.4	Mr Coulter asked how this project linked to other work in the area of patient experience and whether there would be an evaluation undertaken. Ms Brown said that with regard to patient experience work, she said that PHA had received requests to do this work in other areas. She added that at the end of each stage, an evaluation is undertaken and there is also a workshop at which an action plan is developed and the survey reviewed.
127/14.5	Mr Coulter asked if there was an intention to take this project into other aspects of primary care and Ms Brown confirmed that this was the case.
127/14.6	Members APPROVED the 10,000 Voices Phase One Report.
128/14	**Item 12 – HSCB / PHA Annual Quality Report (PHA/04/09/14)**
128/14.1	Ms Brown explained to members that it is a requirement for the

	HSCB and PHA to develop an Annual Quality Report. She added that the aim of this report is to share learning from SAIs and share the outcomes of the extensive work carried out around Quality 2020.
128/14.2	Mrs Erskine noted that the report contains information about staff appraisal, but not staff supervision and she suggested that this be included in future reports. Dr Harper agreed that this was a good suggestion as there are standards for staff supervision.
128/14.3	The Chair asked whether this report would be submitted to DHSSPS to be formally launched. Ms Brown confirmed that it would be the intention to launch the report as part of World Quality Day.
128/14.4	Members APPROVED the HSCB/PHA Quality Report.
129/14	**Item 13 – Perinatal Mortality Report (PHA/05/09/14)**
129/14.1	Heather Reid joined the meeting and began her presentation with an outline of the work of the NIMACH team before moving on to the Perinatal Mortality Report for 2012. Members were given an overview of statistics relating to stillbirth, perinatal and neonatal deaths, with a more in-depth analysis in terms of age, deprivation, BMI, smoking and type of delivery.
129/14.2	Ms Reid outlined the causes for neonatal deaths and finished her presentation with an overview of the recommendations in the report.
129/14.3	The Chair said that the report was well presented and asked if there was anything further PHA could do. Dr Harbison asked whether the findings from the report would help health visitors target those mothers who are most at risk. Ms Reid said that there is work underway across the rest of the UK. Ms Brown added that it is important that obstetricians, midwives and health visitors work together in this area.
129/14.4	Members noted the Perinatal Mortality Report.
130/14	**Item 14 – Any Other Business**
130/14.1	There was no other business.

131/14 **Item 15 – Date and Time of Next Meeting**

Date: Thursday 16 October 2014
Time: 1:30pm
Venue: East Belfast Network Centre
Templemore Avenue
Belfast
BT5 4FP

Signed by Chair: _____

Date: _____

HSC Public Health Agency

PHA Board Report

August 2014

Summary Position August 2014

Income

	Page Reference	Annual £000s	Year to Date £000s
Department Allocation*		98,882	34,084
Income from Other Sources		950	523
Total Income		99,832	34,607
Expenditure			
Non-Trust Programme	2	44,251	11,766
Trusts	3	35,065	13,567
PHA Administration (inc. BSO)	4	20,308	8,197
Total Expenditure		99,624	33,529
Surplus/(Deficit)		208	1,078

*Includes assumed allocations of £797k for the Safeguarding Board for NI (SBNI), £134k for Clinical Excellence Awards, £250k for Research & Development projects from the Department for Social Development and £354k from HSCB re Accommodation charges.

Position Synopsis:

Following a review of all budgets, PHA is predicting a £208k surplus at the year end. It should also be noted that decisions on a balance of funds held for 2014/15 investments still requires to be made by PHA.

Year to date the financial position shows a surplus of £1.1m, relating to the non Trust Programme budget (£811k) and Management and Administration budgets (£268k).

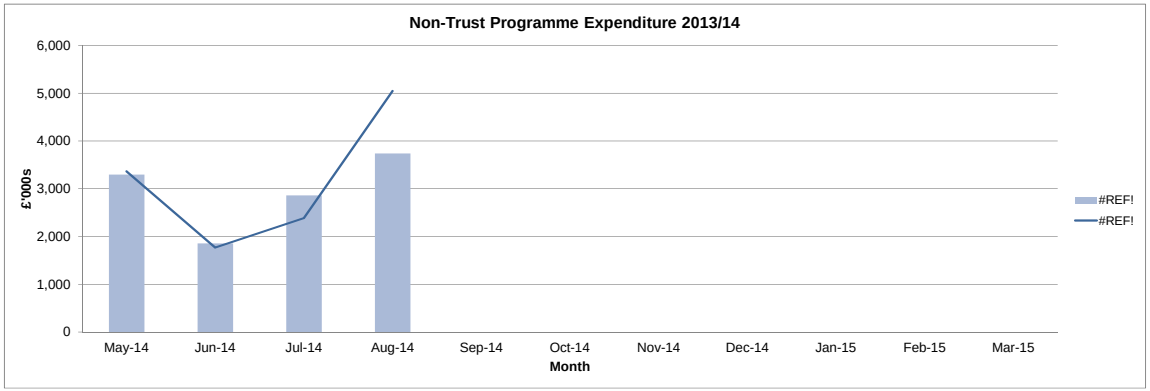
The PHA has yet to approve developments against a balance of £1.1m Full Year Effect and £0.6m Current Year Effect, remaining from the deployment of additional allocations received in 2014/15 and recycled baseline resources, decisions on priorities are currently being considered by PHA. The financial position above assumes that these resources will be fully expended within 2014/15.

HSC Public Health Agency

Non-Trust Programme

August 2014

Non-Trust Programme Spend



	£'000s May-14	£'000s Jun-14	£'000s Jul-14	£'000s Aug-14	£'000s Sep-14	£'000s Oct-14	£'000s Nov-14	£'000s Dec-14	£'000s Jan-15	£'000s Feb-15	£'000s Mar-15	£'000s Total
Budget	3,368	1,769	2,389	5,051								12,577
Expenditure	3,299	1,858	2,865	3,744								11,766
Surplus/(Deficit)	69	(89)	(476)	1,307	0	0	0	0	0	0	0	811
Surplus/(Deficit) made up as follows:												
Health Improvement - Belfast LCG	87	2	(42)	283								330
Health Improvement - South East LCG	(137)	(158)	312	(271)								(254)
Health Improvement - North LCG	(88)	67	(305)	420								94
Health Improvement - South LCG	135	(54)	79	(90)								70
Health Improvement - West LCG	249	(146)	(200)	290								193
Health Improvement - Lifeline Contract	(137)	14	11	(36)								(148)
Health Improvement - Smoking Cessation	0	0	0	22								22
Health Protection	(60)	(12)	(482)	459								(95)
Service Development & Screening	115	65	38	(212)								6
Research & Development	29	(28)	71	707								779
Campaigns	(96)	17	(50)	(73)								(202)
Nursing & AHP	(3)	8	5	(6)								4
Health Improvement - Regional Projects	(25)	136	87	(186)								12

Position Synopsis:

The current position shows an underspend of £811k at the end of August 2014 based on profiles shared by budget managers and the PEM system used by PHA to plan commitments. The Financial Management team have continued to meet with Budget Managers to review budgets, profiles and assumptions regarding expenditure for 2014/15.

Although all the budgets are showing small surpluses and deficits, the main driver behind the large surplus is the underspend in R&D which is the result of late claims from the Universities which is expected to be resolved in September/October.

Budget Holders continue to anticipate that all approved budgets, with the exception of the Lifeline contract, will breakeven at year end.

PHA Management Team continues to scrutinise in detail the pressure with respect to the Lifeline Service and the demand management measures in place. HSCB Financial Management team are being regularly briefed in order to allow an assessment of the potential financial impact that the pressure may have on the year end financial position.

HSC Public Health Agency

Revenue Resource Limits (RRLs) to Trusts

August 2014

	Annual Budget (per revised SBAs) £'000s	Budget to Date £'000s	Variance from Annual Budget £'000s	Main Reasons for Increase in Funding
Western Trust	5,113	5,580	467	
Northern Trust	6,129	6,663	534	The funds shown against specific Trusts have been notified via Service & Budget Agreements and additional adjustments have been made in year. The PHA are continually monitoring the progress of schemes funded in Trusts and taking action accordingly.
Belfast Trust	11,178	12,001	823	
South Eastern Trust	2,889	3,288	399	
Southern Trust	4,595	5,030	435	
Funds identified to Trusts in Budget Paper but not yet allocated	4,751	2,503	(2,248)	
Total	**34,655**	**35,065**	**410**	

HSC Public Health Agency

PHA Administration

August 2014

	Total Budget £'000's	Current Month Budget £'000's	Current Month Expenditure £'000's	Current Month Variance £'000's	Year to Date Budget £'000's	Year to Date Expenditure £'000's	Year to Date Variance £'000's
Salaries	17,639	1,518	1,389	129	7,291	7,034	257
Goods & Services	2,683	262	190	72	1,093	882	211
DHSSPS Retraction	(465)	(194)	0	(194)	(194)	0	(194)
Sub-Total Administration	19,857	1,586	1,579	7	8,190	7,916	275
BSO	659	59	61	(2)	275	281	(6)
Total Administration	**20,516**	**1,645**	**1,640**	**5**	**8,464**	**8,197**	**268**

Position Synopsis:

An overall management and administration surplus of £268k is reported at the end of August 2014 based on budgetary profile. The DHSSPS retraction is shown separately. Any remaining full year surplus will be used for other PHA priorities.

Prompt Payment Statistics

	August 2014 Value £'000	August 2014 Volume of Invoices	Cumulative position as at 31/08/14 £'000	Cumulative position as at 31/08/14 Volume of Invoices
Total bills paid (relating to Prompt Payment target)	1,950	643	11,452	3,797
Total bills paid on time (within 30 days or under other agreed terms)	1,851	563	10,324	3,367
Percentage of bills paid on time	**94.9%**	**87.6%**	**90.2%**	**88.7%**

The BSO has not yet been able to provide a comprehensive prompt payment report which is accurate for PHA. In the interim HSCB finance, on behalf of PHA, continue to generate a prompt payment report based on the audited method which was used to provide the Annual Accounts figures . This will ensure consistency of information reported to PHA on a monthly basis, while BSO works to produce a meaningful report.

PHA staff continue to make progress utilising the new systems to clear invoices promptly, with 78.1% of all undisputed invoices paid within 10 days of receipt in August, contributing to an overall 10 day performance of 74.5% year to date. However, overall 30 day performance has slightly reduced since July with 87.6% of all undisputed invoices paid within 30 days of receipt.

The cumulative position for 2014/15 by volume of invoices is 88.7% and by value 90.2%, which remains short of the 95% DHSSPS target.

Minutes of the 25th Meeting of the Governance and Audit Committee held on Wednesday 11th June 2014 at 1.00 pm,in Public Health Agency Conference Rooms, 12-22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mrs Julie Erskine	(Chair)
Mr Brian Coulter	Non-Executive Director
Mrs Miriam Karp	Non-Executive Director
Mr Thomas Mahaffy	Non-Executive Director
Alderman Paul Porter	Non-Executive Director

IN ATTENDANCE:

Dr Eddie Rooney	Chief Executive, PHA
Mr Edmond McClean	Director of Operations, PHA
Miss Rosemary Taylor	AD Planning & Operational Services, PHA
Mr Paul Cummings	Director of Finance, HSCB
Mr Simon Christie	AD Finance, HSCB
Mr Martin Pitt	Pricewaterhouse Coopers
Mr David Charles	Internal Audit, BSO
Mr Craig Morrow	Northern Ireland Audit Office
Mr Mark Anderson	Sponsor Branch, DHSSPSNI
Mrs Cathy McAuley	Secretariat

APOLOGIES:

Ms Dorinna Carville	Northern Ireland Audit Office
Mr Gary Christie	Northern Ireland Audit Office
Mrs Catherine McKeown	Internal Audit, BSO

42/14 Item 1 - Welcome and Apologies

Mrs Erskine welcomed everyone to the meeting and noted apologies.

43/14 Item 2 - Declaration of Interests

	Mrs Erskine asked if anyone had any interests to declare relevant to any items on the agenda. None were declared.	
44/14	**Item 3 - Chair's Business**	
	Mrs Erskine welcomed Mr Paul Cummings and Mr Craig Morrow to the meeting.	
	Mrs Erskine advised following a meeting with Mr Hugh McPoland, Mr Coulter would correspond with Mr David Bingham, Chief Executive, BSO inviting him to a future meeting of the GAG committee.	Mr Coulter
26/14	**Item 4 - Minutes of the GAC Meeting held on 5 December 2014**	
	Members agreed the minutes of the GAG meeting held on 6 February 2014 as an accurate record of the meeting subject to two minor typing amendments on page 3.	
27/14	**Item 5 - Matters Arising**	
	32/14: Mr McClean advised the MOU between PHA and HSCB had been developed and signed.	
28/14	**Item 6 – Head of Internal Audit Report for year ended 31 March 2014**	
	Mr Charles presented the HIA Annual Report for noting and gave a verbal summary of the report. The report included the priority 1 and priority 2 weakness identified. A satisfactory level of assurance was provided and all recommendations were accepted by management.	
	Mr Charles advised that a limited level of assurance had been provided to the management of contracts for voluntary and community organisations. Mr Charles said that Internal Audit did recognise that the PHA had put a process in place to ensure a rolling programme of procurement over the next 3 years.	

	Alderman Porter referred to management of contracts for voluntary and community organisations and enquired about the mechanisms for highlighting the programme of work on behalf of the PHA. Mr Charles responded by saying that all the community groups were advised in advance that audits would be carried out. Dr Rooney highlighted to the committee the importance of good governance amongst the community and voluntary sector, he added that the management response was to ensure that all the recommendations were implemented and the actions taken. Alderman Porter referred to the funding released to one voluntary organisation under the MARA project and questioned the gap in the expenditure. Dr Rooney responded by saying that this service had been a new development. He added that this particular issue had escalated to AMT and that investigations had been carried out and appropriate actions taken. Mr McClean assured members that whilst there were pressures on the procurement system, an action plan had been developed and implemented to address capacity issues. Members noted the report.	
29/14	**Item 7- Annual Accounts Including Governance Statement and Annual Report** Mr McClean presented the PHA Annual Report 2013/14 and the Governance Statement to members for recommendation for PHA board approval. Members recommended the report and the governance statement for board approval. Mr Christie presented the PHA Accounts for the year	Mr McClean

	ended 31 March 2014 and summarised the report to members.	
	Members recommended the report for PHA board approval.	Mr Christie
30/14	**Item 8- External Auditor's report to those charged with Governance** Mr Pitt presented the draft report to those charged with Governance to members for noting and gave a verbal summary of the report including the key risks identified in the audit strategy. It was noted that there were 4 priority 1 findings; • Reliance on third party organisations • Payroll information • BSO Shared Services Centre • Supplier amendments to standing data During discussion regarding 'reliance on third party organisation' Alderman Porter requested; section (c); Prompt payment, is amended to reflect the PHA's position. Members raised their concerns surrounding the new BSO shared services systems. Mr Pitt responded by acknowledging members concerns and further highlighted that the BSO shared services system was a new system. Dr Rooney assured members he would raise the committee's concerns at the PHA End of Year Assurance and Accountability Review meeting 18 June 2014. Members noted the report.	
31/14	**Item 9- Annual meeting with Auditors (External and Internal) without officers present.**	

Officers left the room for this part of the meeting.

32/14 Item 10- Corporate Risk Register as at 31 March 2014

Mr McClean presented the Corporate Risk Register for approval. He confirmed 2 risks had been de-escalated to the Operations Directorate Risk Register;

- CR18, Ensuring continuity of website communication
- CR29, Implementation of new Information Management Controls Assurance Standard.

Members recommended the report for PHA board approval. — Mr McClean

33/14 Item 11 -Single Tender Action for Goods and Services Procurement 2013/14

Mr McClean presented an update on the use of "Single Tender Actions" for Goods and Services Procurement.

Members noted the report.

34/14 Item 12 - Items to be brought to the PHA Board

- Annual Accounts Including Governance Statement and Annual Report
- PHA Corporate Risk Register as at 31 March 2014

35/14 Item 13 – Date of next meeting
Wednesday 8th October 2014.

Signed: _____
Brian Coulter (Chair)

Date: 8 October 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	16 October 2014
Title of Paper	PHA Mid-Year Assurance Statement
Agenda Item	9
Reference	PHA/03/10/14

Summary

All DHSSPS arm's length bodies are required to submit a mid-year assurance statement to the Department, to enable the Chief Executive, as Accounting Officer, to attest to the continuing robustness of the organisation's system of internal governance.

The attached draft mid-year assurance system has been prepared based on PHA governance and performance processes, and internal audit reports received to date.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The Mid-Year Assurance Statement was considered by AMT on 30 September and by the Governance and Audit Committee on 8 October
Recommendation / Resolution	For Approval
Director's Signature	
Title	Chief Executive
Date	8 October 2014

PUBLIC HEALTH AGENCY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the *Public Health Agency as at 30 September 2014*.

The scope of my responsibilities as Accounting Officer for the Public Health Agency, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organization's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on *11 June 2014*. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance framework

The Governance framework as described in the most recent Governance Statement continues in operation. The *Governance and Audit Committee and the Remuneration Committees* have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

An Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the board. Minutes of board meetings are available to further attest to this.

3. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by the board of the organisation and that risk management systems/processes are in

place throughout the organisation. As part of the board-led system of risk management, the Register is presented to the *Governance and Audit Committee* for discussion and approval and all significant risks are reported to the board – most recently on *19 June 2014.*

In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Controls Assurance

I confirm implementation of action plans arising from the year-end self-assessments of compliance with Controls Assurance Standards.

5. External audit reports

I can confirm implementation *is actively being progressed on the external auditor's accepted recommendations, of which there were one priority 2 and four priority 1 issues raised as detailed below:*

Priority 1

- *Reliance on Third Party Organisations – Business Services Organisation (BSO)*
- *Payroll Information - BSO*
- *Shared Service Centre - BSO*
- *Supplier amendments to standing data – BSO*

Priority 2

- *Prompt Payment Policy*

All of the recommendations made within the Report to Those Charged with Governance related to the new Shared Services environment and the operation of the new systems implemented under the Business Services Transformation Project (BSTP) in late 2012/13. The implementations of these recommendations are not within the direct control of the PHA. However, the

HSCB Finance Directorate, on behalf of the PHA, continues to work closely and proactively with the BSO, to assist with driving forward the service improvements required to ensure that Shared Service performance is of a sufficiently high standard. Whilst progress has been made the priority 1 and 2 recommendations within the RTTCWG reflected the issues experienced by the PHA. The HSCB Finance Directorate has been advised by the Permanent Secretary of the DHSSPS that the BSO is setting up formal customer forums. These forums would ensure that an accountability and governance framework is put in place for common issues to be raised and addressed across the HSC, although these have not yet been set up by BSO.

The Director of Finance (HSCB) ensures that the Governance and Audit Committee are kept apprised of progress at each meeting.

6. <u>Internal audit</u>

I confirm implementation of the *majority of* accepted recommendations made by internal audit*. Action is currently being taken to ensure the remaining recommendations are being fully implemented.*

Internal Audit carried out a full review of the recommendations from the 2013/14 internal audits and provided a detailed progress report to the Governance and Audit Committee on 8 October 2014. A copy of this report is available if required. Of the 29 recommendations identified, 93% have been fully implemented and 7% (2 recommendations) partially implemented.

The PHA has in place an agreed internal Audit Plan for 2014/15, which was approved by the Governance and Audit Committee on 10 April 2014. The plan proposes corporate risk-based audit assignments that will provide a source of assurance against the risks included in the PHA Corporate Risk Register, thus integrating the Internal Audit plan with the PHA's own risk assessment process.

Two reports have been finalised for 2014/15. Satisfactory assurance has been given in respect of PHA Risk Management and Research and Development.

7. RQIA and other reports

There have been no inspections by RQIA or any other relevant authorities.

8. Performance against Departmental Objectives

I confirm satisfactory progress towards the achievement of the objectives and targets set by the Department. *The PHA is currently reporting that it is on target to deliver 5 out of the 7 Commissioning Plan Directions targets applicable to the PHA. Reports to the Department have identified that there may be a delay in achieving the target to reduce MRSA and Clostridium difficile infections by a further 9% and in the progression of the programme of work to develop and implement normative nurse staffing. The PHA continues to take forward actions, along with relevant HSC organisations, and monitor the same, to progress both targets.*

9. Internal Control Divergences

Accommodation

The majority of the issues relating to Ormeau Baths have now been resolved, with PHA working well with the new agents for Ormeau Baths, ensuring that any issues are dealt with promptly. PHA and SBNI staff continue to be accommodated in Ormeau Baths, along with PCC, who moved in during November 2013.

During 2013/14 PHA staff worked with Health Estates to finalise the business case for new accommodation to resolve the continuing problems, especially in respect of 4th floor 12-22 Linenhall Street, and Alexander House with the

number of staff significantly in excess of capacity, with consequent problems including noise, lack of meetings space and challenges regarding data confidentiality. These issues continue to have a negative impact on PHA staff, resources and how the PHA carries out its business.

While significant progress was made towards implementation of the preferred option, this building was taken off the market at the last minute. The result is that a new search for alternative accommodation is required along with the subsequent revision of the business case. PHA will continue to work with Health Estates in particular, along with Land and Property Services (LPS) and the other regional organisations (HSCB and BSO), to progress this.

Management of Contracts with the Community and Voluntary Sector

While the 2013/14 internal audit report on the management of health and social wellbeing improvement contracts provided satisfactory assurance on the management of contracts, it provided limited assurance in respect of the procurement of voluntary and community organisation contracts. The report acknowledged that a procurement plan was in place; however at the date of the 13/14 audit, the procurement plan was yet to be implemented. Implementation of the procurement plan has subsequently commenced, and is monitored by the PHA procurement board.

PHA continues to work closely with BSO Procurement and Logistics Service (PALS) and Directorate of Legal Services (DLS) to develop appropriate social care procurement processes and documentation. This work is overseen by the PHA procurement board which meets on a regular basis.

It is recognised however that social care procurement is a new area for the wider HSC, and the PHA continues to work closely with colleagues in HSCB,

BSO and the Trusts to develop and put in place regional processes to meet the forthcoming new procurement regulations.

Progress against the PHA procurement plan has however been slower than expected, given the challenges of developing and implementing new procurement processes. The PHA will continue to work with colleagues to ensure that it commissions services in a satisfactory and timely manner.

Business Services Transformation Project (BSTP)

Since implementation of the two new regional computer systems (Finance, Procurement and Logistics and Human Resources, Payroll and Travel) in 2012/13 significant difficulties were encountered over a range of areas which were not solely within the PHA's control. The PHA, through the Director of Finance of the HSCB, had raised and continues to monitor the seriousness of the issues formally with BSO and the DHSSPS.

The issues identified resulted in a series of mitigations and additional processes being introduced by the Financial Management team to ensure that the most serious risks to financial management and control over the PHA's resources were managed. In the Report to Those Charged with Governance (2013/14) the External Auditor made four priority 1 recommendations on the shared services provided by BSO, which are highlighted in the External Audit section of this report. Since the start of this financial year a number of improvements have been implemented, in addition actions have been taken by the BSO to continue to improve the overall performance and control of the systems.

Taking the current position and progress since the start of the financial year into account, the HSCB Finance Directorate believes that with the continued commitment from BSO these issues can be improved during 2014/15.

Quality, Quantity and Financial Controls

This issue reflects the difficulties faced by the PHA in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase whilst the budget available for commissioning them remains constrained.

The PHA has taken action and continues to develop plans and associated efficiencies for 2014/15 which will contribute towards maintaining the integrity of the services that it currently commissions along with ensuring that the additional priorities identified continue to be implemented and progressed.

10. Mid-year assurance report from Chief Internal Auditor

I confirm that I have referred to the Mid-Year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations eg Controls Assurance Action Plans and Risk Register Action Plans.

Signed

CHIEF EXECUTIVE & ACCOUNTING OFFICER

16 October 2014

HSC Public Health Agency

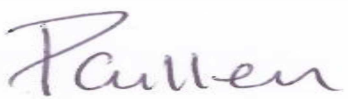
PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	16 October 2014
Title of Paper	Second Annual International Family Nurse Partnership Report
Agenda Item	10
Reference	PHA/04/10/14

Summary

The Annual International Family Nurse Partnership(FNP) Report is a requirement of the FNP Programme license. A Regional Stakeholders Group chaired by Dr E. Rooney held the first meeting at the end of June 2014. Kate Billingham, Senior International Consultant for FNP was in attendance at this meeting. Ms Billingham commented on the excellent programme fidelity and outcomes

Members are asked to note the International Report which has been signed off by Ms Billingham.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was considered by AMT on 26 August 2014.
Recommendation / Resolution	For noting
Director's Signature	
Title	Director of Nursing and AHPs
Date	26 August 2014

University of Colorado
Anschutz Medical Campus

Nurse Family Partnership International: Annual Report Phase 2 (April 2012)

"Phase Two – Feasibility and Acceptability through Pilot Testing and Evaluation. *Phase Two involves the conduct of a pilot test of the adapted NFP program with the projected number of Sites and/or clients specified in the licensing agreement. The results of this work will inform what additional adaptations may be needed to ensure the feasibility and acceptability of the NFP program within local contexts. Continued recruitment of clients in existing pilot sites may be approved if requested"*

We have devised this annual report template for societies in the pilot testing and evaluation phase. It provides an opportunity for reflection and learning during a time of learning, adapting and testing and focuses on the early stages of delivering the intervention. There is an expectation that you will illustrate this report with early information and we include several annexes of tables to use if you have delivered NFP for long enough to collect the relevant data.

Summary of content

- Part One: Program overview
- Part Two: NFP model elements
- Part Three: Additional learning on implementation
- Part Four: Assessment of program implementation and adaptation
- Part Five: Action planning

The process

The annual report is completed by the license holder in each country and sent to David Olds and Kate Billingham. The NFP International Unit will analyse the report prior to a meeting (face to face or by VC/tel conference) within four weeks of receiving the report. This meeting will provide an opportunity to celebrate successes, reflect on any issues arising from the report and agree plans for the coming year. At the same time the NFP International Unit will share learning from other countries and update national teams on programme developments and research in the US. The action plan will be reviewed together after 6 months.

This tool is designed to be used flexibly as there will be variations in the language, delivery stage, number of nurses, context and information systems in each country/province. We look forward to receiving your feedback on the value of this format. The content of this report is confidential and will not be shared without each national/provincial/state[1] team's permission.

[1] In the biggest countries the state or provincial level of Government may be the licensing authority

Part One: Program Overview

Name of country (province/state): Northern Ireland Date of review: 25th June 2014

Year covered (dates): 2013
1.1.2013 – 31.12.2013

Completed by (license holder): Deirdre Webb

Phase of replication: 2

Date when enrolment of clients began: 2011

The size of our program

a. We have 14 (12 Whole Time Equivalent (WTE)) NFP Nurses and 3WTE Supervisors today

b. We have 3 teams (supervisor-led groups of nurses)

c. We have 3 local areas (defined nationally)[i]

d. We have 309 potential places available for families in our country

e. We have enrolled 148 new families in the last year

Comment
One of our teams (Belfast) had two individuals (one Supervisor and one Family Nurse) on Maternity leave. This resulted in only 64 available places on the programme in the past 12 months. Since both team members have now returned, the 40 remaining places will now be available.

What are our plans for the number of nurses, supervisors, local areas and places for NFP in the coming year?

The Commissioning directions in Northern Ireland for 2014/2015 have recommended the extension of Family Nurse Partnership with two additional Teams in the Northern and South Eastern Trust areas. These two small teams will have 1 WTE Supervisor and 4 WTE Family Nurses. This would create an additional 206 places.

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

Clinical leadership, support and guidance
During the past 12 months, the Lead has been supporting the implementation of the Programme in Northern Ireland. Supervision has been provided monthly to Supervisors and quarterly meetings with the Site Provider Leads (PL). The Supervisors are growing in confidence in building cohesive teams. The PLs have attended all Family Advisory Board meeting and local Celebration Events. The local teams are growing and developing the skills

required and delivering FNP in the way it has been designed and within the conditions of the license.

Programme Board

The first Programme Board will be held on June 25th 2014. Kate Billingham, Senior Advisor NFP International and Consultant on Prevention in Early Like from the International FNP Unit is to be in attendance . The terms of reference for the Programme Board will be agreed at the first meeting.

The purpose of the board:

- To create and communicate the vision and strategic plan for FNP in Northern Ireland;
- To develop a strategic approach to FNP implementation in Northern Ireland;
- To ensure processes and structures are in place to meet the licence requirements and Programme fidelity;
- To ensure FNP training is available to local FNP teams;

The frequency of the meeting of this forum will be agreed at the first meeting.

Members of the Programme Board include a wide range of agencies and programmes:

- Department of Health
- Public Health Agency
- Department of Education
- Policy Lead (DHSS)
- Social Services (DHSS and HSC)
- Nursing
- Public Health Medicine
- National Children's Bureau
- Barnardos
- Queens University Belfast

The Service Quality and Improvement Nurse (SQIN) had a busy year attending a robust Induction programme developed by the English National Unit and has established bi-monthly meetings with the three Supervisors. This provides an opportunity for peer support, reflection on practice, a review of practices, development of agreed regional standards and an opportunity to share practice. In addition, the SQIN has established a quarterly Clinical Quality Improvement Meeting of the National NI Team and Supervisors. The purpose is focus on improving Quality by practice, education, research and information .A short paper on Quality is attached to the report.

Regionally we have held three team learning days with all the teams attending.

Service / Implementing Agency Development

The Implementing Agencies are the Health and Social Care Trusts. The National Team have a strong credible working relationship with the Trust Senior Management Teams and the Directors and Assistant Directors acknowledge the difference the FNP Programme makes for Clients within the Children's and Families service. The Chairperson and Chief Executive of the organisations have visited the teams in their Trust area and are invited to attend all Client Celebration events. The provider leads were provided with the opportunity to attend a two day Strengths Based Leadership Programme. Key senior personnel within the Implementing Trusts have developed a deeper understanding of the model of client involvement and acknowledge the importance of case studies and presentations at all events and meetings.

Information System and Quality Analysis

The Research and Information officer has been working on the database development for the past 12 months. In addition to supporting the System development, she has been training and supporting staff through the implementation stage and has developed a comprehensive User Guide to support users. She has contracted support from the English National Research Unit and attends quarterly UK Data and Information group meetings. The new Information System is now live; however reports remain in the testing and quality assurance phase.

Policy

The policy context for Family Nurse Partnership is strong as it is featured in all the Key Policy Documents such as:

- Transforming your Care;
- Delivering Social Change;
- Making Life Better;
- Health Futures.

It is also highlighted in the Department of Health and Social Services for Northern Ireland (DHSSPSNI) Business Plan and The Commissioning Plan 2014/15.

Description of our local and national/provincial funding arrangements

The Family Nurse Partnership programmes in Northern Ireland are funded by Programme of Government Funding. This is recurrent funding and all Supervisors and Family Nurses hold permanent contracts

Current policy support for NFP

There is good Policy Support for Family Nurse Partnership. It is detailed in a number of key policies:

- Programme for Government ;
- DHSSPS Business Plan ;

- Healthy Futures;
- Transforming your Care;
- Public Health Policy- Making Life Better.

All the aforementioned policies highlight the unique contribution FNP makes to transform the lives of Young People and their children.

Delivering Social Change for Children and Young People is the Northern Ireland Executive Framework to facilitate the co-ordination of efforts across departments to take forward work on priority social policy areas. It represents a commitment to deliver a sustained reduction in poverty across all ages and an improvement in children and young people's health, wellbeing and life opportunities. The policy's action recommends delivery of preventative support to vulnerable first time families, young parents to improve antenatal health ,child development and parent's economic self sufficiency

Other useful information on our program

Our Supervisor in the Western Trust Team won Public Health Nurse of the Year 2013 and the Belfast Trust Team were runners up for the Chairpersons Award.
The Southern Team were nominated for Southern Health and Social Care Trust (SHSCT) excellence award under the category 'Raising Standards' and have been shortlisted as finalists in this category.

PART TWO: NFP CORE MODEL ELEMENTS/FIDELITY REQUIREMENTS

OUR CLIENTS

Element 1: Client participates voluntarily in the NFP program Yes

Comments: All client involvement is voluntary

Element 2: Client is a first-time mother Yes

Comments: All clients are first time mothers

Element 3: Client meets socio-economic criteria that indicate significant disadvantage

Yes Further information on those enrolled to date:

f. Our eligibility criteria:
- Enrolment and participation is voluntary
- 19 and under at LMP
- Enrolled before 28th week of pregnancy
- First time mother
- No planned adoption
- Pregnancy confirmed by scan
- Living in agreed catchment area

g. Age group (mean, standard deviation, range):

Overall (N.147) all sites the average age at LMP was 17.6 (SD = 1.3, range = 13.4 – 19.8 yrs)

h. In education and/or in employment (%)

Of the 93.9% who have EET recorded at intake, 55.4% clients are in Education and 16.5% are in Employment.

i. Low income or other poverty indicator for the mother (please specify indicator used)

85% of mothers have an annual income of less than £10,400

Relative poverty can be defined as 60% below the medium income. Annual income in N.I, before having costs, was £19,400. 60% of this is £11,640 (Northern Ireland Poverty Bulletin 2011/12)

j. Additional key indicators of need and vulnerability e.g. use of substances during pregnancy, % of mothers who cross clinical threshold for depression/anxiety.

Use of substances at intake: 93% of mothers have alcohol use record at intake, 2.9% reported drinking alcohol in the last 14 days at intake and no drug use was reported.

Anxiety scores were recorded for 88.7% of clients at intake. Of these, 7 (8.1%) were found to have probable anxiety and 7 (8.1%) were found to have borderline anxiety. Depression scores were recorded on 86.6% clients at intake. 5(6%) were found to have borderline depression.

k. Ethnicity relevant to our country/province
45.3% white British;
61.0% white Irish;
7.9% white Other;
1.4% Black
1.4% Other – Chinese

Comments: Need to improve the recording of the HADS scoring – 11 mothers had no data recorded.

Element 4: Client in enrolled in the program early in her pregnancy and receives her first home visit no later than 28 weeks

(Yes) / No Further information on enrolment to date:

Of the 148 clients enrolled in the programme 2012/13, 57% were enrolled by 16 weeks

% enrolled by 28 weeks gestation:
100% were enrolled by 28 weeks

Our assessment of our recruitment pathway:

In the three sites, the main source of recruitment to the programme was through the recommendation of the booking Midwife. Other sources of recruitment were clients, GPs, and social services.
In the early few months of the programme however, it became clear that some eligible young mothers were not being identified by the midwifery team. Recruitment via the midwives' recommendation remains the preferred route however; to ensure that all first time mothers aged 19 years and under who have booked are offered the programme, a monthly print out from the Northern Ireland Maternity Information System is provide to supervisors.

Element 5: Client is visited one-to-one, one nurse home visitor to one first time mother or family: Yes Each client has their own family nurse

Element 6: Client is visited in her home: Yes

Visits are mostly carried out in the client's home

Element 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current NFP guidelines. Yes

The Visiting Schedule is carried out in line with National Guidelines

OUR NURSES AND SUPERVISORS

Element 8: Nurse home visitors and nurse supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing. Yes

Comments: All the Supervisors and Family Nurses are registered Nurses and are educated to degree level

Element 9: Nurse home visitors and nurse supervisors complete the education program as agreed with UCD. Yes

Comments: All Supervisors and Nurses have attended the Training Programme delivered by the English National Unit. Most of the SVs and FNs have completed the formal education programme with a few nurses still to complete DANCE training

…and deliver the intervention with fidelity to the Nurse-Family Partnership model.

Our assessment and comments, including evidence/data on program delivery to date:
At present the FNP teams are gaining confidence and are building their expertise.

Element 10: Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.

How we support nurses to do this and our assessment and evidence of this to date:

Supervision and Team Learning sessions help support the Family Nurses further develop and improve professional knowledge and skills. The Family Nurses adhere to the Family Nurse Guidelines and agenda match to take account of the family's individual needs. Supervision allows for a deeper analysis of the time apportionment across all the program domains.

A regional workshop is planned on the concept of analysis to support Family Nurses when assessing, analysing and understanding the client's unique situation and determining how best they can use the program resources to optimise the client's wellbeing and improve outcomes.

Element 11: Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods.

How we ensure this and our assessment of the success of this model element to date:

Case Presentations, Case Studies and stories are the best media to see the application of the theoretical frameworks that underpin the programme in action. The Nurse articulates how the theory of self-efficacy, human ecology and attachment theories benefit the work between the client and the Nurse.

The Family Nurse presents their clients to the team two weekly. The Team psychologist or

the Trust Safeguarding Nurse may be asked to join the session if the issues are challenging and an expert input is required.

A Case Study is presented to each Family Advisory Board Meeting. The case studies support the Board members understanding of the programme.

Element 12: A full-time nurse home visitor carries a caseload of no more than 25 active clients.

Nine Family Nurses work 30 hours per week and hold a caseload of 19-20 families. The Family Nurses who work full time and hold 23-25 families.

Comments:

…and work exclusively in this programme

Comments:
All Supervisors and Family Nurses work exclusively in the Family Nurse Partnership Programme

Element 13: A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors. Yes

Comments: Each FNP team has 1 wte Supervisor for 4 to 5 Family Nurses

All supervisors carry a small clinical caseload: Yes

Comments: Each Supervisor has a small caseload of 2 to 4 families

Element 14: Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision.

Our assessment of supervision to date with evidence on frequency and quality

One to one supervision is provided weekly and time has been prioritised to ensure this process is fulfilled.

Supervision and the accompanied home visits with Family Nurses has facilitated the Supervisor to chart progress in relation to the integration of FNP learning into practice. The Supervisors and Family Nurses have been reflective in relation to their learning and are growing in both confidence and the skills required for the effective delivery of FNP. The accompanied visits have assisted the Supervisors identify themes for the learning set. Those areas of practice identified as challenging by a Nurse can be used in team learning to review practice. The team meeting provides an additional opportunity for team leaning and peer

support.

Mentor Support provided by Lindsay Andrews to the 3 Supervisors, has assisted the immeasurably in the development of their role.

Element 15: Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership UCD/NSO and use NFP reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.

Partially. During the past year, a new information system has been developed. Supervisors, Family Nurses and the Administrators have been involved in testing the system and identifying issues for revision and development. The system is now live and the process of uploading live clients has been completed. The Administrators demonstrated great expertise and efficiency in gaining understanding of the data system and have been pivotal when providing support to the Teams. This has assisted them to build on their knowledge and confidence when using the system. They have also reinforced the importance of accuracy when entering data. The FNP reports are currently in the testing phase. The reports will provide the Supervisors and Family Nurses with guidance on programme implementation and will inform clinical supervision, enhance programme quality and fidelity and therefore support the development of improved outcomes.

AGENCY REQUIREMENTS

Element 16: A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.

Our assessment of the quality of NFP local implementing agencies:

The Local Implementing Agencies for the three programmes are the local trusts. The Teams are managed within the Children's directorate. These directorates provide a range of different health and social services. FNP would contribute to the Trust pathway of early intervention and prevention in particular for more vulnerable families. The Trusts work closely with a number of strategic partnerships (eg Safeguarding Boards, Early Years Partnerships, Local Strategic Planning Boards, School Aged Mothers Project).The Provider Lead and The Family Advisory Boards (FAB) for each Programme has worked effectively to integrate the programme into the local partnerships and services. All the Programmes have active Communication Plans for all key stakeholders which is reviewed at quarterly FAB meetings.

Element 17: A Nurse-Family Partnership Implementing Agency convenes a long-term

community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.

Yes Information and comments on the quality of the Board (terms of reference, client participation, ways of working etc):

The three FNP Programmes are supported by their Family Advisory Board. They meet quarterly and are chaired by a Lead Commissioner. The Belfast FAB is chaired by the Provider as the Commissioning Lead resigned and until a new Commissioner Representative is appointed. Either the Programme Lead or the Service Improvement and Quality Lead attend the FAB meetings

Element 18: Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner

Yes / No Our assessment of administrative support provided to nurses for the input of data:

ASSESSMENT OF OUR SUCCESS IN MEETING THE NFP MODEL ELEMENTS

Which have gone well?
The FNP Teams are extremely committed to delivering the programme as intended. They understand the core elements of the programme and the need of replication of these conditions to achieve the best outcomes for their clients

Which do we need to do more work on?
Our challenge this year will to use the data to improve the quality of the programme.

PART THREE: ADDITIONAL LEARNING ABOUT IMPLEMENTATION

CLIENTS

What is the % of those eligible offered the program who have enrolled to date (Annex A)
95% of those enrolled
Our reflections on this figure:
Of the 148 ever enrolled, the total attrition rate is 3% (N=5). The FNP Teams work hard to enrol eligible clients onto the programme.

What is the % of clients who have completed – this will depend on the length of time NFP has been running in your society (Annex A)

Pregnancy phase? 4 clients left during the pregnancy stage
Infancy phase? 1 client left during the Infancy stage
Toddler phase?

Our reflections on our learning about retention to date:
The three teams have been successful during this year enrolling eligible clients and retent those clients on the programme.

Key learning from evaluation on acceptability of NFP to clients and their families:
From a local perspective, the Family Nurses have taken a family approach to enrolment on the programme. Grandparents exert considerable influence on the client, acceptance of the programme. The Family Nurses are gaining experience in the approach to the whole family unit.

Father's engagement?

The overall rate of for Father's Engagement is 17.3% but, the range is 14% to 32.2%. The FNP Team in the West have demonstrated a significant improvement in the involvement of fathers in the past 12 months. This was at the main area of focus in the team's annual review last year. The team included father engagement on all Team meeting. In addition, the team have been more careful in their recording of father engagement with the programme. The FNP Teams will endeavour to improve our performance in this area of the programme.

OUR EARLY IMPRESSIONS OF THE FEASIBILITY AND ACCEPTABILITY OF THE NFP

a. Acceptability (with evidence where possible) of the NFP to:

- Clients

One of the most rewarding part of the programme is watching the clients grow in confidence as individuals and as mothers. The FNP Teams listen carefully to feedback that clients give us and what is important to them. The clients value that the family nurse treats them with trust and respect. They appreciate all the knowledge and skills that they gain on the programme and feel it makes them better parents.

- Clients' partners/families

The family nurse involves the client's partner at every visit. Often the partner is not available as they may be working or at school. The family nurse will always include the partner's needs into the visit and leave materials.
The feedback from other family members is extremely positive. The family members indicate that the family nurse has helped improve family relationships and has reduced family stress. Some of the grandmothers report learning so much about parenting from the family nurse and their daughters

- Community stakeholders

The FNP Programme acknowledge the importance of successful relationships with their community stakeholders. As well as working with internal stakeholders such as Midwives, Health Visitors, Social Services ,Sure Starts and CAMHS, the teams work very closely with external stakeholders ,Housing Organizations ,School Aged mothers programme ,Schools , further education providers and community/voluntary sector. In preparation for the Annual review, the teams carry out a feedback exercise with the local stakeholders.

- Nurses/supervisors

The Supervisors and Family Nurses are very committed to their young clients. They report to really enjoying the programme but find it very hard work. Peer support and Supervision help with the emotional challenge of the work, and the input from the Psychologist is really great valued to maintain more complex issues .The family nurses feel that they draw on their extensive knowledge 'experience and skills as well as the formal FNP education programme. Team learning is also rated highly by the teams to assist with very complex clients

b. Feasibility of implementation in our society

The FNP Programme appears to adapt well to the target population with a few small adaptions of the language to the Northern Ireland context.

PROGRAM FIDELITY

Our assessment of program dosage (from the data we have collected so far see Annex B):
The average dosage rate is testament to the hard work carried out by the family nurses and their dedication to their clients and the FNP Programme. The teams have taken on board the FNP learning and are increasing their competence and skill.

Our assessment of program content (from data we have collected so far, see Annex B):
The programme content is within the expected range for most of the FNP programme and within normal range as outlined in the license. The three teams have been very successful in delivering the content within the true spirit of the programme.

PROGRAM IMPACT (depending on clients completing pregnancy stage)

Key learning from our early data (see Annex C)
Tobacco use in pregnancy: Smoking/Tobacco use in pregnancy is a key health behaviour for our young population. At intake, 44% of mothers report smoking and at 36 weeks. Tobacco use in pregnancy is a key challenge for Family Nurses and there has been a small positive impact noted on health behaviour change within the programme.
Immunisation uptake: 100%
Alcohol use in pregnancy:
Illegal drug use in pregnancy:

To add data as relevant depending on completion of program

OUR NURSES

LOCAL ORGANIZATIONAL / SYSTEM CONTEXT

Our assessment of local implementing agencies and systems (strengths and challenges)

The implementing agencies for the three FNP Teams Health and Social Care Trusts. The strengths of the trusts is that they provide numerous services for children and families .They have a proven track record of service delivery and have other support and operation services eg Communication Departments ,IT Departments which have been really helpful in the setting up of the Teams. The challenge for the FNP teams is the maintaining and enhancing relationships with the local community and voluntary groups and organisations

Understanding of and commitment to NFP:
So far the trusts have developed a good understanding of the FNP programmes and ways of working differently with clients. A Senior manager commented on the high calibre of the family nurses and noted that their refreshingly positive based approach at multidisciplinary and inter professional meetings is having an influence on other professionals working with FNP Clients. All three Implementing Trusts are deeply committed to making the programme a success

Integration of NFP within local services
The FNP Teams understand the importance of helping the young parents build a sustainable community of support around the family. The family nurses work closely with a range of local community groups and organisations to support Young families. If the young mother is returning to education, the nurses will help them to prepare well and make the best use of all the community resources available to them.
The Supervisors also have regular contact and visit the key local community and voluntary organisations to build a working relationship and a greater understanding of the programme.

Sustainability and funding for NFP locally:
A phased approach to the implementation of FNP in Northern Ireland has been adopted. However the three teams have been recurrently funded by PHA/HSC on a recurrent basis.

Leadership and professional support to the nurses and supervisors:
The provider lead provides professional and managerial support to the local FNP Team. She will meet with the Supervisor monthly and the Supervisor will attend Trust professional for a

OUR NATIONAL (PROVINCIAL/STATE) LEADERSHIP AND IMPLEMENTATION CAPACITY

Our assessment of our capacity to:

- Provide clinical and professional leadership and guidance to the leadership team, supervisors and nurses to ensure high quality adaptation and implementation.

- The National Unit for NI consists of a Programme Lead, a Service Improvement and Quality Lead and a Research and Information Officer. Over the past 12 months, we have been able to understand and develop our individual roles within the team. We have invested a lot of commitment trying to develop our leadership role in supporting the three FNP teams in a positive way to improve the FNP Programme in NI.

  With the next stage of expansion, A Data Analyst will be appointed. On expansion, further funding has been identified to enhance the Programme coaching role.

- Administer an information system and analyse data to report locally and centrally on programme quality?

  Over the past 12 months, we have developed a new Regional information system. It was developed by Hewlett Packard .The system is currently live and the FNP are using their laptops to record on the database. They are in the process of changing to use mobile devices which will allow for improved real time data collection. The testing and developing of the reports is in progress at present. This process has taken much longer than expected. For the purpose of this Annual report, the data was downloaded and will analysed by the research and Information Officer
  All the data from the Active Client Caseload for all three sites is on the New System. Arrangements are currently in place to back load the data from Graduated Clients from the Western Site.

- Select suitable local implementing agencies and support them so that they can provide the best environment and support for NFP in this early stage of NFP?
  There are only five Health and social care trusts in Northern. The two new teams will be sited in the Trusts who do not have a programme. Both Trusts have well developed Child and family services and they have a positive approach to implementation of early intervention and prevention programmes. Both Trust have appropriate support structures in place for successful implementation of the programme

- Build evidential foundations for the NFP in our country/state/province?
  Following discussions with Dr David Olds, Kate Billingham and local teams, Family Violence and Post Conflict Stress following the troubles are two areas where Northern Ireland has considerable experience and may be potential areas for further FNP research. There may be potential for exploring a collaborative research arrangement with NFP colleagues in British Columbia who have developed A STAR programme which includes enhanced training for Family Nurses in the area of Family Violence.

- Secure senior policy support and funding for NFP through phases 1 and 2?
  One of the objectives from the International Review last year was the establishment of a Regional Programme Board for FNP in Northern Ireland to provide strategic direction and multiagency governance arrangements for the International Annual review. Dr E Rooney, the Chief Executive of the Public Health Agency has established and will chair a FNP Programme Board .The Board consists of Senior Policy leads from Public Health, Medicine, Nursing ,Social Services and the Community/Voluntary Sector. Kate Billingham will be in attendance at the first meeting.

- Build systems and grow capacity for an autonomous, sustainable and high quality program delivered at scale?

- The NI Unit has developed a strong foundation to allow for the careful replication of the FNP programme and scaling up the programme in a phased approach. Due to the small size of Northern Ireland there will only be small scale scaling up and this allows us to try and get it right. The development of the database will be greatly enhanced by the appointment of a System Analyst. The FNP Teams will be enhanced by the development of a Regional Coach/Practice teacher on a sessional basis.

PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

Our reflections on program implementation:

What is going well:

The outcomes for children and families continue to improve. The Family Nurses are growing in confidence delivering the programme ethos. The greatest satisfaction with programme implementation is seeing the young parents growing in confidence in their role as parents and educators of their young infants

Areas for further work: One of the major areas of focus for the next 12 months is to improve our Breastfeeding initiation and continuation rates. Although our Breastfeeding initiation rates are higher than the Northern Ireland figures of 17.4% (2012) The teams will work to improve our initiation rates and to improve our rates at breastfeeding continuation at 6 weeks and 6 months.

Our reflections on our local and national/state/province context for NFP

What is going well:

Over the past three years there has been a Strategic and Policy Shift towards the acknowledgement of positive contribution of Early years programmes . Within Northern Ireland, there is a great understanding of Infant Mental health across all sectors and this has contributed to the acceptance of the FNP Programme within the region and the continued support for the Programme at Policy level

Areas for further work:

As part of the Delivering Social Change Policy, The Office of First Minister and Deputy First Minister (OFMDFM) have established a 30 million pound Early Intervention Transformation Programme for Early Years over the next three years . It would be important to share the early learning from the Implementation of the Family Nurse Partnership with other early years programmes .Although still in our infancy in Northern Ireland, the National team have discovered how important getting the core components right to implement and sustain change in a new programme and system.

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Our reflections on the NFP research program

What is going well:

The second part of the Service Evaluation (Year 3 and 4) for the West Team is underway. Following completion of this paper, it is hoped to amalgamate the two reports and publish a

single report

The Programme lead has been involved in an International review of the FNP International Education Programmes. It has been extremely useful to learn about FNP programmes outside the UK and how the Ni context has many similarities with other areas like Canada.

Areas for further work:
During the next 12 months the NI Team would like to develop a research plan. Previous discussions have centred around Domestic violence and Family Stress. Dr Olds also explored the Impact of Post Conflict Issues on the Programme Implementation. As a Team we would like to explore areas of potential research where we could add to FNP body of knowledge and evidence. Domestic violence on the clients has been a significant factor in a large number of clients recruited.

Our reflections on our capacity and leadership at a national (state/provincial) level

What is going well:
With the appointment of the Service Improvement and Quality Nurse has allowed the team to concentrate on developing each member's role and concentrating on particular area of Programme Implementation and Quality Improvement.
The International Teleconferences have broaden our horizon to think about how the programme should be delivered to a more Targeted vulnerable population .It has been interesting and informative to learn about the programme different application throughout the world.

Areas for further work:
In the next year, the NI team needs to develop and enhance our international relationships with other FNP Programmes and to learn from our colleagues in the US and Canada.

Anything else that UCD needs to know?

Our thoughts on where adaptations may be needed to better align the NFP with our national context:
One of the recommendations from Service Evaluation was that Family Nurses, from a non-Health Visiting background, felt that they required more training on child health and

development. The NI are currently developing a competency and training package to address this issue.

PART FIVE: ACTION PLANNING

OUR OBJECTIVES FOR THE NEXT YEAR

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

In Northern Ireland, the Family Nurse Partnership Programme has established a firm foundation and we will provide a safe and high quality programme, which will continue to develop and grow**.**
The Preparatory work has started with the two new sites and the trusts are committed to preparing well for the programme.

Our three objectives are:

- Implementation of the new data system and ensure all Supervisors and Family Nurses are confident and competent in its use

- Develop a Research Plan and consider how NI can contribute to the International body of Knowledge and Evidence

- Develop a Learning and Development Plan which will support competent Family nurses to move towards advance practice and ensure the delivery of a high quality FNP Programme

How we will know if we have been successful?
We will know if we have been successful by

The Outcomes for the Children and Young People on the Programme continue to improve
The Family Nurses' knowledge and skills grow and develop expertise
The Family Nurses' are using their local data to influence and improve the quality of the programme
The Programmes' ability to influence strategic thinking in Northern Ireland regarding best practice models for supporting young parents and Trust staff
The Programme reaches out to stakeholders through the medium of the Family Nurses and the young parents voice
Local FNP Research is contributing to the International body of FNP Knowledge and Research

It would be really helpful if we could have the following support from NFP International (in order of priority)

It would be helpful if the NFP International Team could provide support in shaping our thinking about Research and the development of a local plan

Our suggestions for how NFP could be developed and improved internationally are:
The International teleconference between all the countries who deliver FNP has been really beneficial to broaden our thinking on the future possibilities for programme delivery in Northern Ireland. This could be further developed by aligning countries with similar profiles together to develop a collaborative working relationship and mutual sharing of ideas and possibilities (FNP Twining).

Annex A: NFP Summary of Fidelity Measures[ii] Reporting year[iii]:…..

Measure	Definition	Notes	% figure for reporting year (aggregate of local site data)	Range	Comments
Client engagement	% of those eligible offered[iv] the program who enrol[v]	Numerator = All eligible women who enroll on FNP in specified year, Denominator = Total number of eligible women offered the program	73.4%	73.9 – 74.6%	
	% of those enrolled by end of 16th week gestation		57%		
	% of those enrolled by 28th week gestation		100%		
	Mean gestational age in weeks at enrolment on program		17.5 weeks	(8.3 – 27.9 weeks)	
Client retention	% of those enrolled who complete the program or the specified stage of the programme				
	Pregnancy	% of clients enrolling on program who do not leave or become inactive by the date of their infant's birth.	95%	71/75	
	Infancy	% of clients enrolling on program who do not leave or become active between the date of their child's birth and first birthday	There were no infancy stage completers at 31.12.13		One client left in infancy stage
	Toddlerhood	% of clients enrolling program who do not leave or become inactive between the date of their child's first birthday and the date of their second birthday	There were no toddlerhood stage completers at 31.12.13		

ANNEX B: Dosage[vi]

		Pregnancy					Infancy			Toddlerhood			Overall		
Year of enrolment[vii]	N	Mean No of actual visits	Mean expected number of visits given gestational age	Mean % expected visits achieved[viii]	Mean % expected visits achieved using 14 expected visits	% clients getting 80% or more of expected visits	Mean no of actual visits	Mean % expected visits achieved	% clients getting 65% or more of expected visits	Mean no. of actual visits	Mean % expected visits achieved	% clients getting 60% or more of expected visits	Mean no. of actual visits	Mean % expected visits achieved	% clients getting 60% or more of expected visits
2012		154	12.1	106.2%	91.7%	83.3%									
2013		709	12.5	90.0%	80.4%	76.2%									
Total		863	11.5	92.5%	82.2%	77.3%									

Length of visit	Mean	Standard deviation	Range
Overall			
Pregnancy	77.7	22.8	(20 – 390)
Infancy			
Toddlerhood			

Visit content

Average % of time spent on 5 domains by phase of program in reporting year[ixx]	Pregnancy	Infancy	Toddlerhood	Comment
Personal health	(35-40%)[xi] 38.5%	(14-20%) 20.7%	(10-15%) NA	
Environmental health	(5-7%) 7.2%	(7-10%) 10%	(7-10%) NA	The Western Trust recorded higher than the average range due to local housing issues
Life course development	(10-15%) 12.6%	(10-15%) 11.49%	(18-20%) NA	
Maternal role	(23-25%)	(45-50%)	(40-45%)	
Family and friends	(10-15%)	(10-15%)	(10-15%)	
	16%	12.7%	NA	

ANNEX C

Programme impacts

1. Change in self reported tobacco use during pregnancy (from intake to 36 weeks pregnancy)	Number and % of clients reporting tobacco use at intake 44% (N=61)	Number and % of users who stopped between intake and 36 weeks 7.4% (N=4)	% change in numbers of clients who smoked between intake and 36 weeks -3%	Site range:	Data completeness % 93	Comment Small positive change
	Mean number of cigarettes smoked at intake amongst those identified as smokers 9.98	Mean number of cigarettes smoked at 36 weeks among intake smokers 7.53	Number of smokers at 36 weeks who denied at intake N=3			
2. Change in self reported alcohol use during pregnancy[xii] from intake to 36 weeks pregnancy	% of clients reporting alcohol use at intake (4 clients) 2.9	Number who stopped between intake and 36 weeks (1 client) 2.0	% change in numbers of clients between intake and 36 wks 66.3%	Site range:	Data completeness % 95/55	Comment
3. Change in self reported (illegal) drug use during pregnancy	% of clients reporting illegal drug use at intake[xiii] 0	Numbers who stopped between intake and 36 weeks 0	% change in numbers between intake and 36 weeks 0	Site range:	Data completeness % 92	Comment
4. Breast feeding	% Initiation: 44.6%	% 6 weeks 13%	% 6 months 0%	Site range: 11.55%	Data completeness %	Comment (including any comparative data)
5. Fathers engagement[xiv]	17.3%					

Sentinel / significant events that deserve review

Event	Number	What was the learning?
Child death	1	The baby was born prematurely. The Family nurse continued to support the mother with her bereavement and developed a memory book

		together
Maternal death		
Other		

Footnotes:

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[1]How many supervisor-led teams do you have?
[1] Data provided for end of reporting period i.e. one year
[1] Reporting year to be decided by each country (either calendar, financial or licensing contract year)
[1]'offered' program
[1]Enroll = receives at least one actual home visit (P1).
[1] You can change this table to reflect your method of calculating dosage
[1] For clients who have completed this phase of the programme within the specified year i.e. excluding those that have not yet completed this phase
[1] This column adjusts the number of expected visits according to gestation at enrolment and leavers/inactivity. The next column is not adjusted for this. Also applies for leavers infancy and toddlerhood.
[1] For clients who have (or should have) completed this phase of the programme within the specified year
[1] You may prefer to represent these data using graphs
[1] Figures in brackets are the fidelity goals
[1] Some countries use 'excessive' as figures very low, please indicate your definition
[1] Definition of what is legal or not may vary between countries, please indicate
[1] To use your own definition and metric

APPENDIX:

Referrals and dispositions				
Disposition	**WHSCT**	**SHSCT**	**BHSCT**	**All sites**
1 Enrolled	149	96	53	298
2 Refused to participate in programme	54	33	18	105
3 Unable to locate	16	2	4	22
4a Didn't meet criteria: Employed/ Qualifications	1	0	0	1
4b Didn't meet criteria: >28 weeks weeks	15	8	0	23
4c Didn't meet criteria: mulitple problems/ mental health	1	0	0	1
4d Didn't meet criteria: miscarried/ other medical crisis	13	8	4	25
4e Didn't meet criteria: incorrect geographical area	4	13	0	17
4f Didn't meet criteria: unknown/ other	17	4	3	24
5 Language issues	0	0	0	0
6 Quota full for the month	50	4	0	54
allocated	1			1
allocated	5			5
on hold	2	0	0	2
Grand Total	328	168	82	578
Total definitely eligible	203	129	71	403
Total Enrolled*	149	96	53	298
Enrolled as percent of definitely eligible	***73.4***	***74.4***	***74.6***	***73.9***

*This table provides figures for total number of enrolled clients based on the year of referral received and as such figures should not be expected to match with year of client's enrolment.

Overall, 73.9% of those eligible clients offered the programme enrolled on the programme.

Overall, 57% of clients were enrolled by the end of 16 weeks gestation and 100% were enrolled by 28 weeks gestation.

The mean gestational age at enrolment was 17.5 weeks.

This report includes data for 148 clients. This includes all of the clients enrolled in the BHSCT (41) and the SHSCT (85) up to 31.12.2013 and all of the clients who were enrolled in the WHSCT in 2013 (N=22). Data for clients enrolled in the WHSCT prior to 1.1.2013 is included in last year's Annual Report (April 2013).

Client Characteristics
Overall: All sites

Population	Number enrolled	% enrolled by end of 16th week gestation	% enrolled by 28th week gestation	Mean gestational age in weeks at enrolment	Change from previous year
2012	13	31%	100%	19.1 weeks (SD =4.8, range =11.4 -27)	NA
2013	135	60%	100%	17.3 weeks (SD =, 4.3, range = 8.3 -27.9)	NA
Overall	148	57%	100%	17.5 weeks (SD = 4.3, range = 8.3-27.9)	NA

BHSCT

Population	Number enrolled	% enrolled by end of 16th week gestation	% enrolled by 28th week gestation	Mean gestational age in weeks at enrolment	Change from previous year
2012	NA	NA	NA	NA	NA
2013	41	56%	100%	17.7 weeks (SD =4.8, range = 8.3-26.8)	NA
Overall	41	56%	100%	17.7 weeks (SD =4.8, range = 8.3-26.8)	NA

SHSCT

Population	Number enrolled	% enrolled by end of 16th week gestation	% enrolled by 28th week gestation	Mean gestational age in weeks at enrolment	Change from previous year
2012	13	31%	100%	19.1 weeks (SD =4.8, range =11.4 -27)	NA
2013	72	57%	100%	17.3 weeks (SD = 3.9, range = 8.7-27.9)	NA
Overall	85	53%	100%	17.6 weeks (SD = 4.0, range =8.7-27.8)	NA

WHSCT

Population	Number enrolled	% enrolled by end of 16th week gestation	% enrolled by 28th week gestation	Mean gestational age in weeks at enrolment	Change from previous year
2012	NA	NA	NA	NA	NA
2013	22	77%	100%	16.7 weeks (SD =3.7, range = 12.9-26.6)	NA
Overall	22	77%	100%	16.7 weeks (SD =3.7, range = 12.9-26.6)	NA

Age at LMP

Overall (N=148) all sites the average age at LMP was 17.6 (SD=1.3, range = 13.4 -19.8)

	N	Average Age	SD	Range
Overall	148	17.7	1.3	13.4 - 19.8
BHSCT	41	17.6	1.5	13.4 - 19.8
SHSCT	85	17.7	1.3	13.9 – 19.8
WHSCT	22	17.7	1.3	14.1 – 19.8

Client Retention

Client retention		
% of those enrolled who complete the program or the specified stage of the programme		
Pregnancy % clients enrolling on programme who do not leave or become inactive between date of child's birth and first birthday	Overall	95% (71/75) (4 inactive/leavers in pregnancy stage)
	BHSCT	95% (39/41) (2 inactive/leavers in pregnancy stage)
	SHSCT	98% (83/85) (2 inactive/leavers in pregnancy stage)
	WHSCT	100% (0 inactive/leavers in pregnancy stage)
Infancy	NA	There were no infancy stage completers at 31.12.13. One client left in infancy stage.
Toddlerhood	NA	There were no toddlerhood stage completers at 31.12.13.

Attrition

Of the 148 ever enrolled, attrition by the 31.12.13 is as follows:

- Total attrition = 3% (5/148)
- Attrition during pregnancy = 4 (2.7%) (4/148)
- Attrition during infancy = 1 (1%) (1/148)
- Attrition during toddlerhood = NA

Ethnicity

		BHSCT	SHSCT	WHSCT	All sites
Total clients enrolled		**41**	**85**	**22**	**148**
Clients who have reported their ethnicity	N	40	78	21	139
	%	97.6	91.8	95.5	93.9
White British	N	19	35	9	63
	%	47.5	44.9	42.9	45.3
White Irish	N	19	30	12	61
	%	47.5	38.5	57.1	43.9
White, Other (specify)	N	2	9	0	11
	%	5.0	11.5	0.0	7.9
Black or Black British, Other (specify)	N	0	2	0	2
	%	0.0	2.6	0.0	1.4
Other ethnic group (specify)	N	0	2	0	2
	%	0.0	2.6	0.0	1.4

EET

		BHSCT	SHSCT	WHSCT	All sites
Total clients enrolled	**N**	**41**	**85**	**22**	**148**
Clients who have reported their EET status at intake	N	40	78	21	139
	%	97.6	91.8	95.5	93.9
Clients in Education at intake	N	20	41	16	77
	%	50.0	52.6	76.2	55.4
Clients in employment (currently) at intake	N	7.0	14.0	2.0	23.0
	%	17.5	17.9	9.5	16.5

- Education and employment status was recorded for 93.9% (N=139) clients at intake
- A total of 55.4% (N=77) of clients were in education at intake.
- A total of 16.5% (N=23) of clients were in employment at intake.

HADS

		BHSCT	SHSCT	WHSCT	All sites
Total clients enrolled		41	85	22	148
Number of clients reaching 36 weeks pregnancy		25	60	12	97
Anxiety					
Clients with HADs anxiety data recorded in pregnancy	N	19	56	11	86
	%	76	93.3	91.7	88.7
Unlikely presence of anxiety pregnancy	N	15	49	7	71
	%	78.9	87.5	63.6	82.6
Borderline presence of anxiety pregnancy	N	1	3	3	7
	%	5.3	5.4	27.3	8.1
Probable presence of anxiety pregnancy	N	2	4	1	7
	%	10.5	7.1	9.1	8.1
High likelihood presence of anxiety pregnancy	N	1	0	0	1
	%	5.3	0	0	1.2
Depression					
Clients with HADs depression data recorded in pregnancy	N	19	54	11	84
	%	76	90	91.7	86.6
Unlikely presence of depression pregnancy	N	17	50	11	78
	%	89.5	92.6	100	92.9
Borderline presence of depression pregnancy	N	2	3	0	5
	%	10.5	5.6	0	6
Probable presence of depression pregnancy	N	0	1	0	0
	%	0	1.9	0	0
High likelihood presence of depression pregnancy	N	0	0	0	0
	%	0	0	0	0

Anxiety

- Anxiety (HADS) scores were recorded for 88.7% (N=86) of the clients at intake.
- Of these, 7 (8.1%) were found to have probable anxiety and 7 (8.1%) were found to have borderline anxiety.

Depression

- Depression (HADS) scores were recorded for 86.6% (N=84) of the clients at intake.
- Of these, 0 (0%) were found to have probable depression and 5 (6%) were found to have borderline depression.

Annual income

	BHSCT		SHSCT		WHSCT		All sites	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Total clients enrolled	**41**		**85**		**22**		**148**	
Clients with income data recorded	40	97.6	78	91.8	21	95.5	139	93.9
Less than £1,600 per year	22	55	33	42.3	7	33.3	62	44.6
£1,600 - £3,099 per year	8	20	17	21.8	10	47.6	35	25.2
£3,100 - £4,699 per year	4	10	10	12.8	1	4.8	15	10.8
£4,700 - £6,199 per year	4	10	3	3.8		0.0	7	5.0
£6,200 - £7,799 per year	1	2.5	2	2.6	2	9.5	5	3.6
£7,800 - £10,399 per year		0	3	3.8		0.0	3	2.2
£10,400 - £12,999 per year		0	5	6.4	1	4.8	6	4.3
£13,000 - £15,599 per year	1	2.5	2	2.6		0.0	3	2.2
£18,200 - £20,799 per year		0	2	2.6		0.0	2	1.4
£20,800 - £25,999 per year		0	1	1.3		0.0	1	0.7
Total	40	100	78	100.0	21	100	139	100.0
<£10,400 per year	39	97.5	68	87.2	20	95.2	127	91.4

	BHSCT		SHSCT		WHSCT		All sites	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Total clients enrolled	**41**		**85**		**22**		**148**	
Clients with income data recorded	40	97.6	78	91.8	21	95.5	139	93.9
Household	3	7.5	9	11.5		0	12	8.6
Self only	7	17.5	12	15.4		0	19	13.7
Missing	30	75	57	73.1	21	100	108	77.7
	40	100	78	100.0	21	100	139	100.0

Low income or other poverty indicator for the mother (please specify indicator used)

85% of the mothers have an annual income of less than £10,400.

Relative poverty can be defined as 60% below the median income. Annual income for NI before housing costs was £19,400. 60% of this is £ 11,640.
(Northern Ireland Poverty Bulletin 2011/12: Table A4
www.dsdni.gov.uk/tables_poverty_bulletin_201112.xls).

In the absence of an agreed indicator of childhood poverty, we have used the indicator described above. However, it would be useful to have a consistent UK definition.

DOSAGE

Pregnancy dosage (All sites)

	Pregnancy Dosage (for all clients who completed pregnancy stage by end of December 2013)						
Year of enrolment	**N Clients**	**N Visits**	**Mean number of actual visits**	**Mean expected number of visits given gestational age**	**Mean % expected visits achieved**	**Mean % expected visits achieved using 14 expected visits**	**% clients getting 80% or more of expected visits**
2012	12	154	12.8 (SD=2.6)	12.1 (SD=2.1)	106.2%	91.7%	83.3%
2013	63	709	11.3 (SD=3.0)	12.5 (SD=1.9)	90.0%	80.4%	76.2%
Overall	75	863	11.5 (SD=3.0)	12.4 (SD=1.9)	92.5%	82.2%	77.3%

This table reports on pregnancy dosage for clients* who had completed pregnancy stage by 31.12.2013. *N=75 clients (12 in 2012, 63 in 2013).

Pregnancy dosage (BHSCT)

	Pregnancy Dosage (for BHSCT clients who completed pregnancy stage by end of December 2013)						
Year of enrolment	**N Clients**	**N Visits**	**Mean number of actual visits**	**Mean expected number of visits given gestational age**	**Mean % expected visits achieved**	**Mean % expected visits achieved using 14 expected visits**	**% clients getting 80% or more of expected visits**
2012	0	NA	NA	NA	NA	NA	NA
2013	18	200	11.1 (SD=2.8)	12.6 (SD=1.9)	88.1%	79.4%	83%
Total	18	200	11.1 (SD=2.8)	12.6 (SD=1.9)	88.1%	79.4%	83%

This table reports on pregnancy dosage for clients* who had completed pregnancy stage by 31.12.2013. *N=18 clients (0 in 2012, 18 in 2013).

Pregnancy dosage (SHSCT)

	Pregnancy Dosage (for SHSCT clients who completed pregnancy stage by end of December 2013)						
Year of enrolment	**N Clients**	**N Visits**	**Mean number of actual visits**	**Mean expected number of visits given gestational age**	**Mean % expected visits achieved**	**Mean % expected visits achieved using 14 expected visits**	**% clients getting 80% or more of expected visits**
2012	12	154	12.8 (SD=2.6)	12.1 (SD=2.1)	106.2	91.7%	83%
2013	36	422	11.7 (SD=2.8)	12.3 (SD=1.9)	95.3 (SD=18.1)	83.7%	83%
Total	48	576	12.5 (SD=2.5)	12.3 (SD=1.9)	103.7 (SD=18)		83%

This table reports on pregnancy dosage for clients* who had completed pregnancy stage by 31.12.2013. *N= 48 clients (12 in 2012, 36 in 2013).

Pregnancy dosage (WHSCT)

	Pregnancy Dosage (for WHSCT clients who completed pregnancy stage by end of December 2013)						
Year of enrolment	**N Clients**	**N Visits**	**Mean number of actual visits**	**Mean expected number of visits given gestational age**	**Mean % expected visits achieved**	**Mean % expected visits achieved using 14 expected visits**	**% clients getting 80% or more of expected visits**
2012	0	NA	NA	NA	NA	NA	NA
2013	9	87	11.1 (SD=3.9)	13.6 (SD=1.6)	73.3	69	33.3%
Total	9	87	11.1 (SD=3.9)	13.6 (SD=1.6)	73.3	69	33.3%

This table reports on pregnancy dosage for clients* who had completed pregnancy stage by 31.12.2013. *N= 9 clients (0 in 2012, 9 in 2013).

LENGTH OF VISIT

Duration (All sites up to end of 2013) Pregnancy Stage Completers

Length of visit*	Mean	Standard Deviation	Range
Overall	NA	NA	NA
Pregnancy (N=863**)	77.7	22.8	(20-390)
Infancy	NA	NA	NA
Toddlerhood	NA	NA	NA

*Minutes, **visits

Duration (BHSCT up to end of 2013) Pregnancy Stage Completers

Length of visit*	Mean	Standard Deviation	Range
Overall	NA	NA	NA
Pregnancy (N=200**)	68.9	14.7	(60-120)
Infancy	NA	NA	NA
Toddlerhood	NA	NA	NA

*Minutes, **visits

Duration (SHSCT up to end of 2013) Pregnancy Stage Completers

Length of visit*	Mean	Standard Deviation	Range
Overall	NA	NA	NA
Pregnancy (N=576**)	83.0	24.6	(20-390)
Infancy	NA	NA	NA
Toddlerhood	NA	NA	NA

*Minutes, **visits

Duration (WHSCT up to end of 2013) Pregnancy Stage Completers

Length of visit*	Mean	Standard Deviation	Range
Overall	NA	NA	NA
Pregnancy (N=87**)	62.6	8.1	(45-90)
Infancy	NA	NA	NA
Toddlerhood	NA	NA	NA

*Minutes, **visits

Overall, the average visit duration for pregnancy visits for pregnancy completers was one hour and seventeen minutes.

Duration (All sites up to end of 2013) All visits

Length of visit*	Mean	Standard Deviation	Range
Overall (N=2057)	74.5	21.3	(15-390)
Pregnancy (N=1358**)	74.9	21.0	(20-390)
Infancy (N=699**)	73.7	21.7	(15-270
Toddlerhood	NA	NA	NA

*Minutes, **visits

Overall, the average visit duration for pregnancy visits for was one hour and fourteen minutes.

Overall, the average visit duration for infancy visits for was one hour and fourteen minutes.

Duration (BHSCT up to end of 2013) All visits

Length of visit*	Mean	Standard Deviation	Range
Overall (N=455**)	66.7	14.6	(30-150)
Pregnancy (N=334**)	67.5	15.2	(60-150)
Infancy (N=121**)	64.4	12.7	(30-150)
Toddlerhood	NA	NA	NA

*Minutes, **visits

Duration (SHSCT up to end of 2013) All visits

Length of visit*	Mean	Standard Deviation	Range
Overall (N=1374**)	79.0	23.0	(15-390)
Pregnancy (N=845**)	80.3	22.8	(20-390)
Infancy (N=529**)	76.9	23.2	(15-270
Toddlerhood	NA	NA	NA

*Minutes, **visits

Duration (WHSCT up to end of 2013) All visits

Length of visit*	Mean	Standard Deviation	Range
Overall (N=228)	62.9	9.6	(40-120)
Pregnancy (N=179**)	63.4	10.4	(40-120)
Infancy (N=49**)	61.1	5.6	(50-90)
Toddlerhood	NA	NA	NA

*Minutes, **visits

Visit Content (All sites pregnancy completers)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 863 visits)**	**Infancy NA**	**Toddlerhood NA)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**38.5%** (35-40%)	**NA**	**NA**	**NA**	
Environmental Health	**7.2%** (5-7%)	**NA**	**NA**	**NA**	
Life-course development	**12.6%** (10-15%)	**NA**	**NA**	**NA**	
Maternal Role	**25.7%** (23-25%)	**NA**	**NA**	**NA**	
Family and Friends	**16%** (10-15%)	**NA**	**NA**	**NA**	

Visit Content (BHSCT pregnancy completers)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 200 visits)**	**Infancy NA**	**Toddlerhood NA**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**38.5%** (35-40%)	**NA**	**NA**	**NA**	
Environmental Health	**7.2%** (5-7%)	**NA**	**NA**	**NA**	
Life-course development	**11.8%** (10-15%)	**NA**	**NA**	**NA**	
Maternal Role	**24%** (23-25%)	**NA**	**NA**	**NA**	
Family and Friends	**18.5%** (10-15%)	**NA**	**NA**	**NA**	

Visit Content (SHSCT pregnancy completers)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 576 visits)**	**Infancy (N= visits)**	**Toddlerhood (N= visits)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**39.5%** (35-40%)	**NA**	**NA**	**NA**	
Environmental Health	**6.9%** (5-7%)	**NA**	**NA**	**NA**	
Life-course development	**13.0%** (10-15%)	**NA**	**NA**	**NA**	
Maternal Role	**25.6%** (23-25%)	**NA**	**NA**	**NA**	
Family and Friends	**15.1%** (10-15%)	**NA**	**NA**	**NA**	

Visit Content (WHSCT pregnancy completers)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 87 visits)**	**Infancy (N= visits)**	**Toddlerhood (N= visits)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**32.2%** (35-40%)	**NA**	**NA**	**NA**	
Environmental Health	**8.9%** (5-7%)	**NA**	**NA**	**NA**	
Life-course development	**12.0%** (10-15%)	**NA**	**NA**	**NA**	
Maternal Role	**30.2%** (23-25%)	**NA**	**NA**	**NA**	
Family and Friends	**16.7%** (10-15%)	**NA**	**NA**	**NA**	

Visit Content (All visits overall)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 1358 visits)**	**Infancy (N= 699 visits)**	**Toddlerhood (N= visits)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**38.3%** (35-40%)	**20.7%** (14-20%)	**NA**	**NA**	
Environmental Health	**7.4%** (5-7%)	**10.0%** (7-10%)	**NA**	**NA**	
Life-course development	**13.0%** (10-15%)	**11.4%** (10-15%)	**NA**	**NA**	
Maternal Role	**25.6%** (23-25%)	**45.3%** (45-50%)	**NA**	**NA**	
Family and Friends	**15.8%** (10-15%)	**12.7%** (10-15%)	**NA**	**NA**	

Visit Content (BHSCT All visits)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 334 visits)**	**Infancy (N= 121 visits)**	**Toddlerhood (N= visits)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**37.9%** (35-40%)	**22.5%** (14-20%)	**NA**	**NA**	
Environmental Health	**7.7%** (5-7%)	**9.1%** (7-10%)	**NA**	**NA**	
Life-course development	**12.6%** (10-15%)	**10.5%** (10-15%)	**NA**	**NA**	
Maternal Role	**24.4%** (23-25%)	**43.8%** (45-50%)	**NA**	**NA**	
Family and Friends	**17.4%** (10-15%)	**14.2%** (10-15%)	**NA**	**NA**	

Visit Content (SHSCT All visits)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 845 visits)**	**Infancy (N= 529 visits)**	**Toddlerhood (N= visits)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**39.6%** (35-40%)	**20.4%** (14-20%)	**NA**	**NA**	
Environmental Health	**6.9%** (5-7%)	**10.0%** (7-10%)	**NA**	**NA**	
Life-course development	**13.3%** (10-15%)	**11.6%** (10-15%)	**NA**	**NA**	
Maternal Role	**25.3%** (23-25%)	**45.9%** (45-50%)	**NA**	**NA**	
Family and Friends	**14.9%** (10-15%)	**12.0%** (10-15%)	**NA**	**NA**	

Visit Content (WHSCT All visits)

Visit content for all clients who completed the relevant stage by 2013					
Average% of time spent on 5 domains by phase of programme in reporting year.	**Pregnancy (N= 179 visits)**	**Infancy (N= 49 visits)**	**Toddlerhood (N= visits)**	**Change from previous year/s (please plot)**	**Comment**
Personal Health	**32.8%** (35-40%)	**19.3%** (14-20%)	**NA**	**NA**	
Environmental Health	**9.3%** (5-7%)	**11.7%** (7-10%)	**NA**	**NA**	
Life-course development	**11.9%** (10-15%)	**11.4%** (10-15%)	**NA**	**NA**	
Maternal Role	**29.2%** (23-25%)	**41.5%** (45-50%)	**NA**	**NA**	
Family and Friends	**16.8%** (10-15%)	**16.0%** (10-15%)	**NA**	**NA**	

Fathers Engagement (Pregnancy Completers)

	Overall	**BHSCT**	**SHSCT**	**WHSCT**
Pregnancy Completers	**17.3%** (N=149/863)	**14.0%** (N=28/200)	**16.1%** (N=93/576)	**32.2%** (N=28/87)
Infancy Completers	NA	NA	NA	NA
Toddlerhood Completers*	NA	NA	NA	NA

Overall, father engagement was 17.3% for pregnancy completers. None of the clients included in the report had completed infancy or toddlerhood stage.

Breastfeeding: All Sites

Total number enrolled	**148**
Total number of (active) clients with infants	**74**
Initiation	
Number (%) of clients with breastfeeding initiation status recorded (ever breastfed	69 (93%)
Number (%) clients initiating breastfeeding	33 (44.6%)
6 weeks	
Total number of active clients with infants reaching 6 weeks	**54**
Number (%) of clients with breastfeeding status recorded at 6 weeks	54 (100%)
Number (%) clients breastfeeding at 6 weeks	7 (13%)
6 months	
Total number of active clients with infants reaching 6 months	**20**
Number (%) of clients with breastfeeding status recorded at 6 months	15 (75%)
Number (%) clients breastfeeding at 6 months	0 (0%)
Number (%) of clients with exclusive breastfeeding status recorded at 6 weeks or 6 months	23 (43%) (23/54)
Average age (weeks) clients exclusively breastfed	2.1 weeks

- Breastfeeding initiation was recorded for 93% (N=69) of clients with infants at intake. Of these, 44.6% (N=33) reported initiating breastfeeding.
- Breastfeeding status was recorded for100% (N=53) of clients who had reached 6 weeks infancy. Of these, 13% (N=7) reported that they were still breastfeeding at 6 weeks.
- Breastfeeding status was recorded for 75% (N=15) of clients who reached 6 months infancy. Of these, no clients reported that they were still breastfeeding at 6 months infancy.

Breastfeeding: BHSCT

Total number enrolled	**41**
Total number of (active) clients with infants	**18**
Initiation	
Number (%) of clients with breastfeeding initiation status recorded (ever breastfed	16 (88%)
Number (%) clients initiating breastfeeding	6 (33%)
6 weeks	
Total number of active clients with infants reaching 6 weeks	**11**
Number (%) of clients with breastfeeding status recorded at 6 weeks	12 (100%)
Number (%) clients breastfeeding at 6 weeks	2 (16%)
6 months	
Total number of active clients with infants reaching 6 months	**1**
Number (%) of clients with breastfeeding status recorded at 6 months	2 (100%)
Number (%) clients breastfeeding at 6 months	0 (0%)
Number (%) of clients with exclusive breastfeeding status recorded at 6 weeks or 6 months	5 (42%) (5/12)
Average age (weeks) clients exclusively breastfed	4 weeks

Breastfeeding: SHSCT

Total number enrolled	**85**
Total number of (active) clients with infants	**47**
Initiation	
Number (%) of clients with breastfeeding initiation status recorded (ever breastfed	46 (98%)
Number (%) clients initiating breastfeeding	26 (55%)
6 weeks	
Total number of active clients with infants reaching 6 weeks	**39**
Number (%) of clients with breastfeeding status recorded at 6 weeks	38 (97%)
Number (%) clients breastfeeding at 6 weeks	5 (13%) (5/39)
6 months	
Total number of active clients with infants reaching 6 months	**19**
Number (%) of clients with breastfeeding status recorded at 6 months	19 (100%)
Number (%) clients breastfeeding at 6 months	0 (0%)
Number (%) of clients with exclusive breastfeeding status recorded at 6 weeks or 6 months	18 (46%) (18/39)
Average age (weeks) clients exclusively breastfed	1.6 weeks

Breastfeeding: WHSCT

Total number enrolled	**22**
Total number of (active) clients with infants	**9**
Initiation	
Number (%) of clients with breastfeeding initiation status recorded (ever breastfed	7 (78%)
Number (%) clients initiating breastfeeding	1 (11%) (1/9)
6 weeks	
Total number of active clients with infants reaching 6 weeks	**4**
Number (%) of clients with breastfeeding status recorded at 6 weeks	4 (100%)
Number (%) clients breastfeeding at 6 weeks	1 (25%)
6 months	
Total number of active clients with infants reaching 6 months	**0**
Number (%) of clients with breastfeeding status recorded at 6 months	NA
Number (%) clients breastfeeding at 6 months	NA
Number (%) of clients with exclusive breastfeeding status recorded at 6 weeks or 6 months	0
Average age (weeks) clients exclusively breastfed	0

Tobacco Use

Change in self-reported tobacco use during pregnancy (intake to 36 weeks)					
		All sites	**BHSCT**	**SHSCT**	**WHSCT**
Number of active clients enrolled		**148**	**41**	**85**	**22**
Clients with smoking during pregnancy recorded at intake	N	138	36	82	20
	%	93.2	87.8	96.5	90.9
Clients who smoked at any time during the pregnancy at intake	N	61	18	38	5
	%	44.2	50.0	46.3	25.0
Clients who smoked in last 48 hours recorded at intake	N	138	36	82	20
	%	93.2	87.8	96.5	90.9
Clients who smoked in last 48 hours at intake	N	42	13	26	3
	%	30.4	36.1	31.7	15.0
Mean number of cigarettes smoked in the last 48 hours at intake	N	9.98	8.8	10.1	14
Number of active clients reaching 36 weeks gestation		**92**	**22**	**59**	**11**
Clients with smoking during pregnancy recorded at 36 weeks	N	54	16	29	9
	%	58.7	72.7	49.2	81.8
Clients who smoked at any time during the pregnancy at 36 weeks	N	26	7	17	2
	%	48.1	43.8	58.6	22.2
Clients who smoked in last 48 hours recorded 36 weeks	N	51	13	29	9
	%	55.4	59.1	49.2	81.8
Clients who smoked in last 48 hours at 36 weeks	N	17	5	11	1
	%	33.3	38.5	37.9	11.1
Mean number of cigarettes smoked in the last 48 hours at 36 weeks	N	7.53	6.6	7.3	10
Of those with data recorded at intake and 36 weeks					
Number (%) of active clients at 36 weeks pregnancy with number of cigarettes smoked in last 48 hours recorded at intake and 36 weeks	N	54	16	29	9

Smokers who stopped between intake and 36 weeks	N	4	1	3	1
	%	7.4	6.3	10.3	11.1
Change in number of clients smoking in last 48 hours between intake and 36 weeks	N	(17-19/54)	(5-6/16)	(11-11/29)	(1-2/9)
	%	-3.7037	-6.25	0	-11.1
Number of smokers at 36 weeks who denied at intake		3	1	2	0

- Smoking during pregnancy was recorded for 93% (N=138) of clients at intake. Of these, 44% (N=61) reported that they had smoked at some time during the pregnancy at intake.
- Smoking during the last 48 hours was recorded for 93% (N=138) of clients at intake. Of these, 30% (N=42) reported that they had smoked during the last 48 hours at intake. Mean number of cigarettes smoked was 9.98 for those who smoked at intake.

- Smoking during pregnancy was recorded for 58.7% (N=54) of clients at 36 weeks pregnancy. Of these, 48% (N=26) reported that they had smoked at some time during the pregnancy at 36 weeks.
- Smoking during the last 48 hours was recorded for 55% (N=51) of clients at 36 weeks. Of these, 33% (N=17) reported that they had smoked during the last 48 hours at 36 weeks. Mean number of cigarettes smoked was 7.53 for those who smoked at 36 weeks.

- 54 clients had smoking status recorded at both intake and 36 weeks. For these clients, a -3% change in smoking between intake and 36 weeks was achieved.

Alcohol Use

Change in self-reported alcohol use during pregnancy (intake to 36 weeks)					
		All sites	**BHSCT**	**SHSCT**	**WHSCT**
Number of active clients enrolled		**148**	**41**	**85**	**22**
Clients with alcohol use during pregnancy recorded at intake	N	138	36	82	20
Data Completeness	%	93.2	87.8	96.5	90.9
Clients who drank alcohol in last 14 days at intake	N	4	1	3	0
	%	2.9	2.8	3.7	0.0
Clients who drank alcohol excessively in last 14 days at intake	N	0	0	0	0
	%	0.0	0.0	0.0	0.0
Number of active clients reaching 36 weeks gestation		**92**	**22**	**59**	**11**
Clients with alcohol use during pregnancy recorded at 36 weeks	N	51	13	29	9
Data Completeness	%	55.4	59.1	49.2	81.8
Clients who drank alcohol in last 14 days at 36 weeks	N	1	1	0	0
	%	2.0	7.7	0.0	0.0
Clients who drank alcohol excessively in last 14 days at 36 weeks	N	0	0	0	0
	%	0.0	0.0	0.0	0.0
Of those with data recorded at intake and 36 weeks					
Number (%) of active clients at 36 weeks pregnancy with alcohol status in last 48 hours recorded at intake and 36 weeks	N	51	13	29	9
% change in proportion of clients drinking alcohol in last 14 days between intake and 36 weeks	N	(1-3/3)	(1-1/1)	(0-2/2)	(0-0/0)
	%	-66.6	0.0	-100	0.0
% change in proportion of clients drinking alcohol excessively in last 14 days between intake and 36 weeks	N	NA	NA	NA	NA
	%	NA	NA	NA	NA
Number of clients who stopped drinking between intake and 36 weeks		1	0	1	0

- Alcohol use was recorded at intake for 93% (N=138) of clients at intake. Of these, 2.9% (N=4) reported drinking alcohol in the last 14 days at intake. No clients reported drinking excessively in last 14 days at intake.

- Alcohol use was recorded at 36 weeks for 55% (N=51) of clients. Of these, 2% (N=1) reported drinking alcohol in the last 14 days at 36 weeks. No clients reported drinking excessively in last 14 days at 36 weeks.

- Alcohol use was recorded at intake and 36 weeks for 51 clients. For these clients, there was a decrease of 66% in the proportion of clients drinking alcohol between intake and 36 weeks. 1 client stopped drinking between intake and 36 weeks.

Drug Use

Change in drug use during pregnancy (from intake to 36 weeks)					
		All sites	**BHSCT**	**SHSCT**	**WHSCT**
Number of active clients enrolled		**148**	**41**	**85**	**22**
Clients with illegal drug use recorded at intake	N	138	36	82	20
Data Completeness	%	93.2	87.8	96.5	90.9
Clients who used illegal drugs in last 48 hours at intake	N	0	0	0	0
	%	0.0	0.0	0.0	0.0
Number of active clients reaching 36 weeks gestation		**92**	**22**	**59**	**11**
Clients with illegal drug use during pregnancy recorded at 36 weeks	N	51	13	29	9
Data Completeness	%	55.4	59.1	49.2	81.8
Clients who used illegal drugs in last 48 hours at 36 weeks	N	0	0	0	0
	%	0.0	0.0	0.0	0.0
Of those with data recorded at intake and 36 weeks					
Number (%) of active clients at 36 weeks pregnancy with illegal drug use in last 48 hours recorded at intake and 36 weeks	N	51	13	29	9
Clients who stopped between intake and 36 weeks	N	NA	NA	NA	NA
	%	NA	NA	NA	NA
Change in number of clients with illegal drug use in last 48 hours recorded at intake and 36 week	N	NA	NA	NA	NA
	%	NA	NA	NA	NA

Quality Governance: Family Nurse Partnership in Northern Ireland

August 2014 V2

Deirdre Webb

Introduction

The Public Health Agency (PHA) in partnership with the Department Of Health and Social Services and Public Safety (DHSSPS) and Health and Social Care Board (HSCB), introduced the Family Nurse Partnership (FNP) programme into Northern Ireland in 2010. The vision was to introduce an evidence based programme which would improve outcomes for our children, young people and families into the future. This programme is Government endorsed and identifies the PHA as the lead agency. The vision incorporates FNP into local governance arrangements within Trusts and will have regional direction provided by a Regional Board chaired by the Chief Executive of the PHA.

A long term vision is to create a mutually beneficial partnership for those young parents and their children in Northern Ireland enrolled on the programme though the provision of a high quality service. Quality 2020 is the overarching quality strategy for Health and Social Care services in Northern Ireland and provides a definition of quality relevant to FNP under three main headings:

Safety – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Effectiveness – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcomes.

Patient and Client Focus – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

This document will inform the reader of the structures for Quality Governance within the Family Nurse Partnership Programme in NI, Quality Monitoring processes and Quality Improvement Plans.

Aim

To deliver the highest quality Family Nurse Partnership Programme to young parents in Northern Ireland through adherence to the license and programme fidelity.

Quality Team

As License holders, the Public Health Agency (PHA) is accountable for overseeing the quality of the programme delivered within Trusts. Both the PHA and the International Nurse Family Partnership team need to be assured that quality and good outcomes are being attained and this will be achieved through data evidence,

research, robust on-going learning and supervision and ensuring the maintenance of a strong focus on the young parents and their children.
Quality Improvement runs through the whole programme and is embedded in many aspects of implementation site development, supervision meetings with Supervisors, education programmes.
Ensuring the quality processes will be the responsibility of the Central Implementation Team, inclusive of the Regional Lead Nurse for FNP, a Nurse Consultant for FNP Quality Improvement and a Research and Information Lead, who will support and ensure the high quality delivery of the programme with fidelity and adherence to licensing arrangements.

A Clinical Quality improvement group(CQI) has been established .The main focus of the group is identify key quality issues and put an improvement plan in place .

Quality Framework

Strategy

Quality and fidelity are the drivers of FNP to ensure positive outcomes for children, parents and families.

Capabilities and Culture

The Central Team have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda.

Measurement

The Information System data will be analysed and reported on at each of the Family Advisory Board meetings (FAB), in supervision with the Supervisor, Family Nurses, Clinical Quality Improvement meetings (CQI) and annual reports.

Risk Assessment and Management

To effectively assess and manage risk on-going performance will be reviewed at supervision, the FAB meetings and at the CQI meetings with consideration to fidelity to the core components of the programme and adherence to the license. Assurance is required that common minimum standards are not compromised by reviewing programme reports, considering any organisational learning, the review of incidents and records and client reports.

Quality Monitoring processes and understanding current and future risks to quality will include:

- Ensuring adherence to the license and fidelity to the programme;
- Review on-going performance using the data;
- Review on-going performance a record audit;

A regular review of challenges will be an agenda item at the quarterly Clinical Quality Improvement meeting and actions will be agreed to pinpoint underlying issues.
Clinical Governance Infra structure Appendix 1

The Challenges 2014/15:

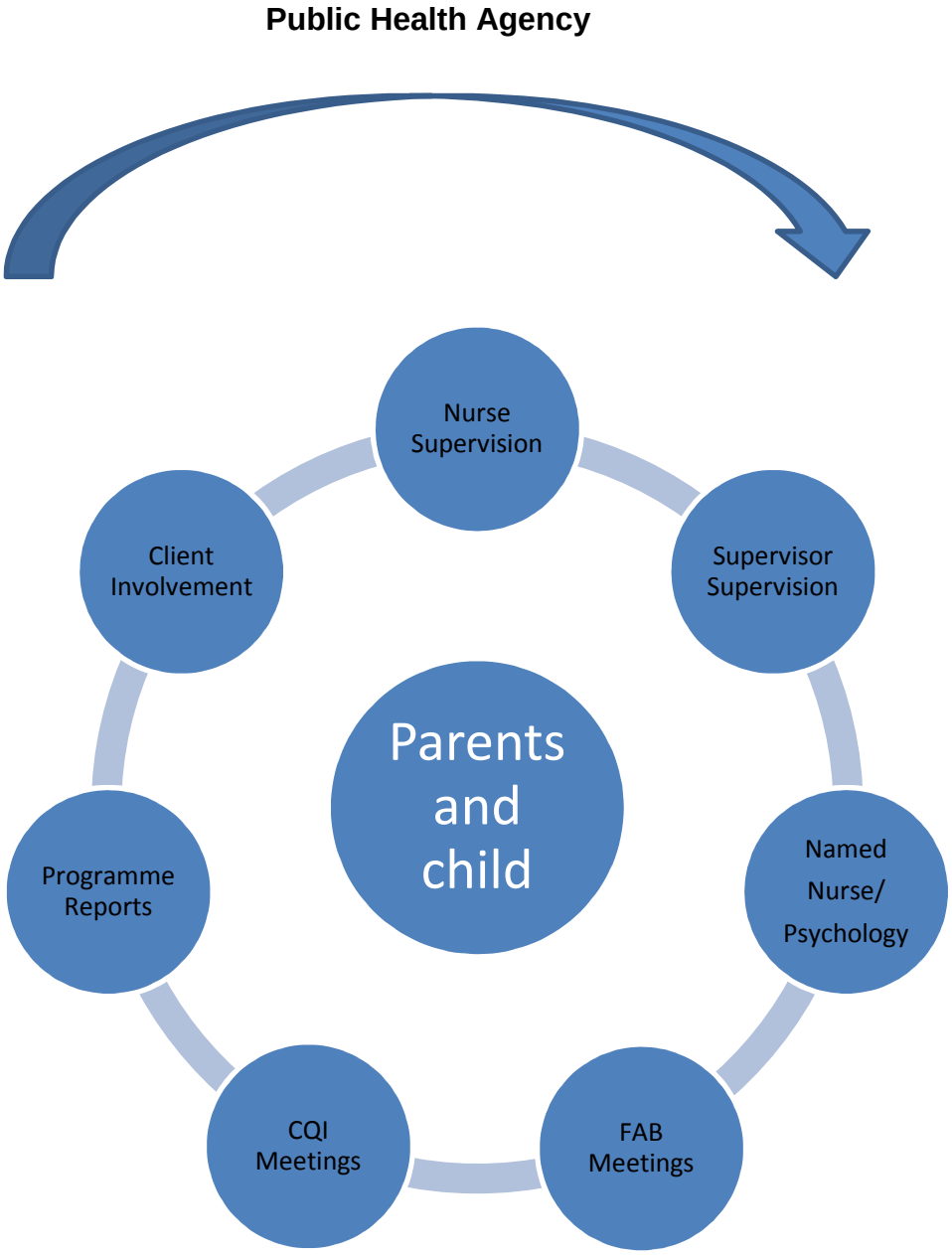
- Development of two new sites;
- Final Quality Assurance of the new Information System and use of mobile devices commenced;
- Increasing vulnerability and complexity of families;
- Early referrals to facilitate enrolment before 16 weeks;
- Increasing safeguarding concerns
- Developing a Systematic approach to Client feedback

Quality Monitoring Plans for 2014/15

- Information System reports;
- Commence use of mobile devices and monitoring and feedback on same;
- Programme reports will remain an agenda item at all supervision meetings and at the FAB and CQI meetings.
- Identified concerns or deviations from the core programme or license will be escalated promptly through the QI infrastructure;
- Additional training needs as identified by Nurses/Supervisors will be delivering in year;
- A record audit template will be agreed and a record audit completed 2014/15 and a report with recommendations completed;
- Client Feedback Survey

Outcome Measures Template Appendix 2

Appendix 1: Quality Improvement Infrastructure



Appendix 2: Outcomes Measures Template

Potential Measure	Rationale	Client/Nurse/ System Measure
Programme reports	To ensure programme fidelity and adherence to the license	Information System