agenda

Title of Meeting	142nd Meeting of the Public Health Agency Board
Date	24 March 2022 at 1.30pm
Venue	Innovation Factory, Forthriver Business Park, Springfield Road, Belfast

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 17 February 2022		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.50	Chief Executive's Business		Chief Executive
7 2.05	Finance Report	**PHA/01/03/22**	Director of Finance
8 2.20	Update on COVID-19 To include: • Terms of Reference for COVID Public Inquiry		Dr Farrell

committee updates

9 2.40	Update from Chair of Remuneration Committee		Chair

items for noting

10 2.50	Family Nurse Partnership Report 2020	**PHA/02/03/22**	Mr Morton

11 3.10	Update on the Development of a new Operating Model for PHA	Chief Executive
12 3.30	Staff Recognition	Chief Executive

closing items

13 3.40	Any Other Business	
14	Details of next meeting: *Thursday 19 May 2022 at 1.30pm* *Location to be agreed*	

HSC Public Health Agency

minutes

Title of Meeting	141st Meeting of the Public Health Agency Board
Date	17 February 2022 at 1.30pm
Venue	Via Zoom

Present

Mr Andrew Dougal	-	Chair
Dr Stephen Bergin	-	Interim Director of Public Health
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
Mr Stephen Wilson	-	Interim Director of Operations
Mr John Patrick Clayton	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Ms Andrea Henderson	-	Assistant Director of Finance, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Mr Aidan Dawson	-	Chief Executive
Alderman Phillip Brett	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Dr Aideen Keaney	-	Director of Quality Improvement
Ms Tracey McCaig	-	Interim Director of Finance, HSCB
Mr Brendan Whittle	-	Director of Social Care and Children, HSCB

11/22 **Item 1 – Welcome and Apologies**

11/22.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr Aidan Dawson, Alderman Phillip Brett, Professor Nichola Rooney, Dr Aideen Keaney, Ms Tracey McCaig and Mr Brendan Whittle.

12/22 **Item 2 – Declaration of Interests**

12/22.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

13/22 **Item 3 – Minutes of previous meeting held on 20 January 2022**

13/22.1 The minutes of the Board meeting held on 20 January 2022 were **APPROVED** as an accurate record of that meeting.

14/22 **Item 4 – Matters Arising**

5/22.8 Fuel Poverty

14/22.1 The Chair said that he is keen to have a discussion around fuel poverty at a future workshop.

6/22.8 Categorisations of Funding

14/22.2 The Chair advised that Ms McCaig had shared information with members on different categories of funding. He noted that the management and administration budget is the area where there would be the most discretion.

6/22.10 Vacancies

14/22.3 Mr Morton reported that he has shared a paper with the Chief Executive about vacancies and as indicated in the action log, the Chief Executive will bring a paper to the Board on vacancies across the organisation. In terms of his directorate, he advised that there were 17 vacancies and that 9 have been filled and 2 have been filled on a temporary basis. He added that of those 17, only 4 had recurrent funding, but he said that all of this will be included in the overall report.

14/22.4 Ms Anne Henderson asked Mr Morton if he feels progress is being made and if it is easy to fill the vacancies. The Chair asked why there were temporary appointments. Mr Morton explained that posts had to be filled temporarily because there was no recurrent funding, but they still counted as vacancies. He added that it was easy to attract candidates for these senior posts, but it can take up to 6/9 months to complete a recruitment exercise. The Chair asked if posts were advertised publicly and Mr Morton confirmed that they are.

15/22 **Item 5 – Chair's Business**

15/22.1 The Chair outlined the list of workshops that have been organised. He advised that he and the Chief Executive had received a letter from Ms McCaig regarding arrangements for the PHA finance function after March 2022. On the subject of poverty, he queried whether PHA could utilise any of its slippage for organisations who help people dealing with issues of fuel poverty.

15/22.2 Mr Clayton commented that it was important to remember the social determinants of health, some of which have been alluded to in the Chair's business. He said that issues such as unemployment, fuel

poverty and gambling addiction should be at the forefront of Board discussion, perhaps in a workshop, when looking at future strategy and the new Programme for Government. The Chair agreed but cautioned that PHA cannot be seen to advocate to or to lobby government.

15/22.3 Ms Anne Henderson noted that in the short term, PHA has an underspend in this financial year, and she asked if there are opportunities for PHA to support organisations dealing with poverty. The Chair said there are organisations that PHA supports.

15/22.4 Ms Mann-Kler said that she supported the views of the other members. She noted that PHA's position is evidence based on the determinants which impact on public health and wellbeing and economic health. She asked if PHA is confident that all of its staff receive the living wage. Ms Andrea Henderson said that under Agenda for Change terms and conditions, she suspected that this would be the case, but she would check this **(Action 1 – Ms Andrea Henderson)**. The Chair asked about staff who are sub-contracted, for example cleaning staff, and if these wage rates could be checked. Ms Andrea Henderson said that may be challenging, but she would look into it **(Action 2 – Ms Andrea Henderson)**. Mr Wilson pointed out that PHA would not be directly involved in contracting staff as it is does not own the building and that the only direct lease PHA has is for Linum Chambers.

15/22.5 Mr Wilson said that Ms Mann-Kler's point relates to not only PHA staff, but work done by third parties, and this is where social value procurement comes in. He advised that PHA is beginning to work more in this area. In terms of fuel poverty, he said that while PHA works with a number of networks and organisations, there are complications in that any of PHA's funding would not go directly to end users. He added that the funding would go to other Government departments and would therefore be retracted from PHA's funding, and there is also the issue of being able to utilise the funding in-year. Ms Andrea Henderson agreed saying that there needs to a robust process with PHA carrying out the required due diligence and then there are procurement matters which tend to take time.

15/22.6 Mr Clayton recalled that there was a conversation at the last Governance and Audit Committee meeting around social value procurement. He sought clarity as to whether PHA is reviewing contracts against the real living wage rather than the national living wage as there is potential for confusion. He said from June 2022 it was his understanding that there is a requirement that all organisations getting Government contracts should be paying the real living wage and therefore if PHA is not doing this, it would set a poor example. Mr Irvine said that PHA needs to be sure that it is implementing a direction that ties in with a policy as that is the only way to ensure contractors are compliant. He advised that in the Council, this can be done for direct service contractors, but there can sometimes be issues with indirect service contractors. He said that all PHA can do is ask for an

assurance, but make sure it is using the right framework and asking the right questions.

15/22.7 Mr Morton said that this wider policy context is crucial in terms of the design and commissioning of services. He agreed that under PfG, there should be joined up approaches and PHA should have a critical role, but he felt that there is some way to go in terms of seeing joined up actions across all of Government and its various agencies.

15/22.8 The Chair said that PHA has been funding a project to improve nutritional standards in HSC catering outlets and he hoped that this would also happen in the canteen in Linenhall Street, but the canteen has since closed. He added he was concerned about whether staff could afford to spend money on food from other outlets. He advised that he is attending an event on nutritional standards in March and has asked for an update on the project.

16/22 Item 6 – Chief Executive's Business

16/22.1 There was no Chief Executive's Business.

17/22 Item 7 – Finance Report (PHA/01/02/22)

17/22.1 Ms Andrea Henderson advised that the Finance Report for the period up to 31 December 2021 showed a surplus of £0.8m which is made up of a small underspend in the programme budget and a larger underspend in the management and administration budget. She added that there is an overspend in COVID-19 funding which reflects downturn of core activities against the cost of contact tracing. She reported that the projected year-end position is a surplus of £450k, but she noted that will change between now and the end of the year as there will be many unknown factors and as this is above PHA's permitted break even target, her team will work closely with the Operations team and the Department.

17/22.2 Ms Andrea Henderson advised that the downturn in the COVID-19 budget relates to bowel screening and smoking cessation. She explained that the projected spend for COVID-19 is £8.3m and PHA has already drawn down £7m. She added that COVID-19 downturn has been offset against that budget so up to an additional £500k can still be drawn down at this stage.

17/22.3 Ms Andrea Henderson reported that there is a surplus in respect of ring fenced funding and since this Report was finalised that surplus has increased. She said that it is a challenge to manage this at this time of the year but reiterated that her team will work to achieve a break even position.

17/22.4 Ms Andrea Henderson gave an overview of the risks saying that PHA needs to monitor programme funding closely, and that there remains

	some funding which has not yet been allocated to Trusts. She added that the underspend in the management and administration budget is unlikely to reduce and she highlighted issues relating to the COVID-19 budget. She advised that as annual leave usage throughout the organisation is lower than at this point last year, there will be a financial impact which is difficult to predict, and is being kept under review, but may need to be reported in the accounts.
17/22.5	Ms Andrea Henderson said that in relation to the capital expenditure position, the majority of the budget is Research and Development. She added that following discussion with the R&D team there are no issues to report.
17/22.6	Ms Anne Henderson asked if the biggest risk for PHA is the funding that has not yet been allocated to Trusts. She also asked about the plans for contact tracing are for next year. Ms Andrea Henderson said that with regard to the Trusts, there is approximately £500k of funding that has to go out and Operations staff are currently reviewing this. She added that she expected there to be some slippage, but PHA cannot pay the funding out until there is confirmation of what work has actually been delivered on the ground. She agreed that it is a risk, but not the biggest one. In response to a follow up query from Ms Anne Henderson, she said the biggest risk is annual leave.
17/22.7	The Chair asked what the cost of annual leave was last year and Ms Andrea Henderson advised that it was around £750k, but for this year it could be up to £200k more. The Chair asked if PHA is compelled to pay this to staff, but Ms Andrea Henderson explained that it is not being paid to staff, it is the cost of the leave that has to be accounted for. She added that there is a buy back scheme, but that will have little impact on the accrual carried forward. She said that the Agency Management Team (AMT) members have been encouraging their staff to take leave and to ensure that the HRPTS system is up to date.
17/22.8	Noting that the Report is the situation as at the end of December and that there was an indication that the surplus will grow, Mr Stewart asked what the forecast is now. Ms Andrea Henderson said that there could potentially be another £300k of surplus. She advised that PHA is therefore unlikely to draw down all of the funding it requires for contact tracing, and that there will be some work to juggle funding. She added that her team will work with Operations staff and the Department to manage this, but she conceded that there may be difficulties.
17/22.9	Ms Mann-Kler asked about annual leave and if there are staff who have not taken leave over the last 2 years. She said that this would represent a wellbeing issue and a safeguarding concern for Non-Executive Directors. She hoped that over the next few months the situation will ease and staff will have the opportunity to use leave. She asked if there will be scope to carry leave forward as she was certain the same situation must exist right across the HSC. Ms Andrea Henderson replied

that in terms of carrying forward leave there is an opportunity. From a finance perspective, she said that finance is using the HRPTS system to calculate a cost, but she acknowledge that behind those numbers are staff and AMT is reinforcing the need for staff to take leave. She said that while she is not directly involved in Trust-related matters, she believed that Trusts are requiring additional financial cover for the cost of their annual leave accrual. She explained that although there is a buy back scheme, there is certain level of leave that all staff must use. Mr Morton reiterated that AMT is encouraging staff to take leave, but at this stage it will be difficult for staff to use their leave entitlement. The Chair said that he was thinking about the health and wellbeing of staff, particularly as the pandemic ends, as some staff may find it challenging to readjust.

17/22.10 Mr Clayton noted the earlier discussion about the number of variables which will determine if PHA can achieve a break even position and he asked that, given it is unlikely there will be a 3-year budget, what implications are there for PHA. He asked if any funding will be retracted if there is a high level of surplus, and how this will affect PHA's allocation for next year. Ms Andrea Henderson explained that to date, PHA has not asked for any funding to be retracted but to be offset against COVID-19 expenditure. She said that she did not think that PHA's potential underspend has been factored into any discussions on the budget but acknowledged that recent events have not helped. She advised that there will be other monies being directed to the overall health budget but the final budget will not be finalised until there is Executive approval. She added that there will be a submission made to the Minister but it may boil down to what can actually be approved in the absence of an Executive.

17/22.11 Ms Anne Henderson asked if the payback scheme would be fully resolved by 31 March, but Ms Andrea Henderson replied that as staff will have until 31 March to submit an application, the costs will fall into the next payroll period which is in the next financial year.

17/22.12 The Board noted the Finance Report.

At this point Ms Andrea Henderson left the meeting.

18/22 Item 8 – Update on COVID-19

18/22.1 Dr Bergin presented the latest data relating to COVID-19. He noted that this is now the third year since PHA established its mechanisms for looking at this. Beginning with the number of daily cases, Dr Bergin showed that the numbers remain high and there is still a long way to go although society is opening up. He noted the drop in numbers which is likely due to recent changes in the testing mechanisms and added that there will be a major announcement next week regarding future

arrangements for testing and contact tracing. He pointed out that PHA has always had a contact tracing function and it will continue to monitor COVID-19 as part of its surveillance and epidemiological work.

18/22.2 Dr Bergin advised that the numbers among younger age groups peaked around 25 January. He reported that Omicron is now prevalent across all age groups. He said that according to the latest ONS data 1 in 11 people had COVID-19 in Northern Ireland during January and that between the vaccine and previous infection more or less all of the population has antibodies. He showed a graph detailing the four waves of the pandemic and the links with hospitalisations. He said that there remains a lot of pressure on the hospital system and that a 1 or 2% increase in bed occupancy can have a major impact given occupancy is usually around 97%. He indicated that because of acquired immunity, the number of deaths has dropped markedly. He said that COVID-19 is going to remain in circulation for the foreseeable future but there should be a lower impact in terms of hospital admissions, numbers ending up in ICU and deaths.

18/22.3 Dr Bergin advised that PHA is dealing with hospital acquired infections (nosocomial infections) as Omicron is now active across all care settings. He said that the impact of nosocomial infections and outbreaks in care homes has to be managed. He reported that at the peak 50% of care homes had an outbreak and this will take time to recede. He said that although the care home population is highly vaccinated, it remains highly vulnerable.

18/22.4 Dr Bergin reported that going forward, PHA will be taking over the vaccination programme from the Department of Health from 2022/23 and that this will be a significant enterprise. He said that he will give a presentation on this at a future meeting, but noted that taking this on is a vote of confidence from the Department and that PHA has a lot of experience in this area.

18/22.5 The Chair thanked Dr Bergin for a comprehensive and comprehensible presentation and said that he would welcome a presentation on the vaccination programme.

18/22.6 The Chair asked if hospitals are differentiating between coincidental infections and hospitalisation due to COVID-19. Dr Bergin said that an effort is being made to differentiate between the two. The Chair noted that there is the issue if COVID-19 is recorded on the death certificate. Dr Bergin agreed that whether COVID-19 is the cause of death or contributed to death can sometimes be a judgement call.

18/22.7 Mr Clayton asked about the vaccination programme and for the arrangements for the 5/11 age group. Dr Bergin explained that PHA will not actually deliver the vaccine and it will be done through, for example, school nursing, or GP practices. He said that in a similar way to approach, PHA will commission the end-to-end pathway and it will have

responsibility for areas such as data, uptake and communications. Mr Morton added that the bank vaccinators will be redeployed to Trusts to deliver this and some of the other vaccinators will support primary care and pharmacy.

18/22.8 Ms Mann-Kler asked at what point does PHA try to pause and reflect on the impact of the last couple of years and look at the implications for its work going forward. She cited elements of trauma, mental health issues, addiction and long COVID as well as other implications and asked whether there has been thought to looking at these areas. Dr Bergin said that about 4/6 weeks ago there was a period when the situation was relatively quiet and then 48 hours later PHA was dealing with the imminent impact of the Omicron variant. He added that PHA will be dealing with COVID for a period of time to come and there hasn't been the opportunity to look back. He said that there may be a Public Inquiry so PHA will need to look at any lessons learnt. Going forward, he noted that the work on the future operating model for PHA will be an opportunity to take stock. He said that while society may feel COVID-19 is over, that is not the case for PHA, i.e. there is still much work to do and plan for.

18/22.9 Ms Mann-Kler said that when thinking about affecting public health behaviours and ensuring a clarity of messaging going forward, there is a real challenge for the PHA as there is a feeling amongst some people that there is no longer a need to wear masks and hand hygiene doesn't matter. Dr Bergin pointed out that public health guidance hasn't changed and before COVID-19, public toilets and bars always displayed messages about hand hygiene and there were always campaigns.

18/22.10 Mr Morton said that there is work being done to model the delayed health impacts of COVID-19 which looks at issues such as long COVID and the socio-economic impact.

18/22.11 The Chair agreed that there is a need to have time to reflect and it is essential to find that time. Mr Morton said that there have been conversations at AMT meetings and there is a need for a period of recovery, not just for Directors but for their teams. He added that he is surprised that there has not been a higher level of sickness absence. He said that consideration is being given to how to create space for staff to recharge their batteries. Mr Stewart said that the current absenteeism rate is to be commended, but from experience, he said that it will increase as soon as the pressure is off.

19/22 Item 9 – Update from Chair of Governance and Audit Committee (PHA/02/02/22)

19/22.1 Mr Stewart advised that the approved minutes of Governance and Audit Committee (GAC) meeting of 3 December were in the papers for members, but that the Committee has since met on 27 January.

19/22.2 Mr Stewart reported that the Committee considered an updated Corporate Risk Register and that the Corporate Risk Register will be brought to the Board meeting in May. He added that consideration was also given to the public health directorate risk register. He advised that the Committee received a request to defer an audit on vaccination programmes until next year and this was approved. He reported that the external auditors presented their strategy for the year-end audit and that it is a similar strategy to last year. He noted that the auditors will look at how PHA accounts for COVID-19 funding and does not use it to minimise underspends. He said that the Committee considered the updated anti-fraud and anti-bribery policy and these were approved subject to some minor amendments which Ms McCaig agreed to undertake. He added that the Committee also received a fraud report and was given an overview of two investigations where PHA is a third party, but to date no suspected fraud has been found in either case.

19/22.3 Mr Clayton noted the reference earlier to the correspondence Ms McCaig has sent regarding the finance function and any implications following the closure of HSCB. He said that during the discussion at GAC, it was noted that nothing significant will change, although staff will work under the banner of the Strategic Planning and Performance Group (SPPG), but he felt it would be useful if there was an update for the PHA Board. The Chair said that he had raised this with the Chief Executive and although Ms Martina Moore has been scheduled to attend the May Board meeting, he felt it may be appropriate that this matter should be dealt with earlier and perhaps Ms Sharon Gallagher rather than Ms Moore might be appropriate. He added that he had had a discussion with the ongoing HSCB Chair and there are still issues that need to be clarified.

19/22.4 Mr Morton advised that since last November, he and other Directors have been actively involved in discussions and attended a number of workshops with officers of HSCB to look at operational arrangements post migration, but these have been paused and there is a need to get them up and running again. He said that although the legal transition to the SPPG has to be worked through, there also needs to be a discussion about the PHA's recovery programme as well as the role it will play under the new planning arrangements. He suggested that 2022/23 will be viewed as a transition year so there is still time for PHA to have an influence on how future arrangements will shape up. The Chair reported that the HSCB Chair had advised him that a group has just now been established to look at commissioning. He also recorded that the HSCB Chair had spoken in eulogistic fashion about the contributions of Mr Morton, Dr Bergin and Dr Brid Farrell to the meetings of that board. Mr Morton assured members that between HSCB and PHA, there is a commitment to establish multi-disciplinary planning teams and to ensure that PHA has a role in the new integrated care system planning model. He said he was confident that HSCB and PHA are on the same page.

19/22.5	The Chair asked if PHA still leads in terms of assessing healthcare needs. Dr Bergin said that this would be done at a national level and there is a wide variety of people who would do this work. The Chair said that PHA should work in tandem with the community and voluntary sector. Mr Morton said that under the new planning model PHA will want to have a lead role.
19/22.6	The Board noted the update from the Chair of the Governance and Audit Committee.
20/22	**Item 10 - Pilot Buddy Project for PHA Board (PHA/03/02/22)**
20/22.1	The Chair asked members if they had any thoughts on the project which he felt was a positive move.
20/22.2	Ms Mann-Kler said that it will be useful, but asked if any thought has been given in terms of targets, measurement and impact. She added that when reflecting on HSCQI and learning, it is important to integrate that learning culture and that should be driven at Board level. However, she said that she was not clear about what that looks like. She noted that the "buddying" should operate at a strategic level and not stray into operational matters.
20/22.3	Mr Clayton agreed that it should be an informal relationship and that in terms of outputs, there should be something to bring back at the end. He suggested that it may be worth considering switching buddies in order to help Board members get to know the totality of PHA's business. The Chair agreed with that proposal.
20/22.4	Ms Anne Henderson said that she also welcomed the proposal and she noted that with COVID-19 people are more detached and there are less opportunities to meet people. She agreed that there should be a rotation after 6 months. She also agreed with the points made about how the learning and benefits are noted.
20/22.5	The Chair undertook to report members' comments back to the Chief Executive **(Action 3 – Chair)**.
20/22.6	The Board **APPROVED** the pilot buddy project.
	At this point Mr Clayton left the meeting.
21/22	**Item 11 - Update on Personal and Public Involvement (PHA/04/02/22)**
	Mr Martin Quinn, Ms Bronagh Donnelly and Mr Martin McCrory joined the meeting for this item
21/22.1	Mr Morton introduced the Personal and Public Involvement (PPI) update and explained that PPI is a statutory responsibility for all HSC organisations and HSC has a delegated responsibility to oversee the

	implementation of PPI standards. He advised that this work sits alongside PHA's work in the areas of co-production and patient experience. He said that those attending today will give an overview of the work that has been carried out during the year and added that against a backdrop of staffing challenges and staff being redeployed, the team has continued to deliver on its statutory responsibilities.
21/22.2	Mr Morton welcomed Mr Quinn, Ms Donnelly and gave a particular welcome to Mr McCrory who has recently joined PHA as a Peer Mentor to champion to voice of lived experience across the HSC system. He said that it is critical that PHA can provide that peer mentorship leadership.
21/22.3	Mr Morton said that going forward to 2022/23, there are five objectives for the PPI team; to review its current work, to develop peer mentoring and leadership across the HSC, to focus on the outcomes of PPI, to look at PPI and lived experience can influence the public health agenda and to develop a patient experience dashboard that draws together critical intelligence and puts it into a usable format going forward.
21/22.4	Mr Quinn reported that the PPI team has gone full circle with previous staff having left to take up leadership roles in other organisations and new staff coming in and added that he was impressed with how the team has recovered during this period of change.
21/22.5	Mr Quinn said that the team has commenced research into outcomes based monitoring and he agreed that the team has provided to the commissioning and service development agendas. He added that the team will be happy to look at how it can influence the public health agenda. In spite of the pressures that the HSC system has faced, he reported that every course that has been organised has been over-subscribed which shows that there is a continued appetite for this work. He advised that for the seventh cohort of the leadership programme, there were 80 applicants and the programme has been enlarged to facilitate 30 participants.
21/22.6	Ms Donnelly began her presentation by reiterating the fact that the latest cohort of the PPI leadership programme has seen demand outstrip the capacity to deliver. She reported that over 220 participants have booked on one of the four recent webinars which were developed in partnership with the Consultation Institute.
21/22.7	Ms Donnelly advised that a lessons learned reflection workshop has been arranged for early March which will look at the experiences of service users and carers during the pandemic and that PHA will work with both Queen's University to produce a paper following the workshop.
21/22.8	Ms Donnelly said that, working with the Consultation Institute, an Executive briefing has been devised and that the AMT availed of this in November 2021. She said that other senior teams across the HSC have been offered the opportunity to receive the briefing.

21/22.9	Ms Donnelly reported that the revamp of the Engage website in its final stages and that it has been shared with the Regional PPI Forum members for their comments and their feedback will be taken on board prior to the launch of the new site in the Spring.
21/22.10	Mr McCrory introduced himself as PHA's Regional Peer Mentor Lead for Service Users and Carers. He said that this is a post which has been championed by Mr Morton and a key part of the role will be to embed service user and carer roles in the HSC and how the recruitment of these individuals can bring tangible benefits for them and for the HSC. He added that his role will look at mentoring and development opportunities and he will also be looking at areas such as recruitment, remuneration and reimbursement. He said that he is looking forward to working with the Trusts and the PCC in this role.
21/22.11	Mr McCrory advised that PHA is running a bursary scheme to support service users and carers and any applications for these will be scored by a panel of service users and carers and staff across HSC organisations.
21/22.12	Mr McCrory gave an overview of the different Department of Health projects that the PPI team has continued to support as part of the Rebuild agenda.
21/22.13	Mr McCrory reported that PHA has been working to update the PPI monitoring arrangements that will be place from 1 April 2022. He explained that the revised tool will allow for the collation of consistent data which will help evidence the range of involvement and co-production work that is taking place and allow PHA to be able to more readily demonstrate the impact of this work and the difference it is making.
21/22.14	Mr Quinn said that the presentation was a quick overview of the range of work the team is involved in.
21/22.15	Ms Anne Henderson said that the presentation gave an overwhelming sense of the programme of work in this area, but she asked for a definition of who the service users and carers are, and how PHA can measure success. She noted that many people are now looking to the private sector for healthcare. She added that she was particularly interested in how PHA reaches those who are seldom online. *At this point Mr Clayton re-joined the meeting.*
21/22.16	Mr Morton explained that PHA and the Patient Client Council (PCC) have a role in this area and while PCC has the anchor role, PHA looks at specific groups and their experience of healthcare services, both citizens who use the service, and their carers. He said that the PPI team encourage these people to give their views and there is an online forum called Citizen Space. In terms of the increased use of the private sector, he said he felt that this was more to do with waiting lists. Ms

Anne Henderson said that more and more people are using private GPs which shows a failure on behalf of the HSC in not having sufficient GPs.

21/22.17 Ms Mann-Kler said that the presentation showed that a huge amount of work has been carried out, and said that it was interesting to note a culture change in terms of how the nature of engagement is shifting. She noted that she would like to see a bird's-eye view of impact of PPI in future reports. She also picked up on the reference to PCC, and noted that there used to be PCC representation on the PHA Board, which is no longer there, and suggested that this should be revisited in order to tighten PHA's PPI agenda. She asked the team what they felt to be the three main challenges going forward.

21/22.18 Mr Stewart commented that one of the most difficult things about communication and engagement is being able to show that it has paid dividends. He added that initially there is a burst of enthusiasm from people to be engaged, but this can quickly wane. The Chair asked whether PPI training can be included in the initial training of healthcare professionals, and he asked about training uptake within medical consultants.

21/22.19 Mr Quinn said that he would be happy to prepare a 1 or 2 page overview on the impact of PPI. He advised that PHA will be gathering a lot of data over the next period of time and it needs to look beyond this data and look at impact. He added that there will shortly be a launch of the updated Engage website and on that site will be examples of good practice, intervention and outcomes. He agreed that while there are many good news stories about user involvement, there is a need to be better at celebrating these. He noted that positive experiences are rarely picked up on and celebrated as there tends to be a focus on negative experience, although 80% of the stories PHA has collected are positive. He advised that there has been a good uptake for the recent series of webinars and undertook to get details of these shared with Board members **(Action 4 – Mr Quinn)**. He explained that although there has been direct links with Ulster University as well as social care, nursing and pharmacy staff, the uptake among medical staff has not been as high. Mr Morton agreed that there has been a struggle to attract medical staff and this remains a challenge, but he said that it is not for the want of trying and efforts are made to understand why there is such a low uptake.

21/22.20 In terms of the three challenges going forward, Mr Morton reiterated the need to be able to demonstrate impact. He said that while PHA is data rich, there needs to be an improvement in turning this data into reports which are consumable and show the outcomes. Secondly, he said that PHA needs to mainstream lived and living experience and to grow the role of peer mentors, something which is viewed as a public health intervention. He advised that every peer mentor that PHA employs, there is a £20k improvement in economic status. Finally, he said that PHA needs to work in an integrated way and work within the new

integrated care model and ensure that it does not end up consulting the same people all over again.

21/22.21 The Chair thanked Mr Quinn, Ms Donnelly and Mr McCrory for their presentation and for attending today's meeting.

21/22.22 The Board noted the update on Personal and Public Involvement.

22/22 Item 12 - Performance Management Report (PHA/05/02/22)

22/22.1 Mr Wilson advised that the Performance Management Report records progress against actions in PHA's Business Plan and of the 53 actions, 42 are rated "green", 11 are rated "amber" and none are rated "red". He said that this is a positive outcome given the events of the past year and he envisaged that those actions rated "amber" would be completed. He advised that the layout of the Report has been changed to bring all of the actions rated "amber" to the front, but he noted that they go across a range of areas. He reiterated that it is a positive Report, and that some of the mitigations for not completing actions are because staff have been redeployed. He hoped that once staff return to their normal duties the outstanding actions will be completed, and he felt that the level of risk of not completing these is not major.

22/22.2 Mr Irvine said that the Report contained a lot of information and suggested that it may be helpful if there was a short summary indicating any changes in rating and the reasons for the change. He added that it was good to see that all actions were rated either "green" or "amber".

22/22.3 Mr Clayton commented that there is a lot of useful information in the Report but going forward into the next business planning cycle, he suggested that there needs to be more clarity about what PHA's targets are and how they link to its strategic objectives and PfG. Looking at the data on contact tracing, he noted that when there was a record number of daily cases, PHA was not reaching many of these within 24/48/72 hours and he asked if this was due to the sheer volume of cases. Dr Bergin advised that it a matter of supply and demand. He said that the Contact Tracing Service (CTS) has been operating in "purple" status for a while and that the number of cases exceeded what PHA had planned for. He added that PHA was not prepared for this level of transmissibility and acknowledged that performance has struggled. He said that a significant number of PHA staff were redeployed.

22/23.4 Mr Wilson thanked members for their comments on the Report and advised that work is ongoing on a new Performance Management Framework. He undertook to add more detail into the introductory section of the Report.

22/23.5 The Chair noted that in the updates from Health Improvement, there are some references to outcomes. Mr Wilson agreed that this is the case and said that PHA is looking to evolve its Outcomes Based Accountability (OBA) approach and have this established throughout the

Report. The Chair noted that this could be discussed at the workshop in March.

22/23.6 Ms Mann-Kler welcomed the Report and asked how often it will come to the Board. She also welcomed the update on diabetes which was shared with members, but asked if there were any targets. With regard to screening, she noted that there was a benchmark with performance in 2019 and she asked why that was chosen as a benchmark as she thought the targets would have been changed each year. She said it was good to see the information about HSCQI and EISS, but asked why this information was appended to the Report.

22/23.7 Ms Anne Henderson said that it was reassuring that in future there will be links to outcomes. With regard to contact tracing, she asked that if the people contacted are purely random, does this not make the service meaningless. She also asked if PHA is content that the bowel screening catch up will be completed by August 2022 and how it was agreed that this was an appropriate target.

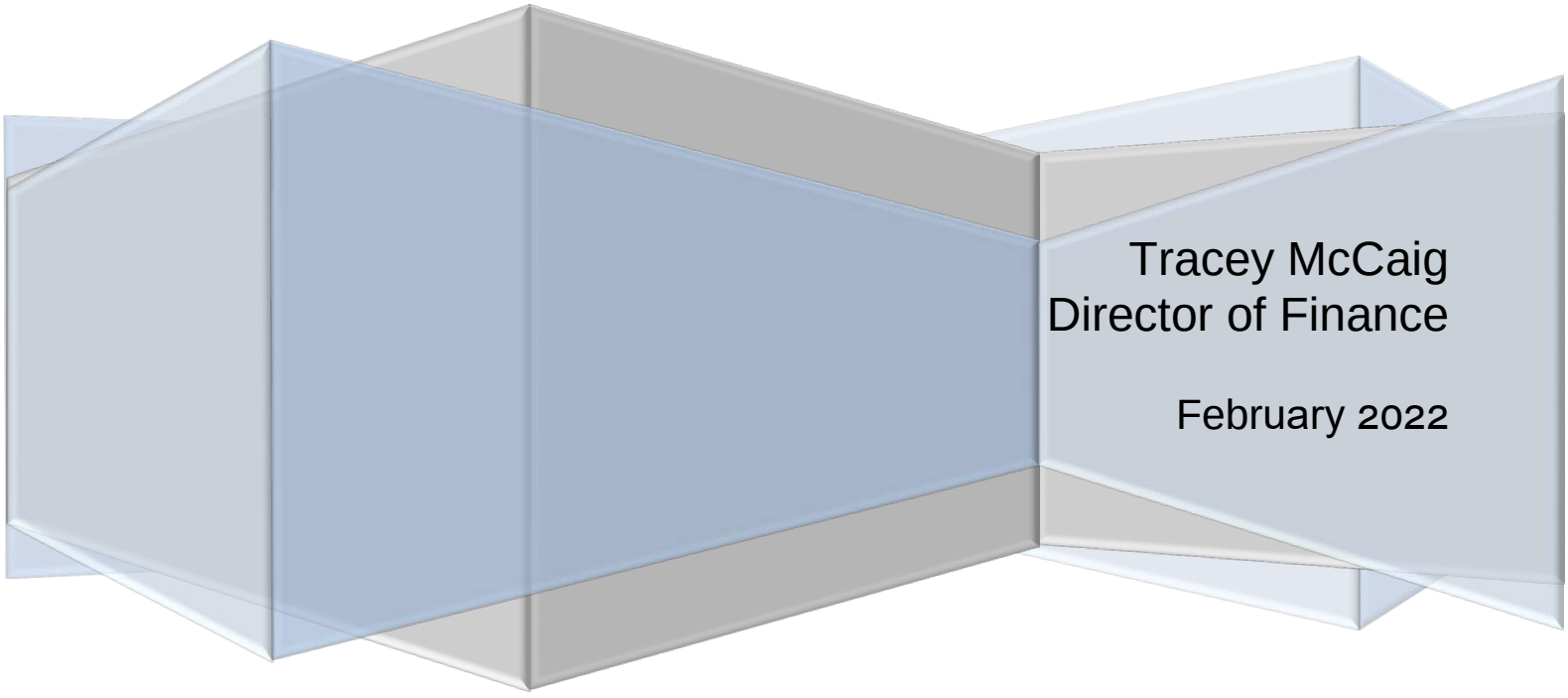
22/23.8 Mr Wilson advised that the Report will be brought to the Board quarterly. In terms of the updates on diabetes, he noted that this was an action from the previous meeting, and that the updates on HSCQI and EISS were appended because leads were asked that if they had further detail on outcomes, these should be appended. However, he said that PHA is looking to produce a more rigorous report. Responding to Ms Mann-Kler's query about targets for diabetes, Mr Wilson said that the target was to have the programme regionalised as it was only within the South Eastern Trust area. He added that PHA is looking to get more sustained funding for the programme going forward. Dr Bergin explained that there is no funding beyond March 2022.

22/23.9 Dr Bergin picked up on the queries about screening and explained that in April 2020 screening was paused for a few months and the wider infrastructure slowed down. He added that people did not want to go to hospitals so putting these factors together has resulted in programmes being 6/9 months behind. He said that time cannot be got back quickly as there is only limited capacity. Ms Anne Henderson said that while she accepted that, she questioned whether the target should be rated "green". Dr Bergin replied that there are harms attributable to COVID-19 right across the system with the pausing of these programmes, but in terms of the target in this Report, the infrastructure will be completed by August 2022 which is why it is rated "green". The Chair expressed concern that a target can be rated "green" that is for 6/9 months' time. He added that it would be useful to see the percentage of uptake of screening compared to 2019. Dr Bergin advised that Dr Tracy Owen is due to attend a future Board meeting with a full report on screening.

22/23.10 The Chair said that a new PfG will be developed during the first year of any new Assembly and this effectively leaves organisations rudderless being able to develop a new Strategy. With regard to the future planning

	group looking at intelligence, he asked if there is external representation on that group.
22/23.11	Mr Wilson responded that with regard to PfG, PHA will work on the basis of a direction from the Department of Health. He advised that the new planning group has inputs from across the PHA and not only Health Intelligence and is chaired by Dr Declan Bradley. He added that it was his understanding that there is academic input. The Chair said that it would be useful to have a report on this and that it is important that there is that peer review **(Action 5 – Mr Wilson)**.
22/23.12	The Chair said that he was looking forward to the workshop in March where there would be a discussion on strategy. Mr Stewart noted that when thinking about strategy and PfG, he suggested that it is unlikely that any of the challenges in PfG in relation to health will change.
22/23.13	The Chair thanked the Executive Directors for compiling this Report.
22/23.14	The Board noted the Performance Management Report.
23/22	**Item 13 – Any Other Business**
23/22.1	With there being no other business, the Chair thanked members for their time and drew the meeting to a close.
24/22	**Item 14 – Details of Next Meeting**
	Wednesday 16 March 2022 at 1:30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7BS
	Signed by Chair:
	Date:

Finance Report
January 2022



Tracey McCaig
Director of Finance

February 2022

Section A: Introduction/Background

1. The PHA Financial Plan for 2021/22 was approved by the PHA Board in the June 2021 Board meeting, which described the opening financial position of the organisation and reported an anticipated breakeven position within 2021/22.

2. The Financial Plan identified a number of areas of projected slippage and how this was to be used to address in-year pressures and priorities.

3. This executive summary report reflects the latest position, as at the end of January 2022 (month 10). Supplementary detail in the format of previous reports is provided in Annex A.

Section B: Update – Revenue position

4. The PHA has reported a year to date surplus, at January 2022, of £0.8m (£0.8m at December 2021).

5. In respect of the year to date surplus of £0.8m:
    - The profiled PHA Programme budget is showing a small overspend against profile for the year to date, mainly due to some expenditure ahead of profile within Health Improvement. This is a timing issue only, and no overspend is anticipated in these areas at year-end. Budget holders continue to be reminded to keep all budgets under close review, and report any expected slippage or pressures when emerging.
    - As reported previously, there continues to be an underspend in the Management & Admin budget, primarily in the areas of Nursing & AHP and Operations, which reflects a high level of vacant posts in each area, along with reduced non-pay expenditure which is a result of different working arrangements due to the pandemic. Efforts are on-going to fill vacant posts as soon as possible.
    - An overspend is noted in respect of Covid funding (c£0.1m) which reflects Covid downturn in respect of core operations, being offset against funding requirements for, primarily, the Contact Tracing Centre. This is anticipated

to increase significantly by year end, in line with previously identified Covid downturn within Core services.

- A surplus is being reported in respect of strictly ringfenced funding (c£0.2m), primarily in the area of Delivering Care. This has been reported to DoH, however DoH have indicated that they currently do not intend to retract this funding.

6. The updated position is summarised in the table below.

PHA Summary financial position - January 2022

	Annual Budget £'000	Year to date budget £'000	Year to date Expenditure £'000	Year to date variance £'000	Projected year end Surplus / (Deficit) £'000
Health Improvement	12,251	10,209	10,209	0	
Health Protection	7,750	6,458	6,458	0	
Service Development & Screening	14,064	11,720	11,720	0	
Nursing & AHP	6,576	5,480	5,480	0	
Centre for Connected Health	1,566	1,305	1,305	0	
Programme expenditure - Trusts	**42,207**	**35,173**	**35,173**	**0**	**0**
Health Improvement	27,467	20,857	21,763	(906)	
Health Protection	14,570	13,177	12,758	419	
Service Development & Screening	2,725	1,645	1,573	72	
Research & Development	3,411	1,700	1,700	0	
Campaigns	1,472	1,074	1,026	48	
Nursing & AHP	1,827	130	176	(47)	
Centre for Connected Health	326	114	109	5	
Quality Improvement	170	130	113	18	
Other	(53)	0	0	(0)	
Programme expenditure - PHA	**51,916**	**38,827**	**39,219**	**(392)**	**(78)**
Subtotal Programme expenditure	**94,123**	**74,000**	**74,391**	**(392)**	**(78)**
Nursing & AHP	5,246	4,315	3,777	538	
Quality Improvement	592	493	450	43	
Operations	4,233	3,527	3,241	286	
Public Health	16,653	13,792	13,667	125	
PHA Board	328	270	288	(18)	
Centre for Connected Health	426	355	335	20	
SBNI	771	634	549	86	
Subtotal Management & Admin	**28,249**	**23,386**	**22,307**	**1,079**	**1,186**
Trusts	1,096	913	913	(0)	
PHA Direct	10,003	7,425	7,511	(85)	
Subtotal Covid-19	**11,098**	**8,339**	**8,424**	**(85)**	**(780)**
Trusts	142	118	118	0	
PHA Direct	64	0	0	(0)	
Subtotal Transformation	**206**	**118**	**118**	**(0)**	**0**
Trusts	0	0	0	0	
PHA Direct	528	326	160	166	184
Other ringfenced	**528**	**326**	**160**	**166**	**184**
TOTAL	**134,205**	**106,168**	**105,401**	**767**	**512**

N.B. Table may be subject to minor rounding differences

7. The forecast year end position is a surplus of £0.51m (£0.45m at month 9), and is being largely driven by management and administration slippage. It should be noted that this is marginally above the PHA's breakeven limit of approximately £0.33m and opportunities to utilise are continuing to be sought.

8. Following a review of Programme planned expenditure it should be noted:
    - The position in relation to Programme expenditure continues to be under constant review, to identify slippage and / or pressures;
    - Covid related downturn has been projected in a number of areas, including the Smoking Cessation budget (£0.6m surplus) and Bowel Screening (£0.2m surplus), which will be offset against Covid allocations for the Contact Tracing Centre (CTC), leaving a net pressure on Covid funding;
    - Contact Tracing Centre expenditure totalling £8.3m has been projected, with a net allocation requirement of £7.5m being advised to DoH Finance as a result of the Covid downturn set out above. As case numbers fluctuate, the estimate of additional funding required continually changes, and this position will be managed closely in the approach to year-end. Funding of £7m has currently been received and any balance required will continue to be managed in the context of PHA's overall financial position;
    - Anticipated slippage within management and administration budgets remains high as the expected start dates of some senior posts within Public Health and Nursing have been delayed. An element of the year-end annual leave accrual has been released to reflect leave carried forward from 2020-21 now being utilised, however this is being kept under review in the approach to 31 March 2022;
    - A surplus is being reported in respect of strictly ringfenced funding (c£0.2m), primarily in the area of Delivering Care. As referenced above, this has been reported to DoH, however recently DoH have indicated that they currently do not intend to retract this funding.

Section C: Risks

9. **Internal Programme expenditure outturn.** As in previous years, Programme expenditure continues to be monitored closely to ensure that planned expenditure is met. The PHA senior team has conducted a mid-year review of expenditure plans and action has been taken to reallocate funding to approved developments and pressures. Continual reviews are ongoing as any slippage or pressures on expenditure emerge. The reported position reflects these reviews, however this will continue to be subject to ongoing monitoring for the remainder of the financial year.

10. **Management and Administration expenditure outturn.** This is closely monitored by the Finance team, in conjunction with PHA management, to ensure that the forecast financial position is updated on a monthly basis. However, given current plans and timelines for recruitment, the level of slippage is unlikely to reduce before year-end.

11. **Ring-fenced funding - Covid.** The position assumes that all areas of expenditure funded via Covid funding will breakeven, with the exception of the Contact Tracing Centre, where Covid downturn within PHA has been identified to offset Covid funding required. Currently the majority of Covid expenditure (circa. £6.7m) relates to the Contact Tracing Centre, with the balance of £1.7m relating to smaller Covid projects. PHA will work closely with DoH Finance as we approach year-end to manage the breakeven position. Regular reviews are undertaken on all areas relating to Covid ring-fenced funding, to identify any areas of risk in respect of budget requirements and close liaison will continue with the DoH.

12. **Annual leave.** The annual leave usage levels reported to date remain proportionately lower than reflective of the point in the financial year, which may ultimately result in an additional cost in the financial year. The financial impact of this is being kept under review.

13. **Funds not yet allocated to Trusts.** Good progress has been made in this area, with substantially all funding intended to go to Trusts now allocated. A small number of low value allocations remain to be processed, and management are

proactively working to ensure these remaining balances are allocated as a matter of priority to minimise risk of the funds remaining unspent at year-end.

14. **Covid response impact on PHA.** It has been a challenging period for PHA, not least from the focus on the operational nature of the Contact Tracing Service and the support to manage service pressures due to Covid response. Staff members have been diverted internally to support the response, which has impacted the PHA's ability to fully conduct its business as usual operational requirements.

15. Due to the complex nature of Health & Social Care, there will undoubtedly be further challenges with financial impacts which will be presented in year. PHA will continue to monitor and manage these with DoH and Trust colleagues on an ongoing basis.

Section D: Update - Capital position

16. The PHA has a current capital allocation (CRL) of £14.0m. The majority of this (£12.6m) relates to Research & Development (R&D).

17. Other PHA Capital includes an allocation of £358k for the Congenital Heart Disease Professorship Network to be set up across Ireland and £800k for a Covid-19 Wastewater project. There is also currently a small allocation of £92k for ICT capital expenditure within PHA, and £141k for ICT linked to the Contact Tracing Centre.

18. The overall summary position is reflected in the following table.

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Other Bodies	5,571	2,450	5,571	0
R&D - Trusts	8,089	6,670	8,089	0
R&D Capital Receipts	(1,020)	(257)	(1,020)	0
Subtotal HSC R&D	12,640	8,863	12,640	0
CHITIN Project:				
CHITIN - Other Bodies	2,077	2	2,077	0
CHITIN - Trusts	153	0	153	0
CHITIN - Capital Receipts	(2,230)	0	(2,230)	0
Subtotal CHITIN	0	2	0	0
Other:				
Congenital Heart Disease (CHD) Network	358	0	358	0
Covid-19 Wastewater	800	0	800	0
Covid-19 ICT	141	111	141	0
ICT	92	92	92	0
Subtotal Other	1,391	203	1,391	0
Total HSCB Capital position	**14,031**	**9,068**	**14,031**	**0**

19. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

20. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position. Most of the activity on this project happens during March, hence the low year-to-date expenditure.

21. The Congenital Heart Disease network funding (£358k) is being managed by the Research & Development team, and is expected to fully spend in year. The Covid-19 Wastewater allocation (£800k) will fund a QUB project which is analysing

wastewater to help with tracking of outbreaks of Covid-19. It is also expected to fully spend in year.

22. The Capital position will continue to be kept under close review throughout the financial year.

Recommendation

23. PHA Board are asked to note the PHA financial update as at January 2022.

Public Health Agency

Annex A - Finance Report

2021-22

Month 10 - January 2022

PHA Financial Report - Executive Summary

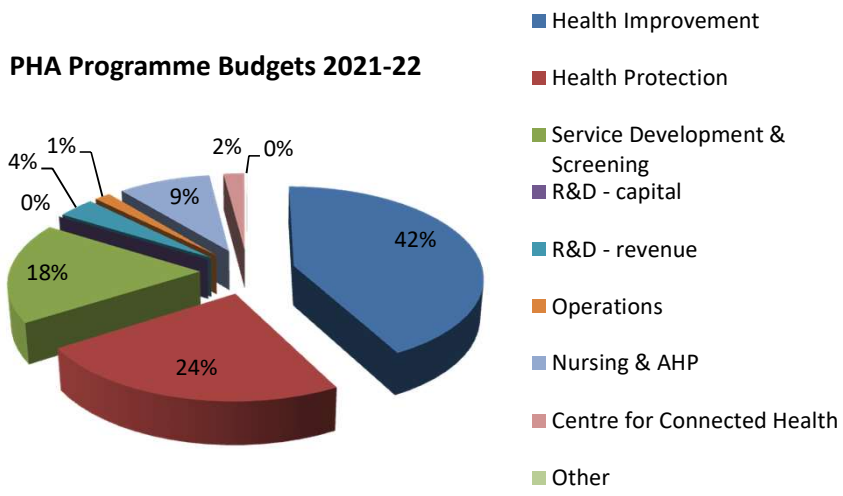
Year to Date Financial Position (page 2)

At the end of month 10 PHA is reporting an underspend of £0.8m against its profiled budget (£0.8m at month 9). This underspend is primarily the result of underspends on Administration budgets (page 6).

Budget managers continue to be encouraged to closely review their profiles and financial positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.

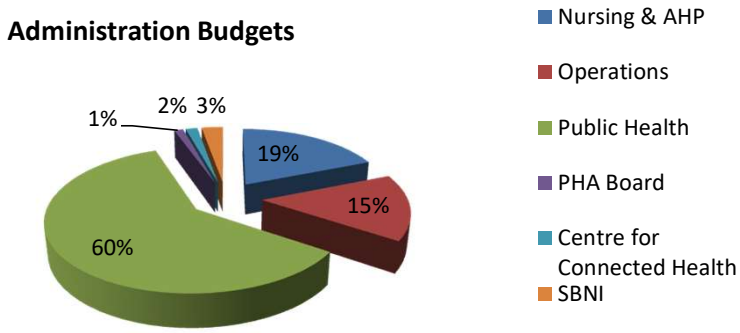


Administration Budgets (page 5)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below.

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a surplus of £0.5m for the full year (£0.4m in month 9 report), arising from identified slippage on Administration budgets offset by pressures in other areas.

The Administration and Programme budgets are being continually reviewed in order to update the full year forecast. The impact of Covid downturn on core budgets has been reflected in the reduced funding requirement for Covid-19 response. Some staff continue to be diverted to assist in PHA's response to the Covid-19 surge, and management are working to mitigate the risk of this impacting expenditure in Programme and Ringfenced budget areas.

Public Health Agency
2021 -22 Summary Position - January 2022

	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	42,208	51,879	11,832	26,963	**132,882**	35,172	38,791	8,783	22,351	**105,097**
Revenue Income from Other Sources	-	37	-	1,286	**1,323**	-	36	-	1,035	**1,071**
Total Available Resources	42,208	51,916	11,832	28,249	**134,205**	35,172	38,827	8,783	23,386	**106,168**
Expenditure										
Trusts	42,207	-	1,237	-	**43,444**	35,172	-	1,031	-	**36,203**
PHA Direct Programme *	-	51,994	11,191	-	**63,184**	-	39,219	7,671	-	**46,890**
PHA Administration	-	-	-	27,064	**27,064**	-	-		22,307	**22,307**
Total Proposed Budgets	42,207	51,994	12,428	27,064	**133,693**	35,172	39,219	8,702	22,307	**105,400**
Surplus/(Deficit) - Revenue	-	(78)	(596)	1,186	**512**	-	(391)	81	1,079	**767**
Cumulative variance (%)						***0.00%***	***-1.01%***	***0.92%***	***4.61%***	***0.72%***

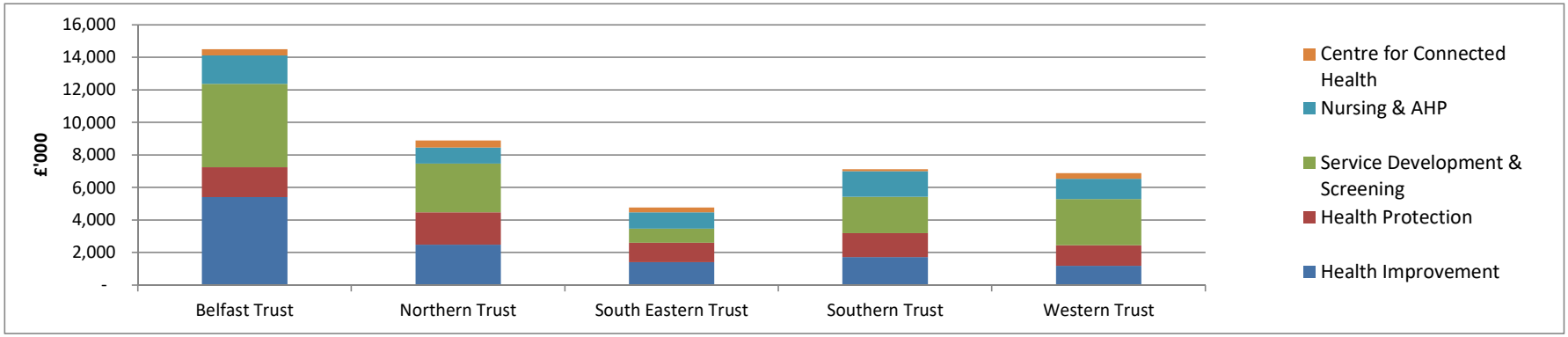
The year to date financial position for the PHA shows an underspend of £0.8m, which is primarily the result of underspend on Admin budgets.

A year-end underspend of £0.5m is currently forecast (£0.4m in month 9 report), primarily caused by vacancies in Admin budgets offset by managed overspends in other areas. This forecast position will continue to be managed through the remainder of the year in the context of any further Covid-19 downturn and response requirements.

** Please note that a number of minor roundings may appear througout this report.*

** PHA Direct Programme includes amounts which may transfer to Trusts later in the year*

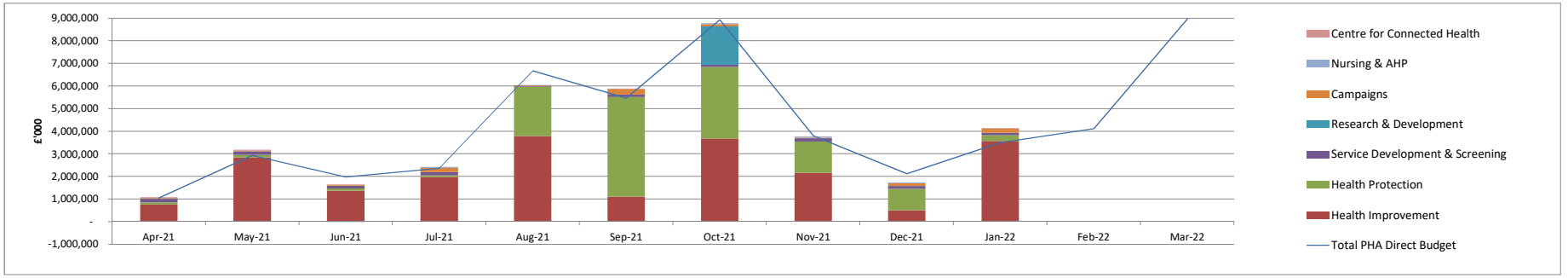
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,423	2,496	1,419	1,728	1,184	**12,251**	10,209	10,209	-
Health Protection	1,834	1,980	1,186	1,476	1,275	**7,750**	6,458	6,458	-
Service Development & Screening	5,127	2,998	874	2,222	2,841	**14,064**	11,720	11,720	-
Nursing & AHP	1,744	984	997	1,579	1,248	**6,576**	5,480	5,480	-
Centre for Connected Health	375	434	298	118	341	**1,566**	1,305	1,305	-
Total current RRLs	**14,503**	**8,893**	**4,774**	**7,124**	**6,889**	**42,207**	**35,172**	**35,172**	-
Cumulative variance (%)									***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date as funds previously held against PHA Direct budget have now been issued to Trusts.

PHA Direct Programme Expenditure



	Apr-21 £'000	May-21 £'000	Jun-21 £'000	Jul-21 £'000	Aug-21 £'000	Sep-21 £'000	Oct-21 £'000	Nov-21 £'000	Dec-21 £'000	Jan-22 £'000	Feb-22 £'000	Mar-22 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	884	2,625	1,357	1,788	4,478	740	3,937	1,656	1,067	2,325	3,260	3,350	**27,467**	20,857	21,763	(906)	*-4.3%*
Health Protection	77	100	87	85	2,142	4,476	3,085	1,638	775	713	100	1,292	**14,570**	13,177	12,758	419	*3.2%*
Service Development & Scree	51	158	470	192	29	235	102	50	159	199	142	937	**2,725**	1,645	1,573	72	*4.4%*
Research & Development	-	-	-	-	-	-	1,700	-	-	-	200	1,511	**3,411**	1,700	1,700	-	*0.0%*
Campaigns	10	10	20	227	10	5	19	414	77	282	134	264	**1,472**	1,074	1,026	48	*4.4%*
Nursing & AHP	4	22	4	1	10	0	56	10	49	- 28	78	1,619	**1,827**	130	176	(47)	*-36.0%*
Centre for Connected Health	20	20	43	11	5	4	5	5	(9)	10	175	38	**326**	114	109	5	*4.7%*
Quality Improvement	-	-	-	58	-	7	34	31	1	-	26	14	**170**	130	113	18	*13.5%*
Other	-	-	-	-	-	-	-	-	-	-	-	(53)	**(53)**	-	0	(0)	*100.0%*
Total PHA Direct Budget	**1,046**	**2,935**	**1,981**	**2,363**	**6,674**	**5,467**	**8,938**	**3,805**	**2,118**	**3,501**	**4,115**	**8,973**	**51,916**	**38,827**	**39,219**	**(391)**	
Cumulative variance (%)																***-1.01%***	
Actual Expenditure	**1,128**	**3,228**	**1,693**	**2,462**	**6,060**	**5,924**	**8,824**	**3,874**	**1,848**	**4,178**	**-**	**-**	**39,219**				
Variance	**(82)**	**(293)**	**288**	**(98)**	**613**	**(456)**	**113**	**(69)**	**270**	**(677)**			**(391)**				

The year-to-date position shows an overspend of approximately £0.4m against profile. There are a number of overspends and underspends at present netting off to create this position at this point in the financial year. These are timing issues only, and the budget is expected to achieve an approximate breakeven position for the year.

Public Health Agency
2021-22 Ringfenced Position

	Annual Budget				Year to Date			
	Covid £'000	Transformation £'000	Other ringfenced £'000	Total £'000	Covid £'000	Transformation £'000	Other ringfenced £'000	Total £'000
Available Resources								
DoH Allocation	11,039	272	528	**11,839**	8,339	118	326	**8,783**
Assumed Allocation/(Retraction)	59	(66)		(7)	-	-	-	**-**
Total	11,098	206	528	**11,832**	8,339	118	326	**8,783**
Expenditure								
Trusts	1,096	142	-	**1,237**	913	118	-	**1,031**
PHA Direct	10,783	64	344	**11,191**	7,511	-	160	**7,671**
Total	11,878	206	344	**12,428**	8,424	118	160	**8,702**
Surplus/(Deficit)	**(780)**	**-**	**184**	**(596)**	**(85)**	**-**	**166**	**81**

PHA has received a COVID allocation of £11.0m to date, £7.0m of which is for Contract Tracing. More detail on the COVID funding allocations PHA has received is provided in page 9 of this report.

Transformation funding has been received for a Suicide Prevention project totalling £0.3m. This project is being monitored and reported on separately to DoH, and a small underspend is expected to be retracted by DoH and a breakeven position will be achieved for the year.

Other ringfenced areas include Safe Staffing and Fresh Start funding for SBNI.

PHA Administration

2021-22 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	5,088	582	3,084	16,327	252	385	505	**26,221**
Goods & Services	159	10	1,149	326	76	42	266	**2,029**
Total Budget	**5,246**	**592**	**4,233**	**16,653**	**328**	**426**	**771**	**28,250**
Budget profiled to date								
Salaries	4,183	484	2,569	13,520	210	320	420	**21,706**
Goods & Services	132	8	958	273	60	35	214	**1,680**
Total	**4,315**	**493**	**3,527**	**13,792**	**270**	**355**	**634**	**23,386**
Actual expenditure to date								
Salaries	3,694	439	2,251	13,450	246	321	431	**20,831**
Goods & Services	83	11	990	217	43	14	118	**1,476**
Total	**3,777**	**450**	**3,241**	**13,667**	**288**	**335**	**549**	**22,307**
Surplus/(Deficit) to date								
Salaries	489	46	318	70	(36)	(1)	(11)	**875**
Goods & Services	49	(3)	(32)	55	17	21	96	**204**
Surplus/(Deficit)	**538**	**43**	**286**	**125**	**(18)**	**20**	**86**	**1,079**
Cumulative variance (%)	*12.46%*	*8.72%*	*8.10%*	*0.91%*	*-6.85%*	*5.68%*	*13.52%*	***4.61%***

PHA's administration budget is showing a year-to-date surplus of £1.1m, which is being generated by a number of long standing vacancies along with the impact of many staff continuing to work primarily from home. This is driving reduced expenditure in areas such as travel and courses. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be £1.2m.

The SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

Public Health Agency
2021-22 Capital Position

	Capital Resource Limit (CRL)	Year to Date Expenditure	Full Year Forecast Expenditure	Forecast Surplus / (Deficit)
	£'000	£'000	£'000	£'000
HSC Research & Development				
R&D - Other Bodies	5,571	2,450	5,571	-
R&D - Trusts	8,089	6,670	8,089	-
R&D - Capital Receipts	(1,020)	(257)	(1,020)	-
	12,640	**8,863**	**12,640**	**-**
CHITIN Project				
CHITIN - Other Bodies	2,077	2	2,077	-
CHITIN - Trusts	153	-	153	-
CHITIN - Capital Receipts	(2,230)	-	(2,230)	-
	-	**2**	**-**	**-**
Total R&D Position	**12,640**	**8,865**	**12,640**	**-**
Other PHA Capital				
Congenital Heart Disease (CHD) Network	358	-	358	-
Covid-19 Wastewater	800	-	800	-
Covid-19 ICT	141	111	141	-
ICT	92	92	92	-
Total Other Capital Position	**1,391**	**203**	**1,391**	**-**
Total PHA Capital Position	**14,031**	**9,068**	**14,031**	**-**

The PHA's Capital Resource Limit (CRL) of £12.6m relates to the regional allocation for HSC Research & Development (R&D). This is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme of €8.84m, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position.

Other PHA Capital includes an allocation of £0.358m for the Congenital Heart Disease Professorship Network to be set up across Ireland and £0.8m for a Covid-19 Wastewater project. There is also currently a small allocation of £92k for ICT capital expenditure within PHA, and £141k for ICT linked to the Contact Tracing Centre.

PHA Prompt Payment

Prompt Payment Statistics

	January 2022 Value	January 2022 Volume	Cumulative position as at January 2022 Value	Cumulative position as at January 2022 Volume
Total bills paid (relating to Prompt Payment target)	£3,953,040	591	£58,407,918	5,577
Total bills paid on time (within 30 days or under other agreed terms)	£3,919,024	582	£54,146,775	5,492
Percentage of bills paid on time	**99.1%**	**98.5%**	**92.7%**	**98.5%**

Prompt Payment performance for January shows that PHA achieved the 95.0% target on both volume and value. The year to date shows that on volume, PHA is achieving its 30 day target of 95.0% but on value it has fallen to 92.7%. The failure to meet prompt payment on value was due to a delay in paying Flu Vaccine invoices of £3.9m in October. Prompt payment targets will continue to be monitored closely over the 2021-22 financial year.

The 10 day prompt payment performance remains very strong at 89.8% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2021-22 of 70%.

PHA COVID-funded Expenditure

	Annual Budget £'000	Spend to 31 January 2022 £'000	Budget Remaining £'000	%	Notes
Contact Tracing Centre	7,513	6,692	821	*10.9%*	*1*
Screening	560	467	93	*16.6%*	
Vaccine Roll Out Programme	627	625	2	*0.4%*	
Infection Prevention Control Nursing	575	446	129	*22.4%*	
NI Advanced Care Planning	350	41	309	*88.2%*	
Band 8s Overtime	51	51	(0)	*-0.2%*	
Schools Support Team	116	102	14	*12.3%*	
Additional Flu Response	573	-	573	*100.0%*	*2*
HP Team - Covid vaccination in schools	500	-	500	*100.0%*	*3*
Other incl. Data Analytics	233	-	233	*100.0%*	*4*
Total	**11,098**	**8,424**	**2,674**		

Notes

1 *An allocation of £7.028m has been received to date for Contact Tracing, with a further £0.5m assumed at this stage. As case numbers fluctuate, the estimate of additional funding required continually changes. PHA are working closely with DoH Finance to manage the overall position to breakeven.*

2 *The additional Flu response funding has been fully spent in month 11 and will show on next month's report.*

3 *The funding for the vaccination programme in schools has been fully allocated to Trusts in month 11.*

4 *The Data Analytics project is expected to be invoiced in March.*

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	24 March 2022
Title of paper	Family Nurse Partnership Report 2020
Reference	PHA/02/03/22
Prepared by	Deirdre Webb
Lead Director	Rodney Morton
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to present the Family Nurse Partnership programme report for 2020 to the PHA Board for noting.

2 Background Information/Summary

The Family Nurse Partnership (FNP) Programme falls under objective 1 of the PHA Corporate Plan, "All children and young people have the best start in life". FNP is an evidence based intensive, preventive, one to one nurse-led home visiting programme for young, first time mothers from early pregnancy until their child reaches two.

3 Overall Key Objectives are to:

The overall objectives of the programme are to

- Improve pregnancy outcomes,
- Improve child health and
- Develop self-sufficiency of the family.

High quality US research into FNP has shown significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes including:

- Improvements in antenatal health
- Reductions in children's injuries, neglect and abuse

- Improved parenting practices and behaviour
- Fewer subsequent pregnancies and greater intervals between births
- Improved early language development, school readiness and
- Academic achievement
- Increases in fathers' involvement

Family nurses work with parents to help them build up their own skills and resources to parent their child well, but also to think about their own future aspirations. In NI, we have spent the last seven years embedding our learning to achieve a high quality of implementation of the FNP programme. There are currently 34 family nurses and 5 supervisors across the 5 HSCTS. The funding for 10 new Family Nurses was secured from the Department of Health's Transformational Fund. Further funding has been secured for an additional Family Nurse in each Team, through the Delivering Care process.

4 Key Objectives for 2021

- Implementation of the Learning from the intimate Partner Violence (IPV) Clinical Study ; **Completed-** IPV innovation and implementation into practice has been completed. Preliminary findings have been shared at the Domestic Violence Conference.
- Implementation of EPDS and GADS7 (mental health screening tools) – **In progress** - Further training is planned using ECHO as a virtual platform. This model works well with FNP concepts. The aim is to use ECHO methodology to support FNP programme delivery and service improvement, enhance the knowledge and skills of staff and provide an environment for collaborative reflective learning.
- Explore the options on the way forward with Information System – **In Progress-** The central team have had meetings with colleagues in BSO and DXC to progress work on the Information System. Our progress has been hindered by changes in workforce dealing with our queries. It is hoped this can be better progressed this year to achieve a system fit for purpose.

5 Key Outcomes for Families

Due to the pressures of the pandemic, including redeployment, there has been a subsequent delay in the analysis of the data. Our research and Intelligence team have also had considerable challenges during this reporting period with reduced staffing levels coupled with the ongoing work on our information system. A supplementary report detailing outstanding data will be provided at a later date.

- Enrolment during pandemic continued with 202 in 2020, 98.3% completed pregnancy stage, 90.8% completed infancy and 83.2% completed the toddlerhood stage.
- Percentage of those eligible clients offered the programme who have enrolled to date is 73.5%. Our national benchmark is 75%.
- Within 2020 we reached 74.1%
- Caseloads have varying degrees of vulnerability –. Many of the young people have experienced a number of adverse childhood experiences - Our data continues to show benefits in the five main areas of child development and in Social and Emotional behaviours. The low numbers of infants hospitalised due to injury or ingestion are also indicative of how improved, safe and supported parenting closes the inequality gap in child development, improves outcomes and is a protective factor.

6 Service User Engagement/Feedback

Clients are included at every opportunity. We have acknowledged how teenagers value peer influence and we have used this to our advantage. Recently we facilitated a Zoom breastfeeding session in which 3 successful breastfeeding young mums shared their feeding journey with some antenatal mothers, in efforts to increase breastfeeding rates and optimized FNP outcomes. This received excellent reviews.

"My Family Nurse was the only person outside of my home that I saw face to face. She had PPE on but I still loved seeing her coming"

"She made me feel safe when I felt so frightened"

"Some of the visits were done by video call and I looked forward to being able to ask questions about my baby. She kept me sane when things were hard"

"I wasn't on my own and it made things easier. I trusted what she said even when I was scared of Covid"

"I liked the virtual visits sometimes… but liked it better when she came to my house"

7 Next Steps

Planned next steps are as follows:

1. Continue to deliver a consistently safe and high quality programme across Northern Ireland replicating and delivering FNP according to the research, thereby maximising the potential benefits for children and families
2. Further explore the options for the stabilisation and development of our Information System to improve its usefulness and functionality.
3. Use ECHO NI to progress Quality Improvement Training using a virtual platform to bring together FNP teams for collaborative learning to enhance practice and service delivery.

4. Continue with Implementation of GAD7 and EPDS into FNP practice in Northern Ireland using a QI approach
5. Consider the need for further investment in a socio-economic study to research long terms benefits

University of Colorado
Anschutz Medical Campus

Department of Pediatrics
Prevention Research Center for Family and Child Health
Mail Stop 8410
13121 East 17th Avenue
Aurora, Colorado 80045

International Nurse-Family Partnership® (NFP)

Phase Four Annual Report

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

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

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

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

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

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

PART ONE: PROGRAM OVERVIEW

Name of country: Northern Ireland

Dates report covers (reporting period): 1st January 2020 – 31st Dec 2020

Report completed by: Shona Johnston

Date submitted: 18th November 2021

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	**30**	**30**
Part time NFP Nurses	**4**	**4**
Fulltime NFP Supervisors	**5**	**5**
Part time NFP Supervisors	**0**	
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	**0**	
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	**0**	
Total		**39**

- We have 5 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:6

- Current number of implementing agencies/sites delivering NFP: 5
- Current number of NFP teams: 5
- Number of new sites over reporting period: 0
- Number of new teams over the reporting period: 0
- Number of sites that have decommissioned NFP over the reporting period: 0
- Successes/challenges with delivery of NFP through our implementing agencies/sites:

The main challenge this year has been the impact of the global COVID-19 pandemic which was particularly challenging for our already vulnerable client group and their families. FNP Teams responded by adapting quickly to new ways of working, using virtual platforms to maintain contact and engagement with clients. Risk assessments were completed to ensure that wherever possible face to face contact was maintained for those families facing the greatest levels of challenge and where safeguarding risks required ongoing review and assessment. Supervision continued and was reported as being essential to ensure Family Nurses were supported in maintaining safe practice during this time. Our Research and Health Intelligence team have also faced challenges this year, as one member of staff has been off on Maternity leave. Emma Larkin has spent considerable time this year working on the Information System. The FNP Information System required an upgrade and migration onto a new site during this reporting period. A newer version of the Information System containing additional functionality, changes and fixes was tested and released on a new FNP Information System URL. This process required an intensive period of development and expansive testing in preparation for the upgrade and following its

implementation. This has obviously resulted in reduced capacity to analyse and compile data and reports. This should be resolved over the next few months. We will provide a supplementary report of data not yet analysed at a later date.

Integration and partnership working continues to be integral to the success of local implementation of FNP in Northern Ireland. Through the development and maintenance of an on-going Communication Strategy, the key messages of FNP have been reinforced amongst our colleagues in each of the 5 Health and Social Care Trusts. This has helped FNP to integrate and work effectively with other services and to strengthen and develop the desired partnership working approach.

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

License holder name: Rodney Morton, Director of Nursing, Public Health Agency
Role and Organisation: Public Health Agency, Northern Ireland

Description of our National implementing capacity and roles:

Clinical Leadership: The Central team includes a Clinical Lead, Nurse Consultant, Research and Information Manager and a Research and Information Officer.
The Family Nurse Partnership programme has been supported by Mrs Charlotte McArdle, the Chief Nurse at the Department of Health and Mr Rodney Morton, Director of Nursing at the Public Health Agency.

Data analysis, reporting and evaluation:
An Information System is in place. Analysis is provided by the Central Team.

Service development/site support:
The FNP Research and Information Team, consisting of Dr Emma Larkin and Shauna Conway, have considerable research, training and experience of conducting both quantitative and qualitative research related to, and gained through, previous research focused on early parenting research and evaluation of outcomes for evidence based interventions. The FNP Research and Information Team are embedded within Health Intelligence at the PHA which provides further access to specialist expertise in quantitative and qualitative evaluation in addition to access to comparative data for the purposes of comparative analysis

Quality improvement:
The focus of our quality improvement programme has been to complete the introduction of the Intimate Partner Violence Programme Augmentation. The preliminary analysis has been completed by Dr Emma Larkin and Emma presented preliminary findings at the 4th European Conference on Domestic Violence, online from Slovenia. The session presented findings from a service evaluation of the implementation of IPV innovation into practice in FNP Northern Ireland, alongside findings from the parallel implementation of this innovation in FNP in Norway, England and Canada.

NFP Educators:
Communication Trainers were appointed in 2018 to provide ongoing Communication Training and Development for the Family Nurse teams in Northern Ireland. They have worked closely with FNP Scotland to develop the required skills and have provided Communication Skills training for the Family Nurses. Further training will be planned.
An additional PIPE trainer has been selected. She will work closely with FNP Scotland and FNP England to provide updates for the family nurses on PIPE activities.

Other (please describe)
A Family Nurse and a Supervisor are enrolled in the Florence Nightingale Leadership Scholarship and both have completed work on a quality improvement project to enhance FNP work. Claire Hannity, Family Nurse in Southern Trust, explored the reasons and difficulties young mothers (16-21years) experience with sustaining breastfeeding. Using a client based questionnaire, Claire has gained an understanding of the clients view and has been able to identify common themes to help improve the service.
Emma Ross, Supervisor in Belfast Trust looked at "The Connected Team". Her project aimed to acknowledge, address and mitigate against the impact of secondary and vicarious trauma and the identified emotional impact of Covid19 on Nurses, Midwives and Administrative staff. In FNP, there is an identification of continual exposure to traumatic material leading to emotional duress in the Nurses and Midwives working with this highly complex service user group. In addition to this, the emotional impact of Covid19 identified negative emotions and feelings that were manifesting in the workplace. This led to a number of interventions in order to address these described psychological consequences, including reflective discussion sessions, reflective supervision, relationship building, team based activities, mindfulness and compassionate, collective leadership. The outcome of this project resulted in staff describing feelings of connection, confidence, motivation and belonging. Staff articulated feelings of psychological safety, feeling heard and of beneficial emotional processing. The impact on service users was evident through emotional availability of staff and of staff feeling confident, motivated and able to carry out their role effectively and with empathy. The result has been hugely positive and continues to evolve as we continue to grow and develop.
Family Nurses from each team are undertaking the M9 Infant Mental Health Diploma. This focuses on social and emotional development during the first three years for an infant and their family, including a child's ability to form relationships with other children and adults; to recognise and express emotions; and to explore and learn about their environment in a safe and happy way.

Description of our local and national NFP funding arrangements: The funding for 10 new Family Nurses was secured from the Department of Health's Transformational Fund. Funding has now been secured on an assumed recurrent basis.

Further funding has been secured for an additional Family Nurse in each Team, through the Delivering Care process.

Funding for the remaining posts is secured on a permanent basis via Programme for Government Funding.

Current policy/government support for NFP: The current policy is the Transformation Plan 'Health and Wellbeing 2026: Delivering Together'. This sets out a clear road map, which is an ambitious plan based on early intervention and prevention. One of the key ambitions in the draft Programme for Government and, therefore, Delivering Together is to give every child the best start in life

How our NFP supervisor and nurse education is organised: At present, education for Nurses and Supervisors is provided by NES FNP Scotland and the English National Unit. The core FNP nurse education would normally be delivered using face to face residential learning, online preparation and consolidation modules as well as materials to support team learning at site level. Throughout this reporting period all learning moved to virtual delivery by NES FNP Scotland. This change has required adaptation to the content as well as attention to creating a safe learning space in which nurses can reflect, explore and practice new knowledge and skills. Our new Nurses have recently returned to face to face training which will help embed new learning through peer support.

DANCE training will now be delivered online by the team in Denver and we are in the process of arranging this transition.

Description of any partner agencies and their role in support of the NFP program: Dr Susan Jack, Associate Professor of Nursing at McMaster University, Canada has supported the Northern Ireland Team with a feasibility study looking at the implementation of the Intimate Partner Violence (IPV) pathway.
Project ECHO has provided a virtual platform for FNP regional learning. ECHO brings together clinical specialist teams and educators to provide opportunities for teaching through case presentations. The FNP model is similar in that it involves weekly team meetings and case based meetings to identify client challenges and solutions and provide peer support and learning.

Other relevant/important information regarding our NFP program:

This past year FNP Teams have completed ECHO sessions to ensure collaborative reflective learning. Some of the topics covered included:

- Impact of Covid19 on Programme Delivery in NI
- Bruising in Pre-Mobile Babies
- Teenage brain and acceptance of Pregnancy/FNP supporting the process and adjusting to life beyond FNP
- The Challenges of Contraception and Sexual Health within the context of vulnerable FNP clients. Access/Updates/Family Planning & Sexual Health services during Covid19,
- Working with clients and Perinatal Mental Health: Psychology themes - Containment, Opposite of containment, Projection, Transference, Counter transference, Ghosts in the Nursery. Perinatal MH Regional Guidance/Anxiety/Key techniques in managing Personality disorders/behaviours & Trauma informed way of working,
- Self/Team Care in FNP
- Smoking Cessation and helpful behaviours
- Food Poverty in Northern Ireland/Food security and Nutrition

PART TWO: PROGRAM IMPLEMENTATION

Clients

NFP clients participating in the program over the last year: 202 of definitely eligible clients were enrolled on the programme in 2020.

•Current clients: Pregnancy phase (%): 98.3% clients completed the pregnancy stage.

•Infancy Stage: 90.8% clients completed the infancy stage.

•Toddlerhood Stage: 83.2% clients completed the toddlerhood stage.

% of those eligible clients offered the program who have enrolled to date: 73.5%

- Our national benchmark for % of eligible women referred/ notified who are successfully enrolled onto the program is 75%
- Within 2020 the % of eligible women referred/ notified who were successfully enrolled onto the program was 74.1%

Our reflections on this figure: Enrolment onto the programme continued throughout the Pandemic. FNP continues to be offered to eligible clients in a positive, strengths based way. Some young people remain challenging to engage as they are reluctant to seek guidance and support from professionals. Family Nurses remain tenacious in their approach to enrolling young women as early as possible so that clients gain maximum benefit. The NIMATS midwifery administrative system – which identifies eligible clients to FNP Supervisor at booking - is a more efficient and effective way of accessing new referrals than an individual referral system.

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: 14.7% for Pregnancy completers, 14.4% for Infancy completers and 11.5% for Toddlerhood completers.

- % of home visits, where other family members are present: 18.0% for Pregnancy completers, 16.8% for Infancy completers and 10.9% for Toddlerhood completers%

- How we engage fathers/partners/other family members in our program: Family Nurses develop strong therapeutic relationships with their clients, including where possible with fathers or partners. The client decides whether the father/partner is present for visits, with the Nurse recognising that these are often new relationships, and may be quite transient. Programme goals, domains and materials generally apply to fathers as well as mothers and include understanding and developing positive relationships and what this means for their child.

- Our reflections on father/partners/other family member's engagement: Involving Fathers/partners and other family members who are important in a client's life is integral to

the FNP programme in Northern Ireland. Some young fathers often have additional barriers to engagement such as being excluded by the maternal family, lacking resources and having a history of risk taking behaviours. Family Nurses are skilled in matching agendas and in judging where a father/partner poses any risks to the child, exploring this with the client and taking action without clients disengaging from the programme.

Nursing Workforce

NFP Information System

- High level description of our NFP Information System, including how data are entered: The FNP Information system (IS) is used to store and manage FNP data. Family Nurses and Supervisors use the IS routinely as part of delivering the programme, in order to improve the quality of the programme and maximise programme outcomes for clients. The data collected has a clinical utility, is collected and used by nurses as part of the programme and is integrated within the guidelines for each visit they conduct.

- Commentary on data completeness and/ or accuracy: Along with the Central Team, Supervisors, supported by Data Quality Support Officers, monitor the quality of data completeness and accuracy.

- Reports that are generated, how often, and for whom: We are unable to automatically generate reports from the information system at present. These are manually generated. The reporting function of our system is currently under review.

Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality: DXC Technology, formerly HP, were commissioned to produce an Information System that supported data input and also the ability for each key user group to generate reports for their data within their site. A functioning FNP information system has been developed that currently enables client management and data input and the reporting function remains under development. Dr Emma Larkin, the central team, along with a working group within BSO and DXC, have been working on this over the past year. The FNP Information System required an upgrade and migration onto a new site during this reporting period. A newer version of the Information System containing additional functionality, changes and fixes was tested and released on a new FNP Information System URL. This process required an intensive period of development and expansive testing in preparation for the upgrade and following its implementation. Work on our Information system remains ongoing to improve its functionality, usefulness and quality. It is our plan this year to improve the completion of the data forms. It is intended to organise a regional training event for the Quality and Data Improvement Officers.

Continuous Quality Improvement (CQI) Program

Brief description of CQI processes: Through our Quality Improvement process we aim to provide a consistently safe and high quality programme across Northern Ireland replicating and delivering FNP according to the research, thereby maximising the potential benefits for children and families.

- How we use qualitative and quantitative information as part of our CQI program: Every year each FNP Team identifies areas for service improvement.

This year we plan to continue to use ECHO to contribute to this process by bringing staff together remotely for learning and service development through regional collaborative education sessions.

- Successes/challenges with our CQI approach: Challenges with our Information System have prevented us from moving on with the reporting function of the system. Supervisors having the capacity to run reports would strengthen our quality improvement process through supervision, enabling them to assess and guide programme implementation, inform supervision, enhance programme quality and demonstrate programme fidelity. Work on our Information system remains ongoing to improve its functionality, usefulness and quality.

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

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

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

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: by signed informed consent	100% voluntary participation	
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Supervisor allocates eligible referrals which meet this criteria.	100% first time mothers	
3. Client meets socioeconomic disadvantage criteria at intake	The socioeconomic disadvantage inclusion criteria for our country are: In NI, socioeconomic disadvantage is not part of the referral criteria to the programme. However there is consideration given to the statistics in areas of deprivation and how this equates with teenage pregnancy rates. Application of these criteria are assured and monitored by: Supervisor in each site and Nurse Consultant in PHA	• % clients enrolled who meet the country's socioeconomic disadvantage criteria The youngest, most vulnerable, pregnant teenagers meet the eligibility criteria and should get a place on the programme.	The programme is targeted at areas most in need, either by density statistics, or areas of social deprivation

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	100% of NFP clients receive their first home visit no later than the 28th week of pregnancy 74.1% are intended to be recruited to NFP are enrolled in the program 21,8% of pregnant women are enrolled by 16 weeks' gestation or earlier	Many of our young clients are hard to reach and are reluctant to engage with professionals. Family Nurses continue to be tenacious, persistent and resilient in their approach to recruitment. They are skilled in knowing that recruitment for some clients be challenging especially at the early stage of pregnancy. **Action:** we may look at our Benchmark in relation to enrollment by 16 weeks gestation
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100% clients are assigned a single NFP nurse	
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.	National/ Country benchmark set is: % visits take place in the home	**Pregnancy:** 83.5% visits take place in the home **Infancy:** 84.0% in the home **Toddlerhood:** 86.1% in the home **% breakdown of where visits are being conducted other than in the client's home:** **Pregnancy**: the visits took place in 0.3% (N=33) children's centre, 2.6% (N=326) in a community location, 1.1% (N=144) in a	We plan to set Benchmarks moving forward.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		doctors or clinic, 6.0% (N=747) in a family or friend's home, 0.4% (N=55) in school or college, 5.8% (N=729) stated other **Infancy:** 0.3% (N=66) children's centre, 3.4% (N=686) in a community location, 0.8% (N=162) in a doctors or clinic, 5.5% (N=1099) in a family or friend's home, 0.1% (N=21) in school or college, 5.7% (N=1147) stated other **Toddlerhood:** 0.3% (N=27) children's centre, 5.2% (N=513) in a community location, 0.6% (N=62) in a doctors or clinic, 3.5% (N=339) in a family or friend's home, 0.2% (N=15) in school or college, 4.0% (N=392) stated other	
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	National/Country benchmarks for : a) Program visit dosage patterns in relation to client strengths and risks benchmarks are: Pregnancy: 14 visits Infancy: 28 visits Toddlerhood: 22 visits b) Length of visits by phase benchmarks: • Pregnancy phase: 60 mins • Infancy phase: 60 mins • Toddler phase: 60mins	• 100% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is: Pregnancy: • Scheduled visits: 12.1 • Actual visits: 9.3 • Dosage: 77.4% Infancy: • Scheduled: 28	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	c) Client attrition by program phase benchmarks: 10% attrition in Pregnancy phase 20% attrition in Infancy phase 10% attrition in Toddler phase	• Actual: 19.9 • Dosage: 71.0% Toddlerhood: • Scheduled: 22 • Actual: 13.6 • Dosage: 61.8% • Length of visits by phase (average and range): • Pregnancy phase: 68.1 mins • Infancy phase: 64.6 mins • Toddler phase: 65.5 mins Client attrition by phase and reasons: 1.7% attrition in Pregnancy phase 9.1% attrition in Infancy phase 7.6% attrition in Toddler phase	
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree. 9.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by: Standardised Job Description	100% NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
10. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula 100% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	100% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities 100% completion of team meetings, 100% completion of case conference and 100% completion of education sessions	
11. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table.
12. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	100% 1:1 supervision and home visit observations undertaken against expected (calculated by time – working weeks- and number of nurse)	95% 1:1 supervision and home visit observations undertaken against expected	All supervisors reported booking weekly 1:1 with all nurses. Completing 1:1 every week was challenging when schedules changed or due to FN Leave. However the attempt to reschedule within the week or make use of Telehealth/Phone check-ins were always considered.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
13. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurse). 100% of 4-monthly Accompanied Home Visits completed (against expected).	100% of NFP teams have an assigned NFP Supervisor 90% of reflective supervision sessions conducted See comment box	Supervisors have reported that accompanied home visits have largely been suspended during the pandemic. The Central Team has advised teams that while supervisors should undertake an accompanied home visit if there are clear clinical practice reasons for doing so, it has not been possible to meet the 4 monthly target this year. Virtual joint visits were attempted in some cases but the appropriateness of this was difficult to assess.
14. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program	No benchmark. Monitored/assured by: Central Team	Progress: Information System currently under review	After very limited progress with the IS developers over the past two years , DXC have re-entered into discussions with the Central Team to resolve the issues and work on the outstanding improvements and help improve the reporting system.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.			
15. High quality NFP implementation is developed and sustained through national and local organized support	100% of Advisory Boards or equivalents held in relation to expected 100% attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation): Supervisors/ Central Team	100% of Advisory Boards or equivalents % attendance at Advisory Boards	FAB continued virtually throughout the Pandemic in all sites Systems will be established to monitor attendance at Advisory Boards. The teams have revised the Terms of Reference and Membership of the Board in each Trust.

Domain coverage*

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35-40%	35.5%	14-20%	22.2%	10-15%	19.5%
Maternal Role (My Child and Me)	23-25%	27.8%	45-50%	41.8%	40-45%	39.7%
Environmental Health (My Home)	5-7%	9.6%	7-10%	11.1%	7-10%	12.1%
My Family & Friends (Family & Friends)	10-15%	15.1%	10-15%	13.6%	10-15%	14.3%

Life Course Development (My Life)	10-15%	12%	10-15%	11.2%	18-20%	14.5%

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
Overall teams do work within normal limits for programme dosage. It is recognised by most teams that Environmental Health reports slightly higher than normal thresholds. This is mainly due to housing issues

PART THREE: PROGRAM IMPACTS

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

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

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

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

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Age at LMP (range and mean)	Average Age at LMP: 17.8 Range: 12.8 - 20.8	Average Age at LMP: 17.8 Range: 12.8 to 20.8
Race/ethnicity distribution	47.9% (N=546)(White British 45.3% (N=516)White Irish 4% (N=46)White Other 2.8% (N=32) Other Ethnic Group	To be included in Supplementary Report
Father involvement	16% for Pregnancy completers, 15.5% for Infancy completers and 12.5% for Toddlerhood completers	14.7% for Pregnancy, 14.4% for Infancy and 11.5% for Toddlerhood
Income (please state how this is defined)	74.8% (N=853) of clients had an annual income of less than £13,000. Annual income in N.I, before housing costs, was £24,960 per year in 2017/2018 and 60% of this is £14,976. Approximately 16% of the population in Northern Ireland were living in relative poverty before housing costs in 2017/2018 (Northern Ireland Poverty Bulletin 2017/2018 [NISRA, 2019]).	To be included in Supplementary Report
Inadequate Housing (please define)	Data not collected	Data not collected
Educational Achievement	Not able to be analysed at this time	Not able to be analysed at this time
Employment	43% (N=491) were not in education or employment (NEET) 23.2% (N=265)were in employment	To be included in Supplementary Report

	43% (N=491) were in education 9.4% (N=107) were in both education and employment 56.9% (N=649) were in education or employment.	
Food Insecurity (please define)	Data not collected	Data not collected
In care of the State as a child	Data not collected	Data not collected
Obesity (BMI of 30 or more)	Not able to be analysed at this time	Not able to be analysed at this time
Severe Obesity (BMI of 40 or more)	Not able to be analysed at this time	Not able to be analysed at this time
Underweight (BMI of 18.5 or less)	Not able to be analysed at this time	Not able to be analysed at this time
Heart Disease	2.1% (N=24)	To be included in Supplementary Report
Hypertension	0.9% (N=10)	To be included in Supplementary Report
Diabetes – T1 &T2	1.4% (N=16)	To be included in Supplementary Report
Kidney disease	0.9% (N=11)	To be included in Supplementary Report
Epilepsy	1.6% (N=19)	To be included in Supplementary Report
Sickle cell Disease	0	
Chronic Gastrointestinal disease	0.9% (N=11)	To be included in Supplementary Report
Asthma/other chronic pulmonary Disease	12.4% (N= 144)	To be included in Supplementary Report
Chronic Urinary Tract Infections	5.4% (N=63)	To be included in Supplementary Report
Chronic Vaginal Infections (e.g., yeast infections	1.7% (N=20)	To be included in Supplementary Report
Sexually Transmitted Infections	Data not analysed separately from Chronic Vaginal Infections	
Mental Illness (eg Depression, eating disorder, substance abuse)	22.5% (N=261)	To be included in Supplementary Report
Other (please define)	8.4% (N=97)	

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

Caseloads have varying degrees of vulnerability – some meeting threshold for either Family Support Planning or Child Protection. Safeguarding children and young people and ensuring the unborn child and infant has the best and safest start in life is at the heart of the programme and FNP clinical practice in Northern Ireland. A number of young parents receiving the programme have had poor parenting experiences and this has the potential to impact on their own parenting capacity. Some children are "children looking after children" making them vulnerable. The Family Nurses work with high levels of risk and

intensity. Understanding the Needs of Children in Northern Ireland (UNOCINI) is the assessment and referral tool used to produce full and accurate holistic assessments of need, considering strengths and resilience factors in families alongside needs and risks. It is a universal tool and ensures collaborative working and good communication with other agencies. Family Nurse Partnership teams continue to build on client and family strengths, whilst continuing to assess and identify any risks to the child.

Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is collected)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum -6 weeks**	**12 months**	**18 months**
Anxiety, (n, % moderate + clinical range) **We have recently introduced GAD7 and EPDS into FNP practice in Northern Ireland. Data is currently being collected at local level and will be analysed at a later date**					
Depression, (n, % moderate + clinical range)**As above**					
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours) **(To be included in Supplementary Report)**	**Smoked at any time intake:** **Smoked in last 48 hrs:** **Mean number**	**Smoked at any time 36 wks:** **Smoked in last 48 hrs:** **Mean number**	**Smoked at any time 6 weeks:** **Smoked in last 48 hrs:** **Mean number**:	**Smoked at any time 12 months:** **Smoked in last 48 hrs:** **Mean number**:	
Alcohol, (n, % during pregnancy, units/last 14 days) **(To be included in Supplementary Report)**	**Drank alcohol in last 14 days:** **Excessive:**	**Drank alcohol in last 14 days:** **Excessive:**		**Drank alcohol in last 14 days:** **Excessive:**	
Illegal Drug Use is recorded at Intake and 36 weeks **(To be included in Supplementary Report)**	**Illegal drug use in last 14 days:**	**Illegal drug use in last 14 days:**		**Illegal drug use in last 14 days:**	
Excessive Weight Gain from baseline BMI during pregnancy (n, %)					
Mastery, (n, mean) **(To be included in Supplementary Report)**	**Intake** **Low mastery**	**24 Months** **Low mastery**			

	Not low mastery **Mean:**	**Not low mastery** **Mean:**			
IPV disclosure, (n, %) – **Data not collected at present**.					
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %)(To be included in Supplementary Report)					
Subsequent pregnancies, (n, %)(To be included in Supplementary Report)					
Breast Feeding, (n, %)	**Initiation** 43.6% (N=545)	**6 weeks** 8.7% (N=102)	**6 months** 4.8% (N=49)	**Average** duration for exclusive Breastfeeding: **4.8 weeks.**	
Involvement in Education, (n, %) **(To be included in Supplementary Report)**	**Intake** **In Education:** **In both education and employment:**			**24 months** **In Education:** **In both education and employment:**	
Employed, (n, %) **(To be included in Supplementary Report)**	**Employment:** **In both education and employment:** **Not in education or employment (NEET):**			**Employment:** **In both education and employment:** **Not in education or employment (NEET):**	
Housing needs, (n, %)	Data not collected.				
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	Data not collected.				

	Monitored at Supervision.				
Father's involvement in care of child, (n, %) **(To be included in Supplementary Report)**					
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g. to previous years, to rates achieved in RCT, to equivalent populations etc)**:** The impact of the pandemic has meant that over the reporting period considerable focus has been on maintaining a safe, quality service in line with the national and local restrictions. We are still in the process of analysing some of our programme impact data sets and will provide an additional report to evidence results as soon as possible.

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

Which are the areas of challenge? Due to the pressures of the pandemic, including redeployment, there has been a subsequent delay in the analysis of the data. Our research and Intelligence team have also had considerable challenges during this reporting period with reduced staffing levels coupled with the ongoing work on our information system. We will provide a supplementary report detailing outstanding data at a later date.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)		
Very preterm (28-32 weeks' gestation)		
Moderate to late preterm (32-37 weeks' gestation)		
Low birthweight (please define for your context)		
Large for Gestational Age (LGA) (please define for your context)		
Other (please define)		

Further analysis and quality assurance of Low birthweight and Large for Gestational Age is required. There are plans to do this moving forward.

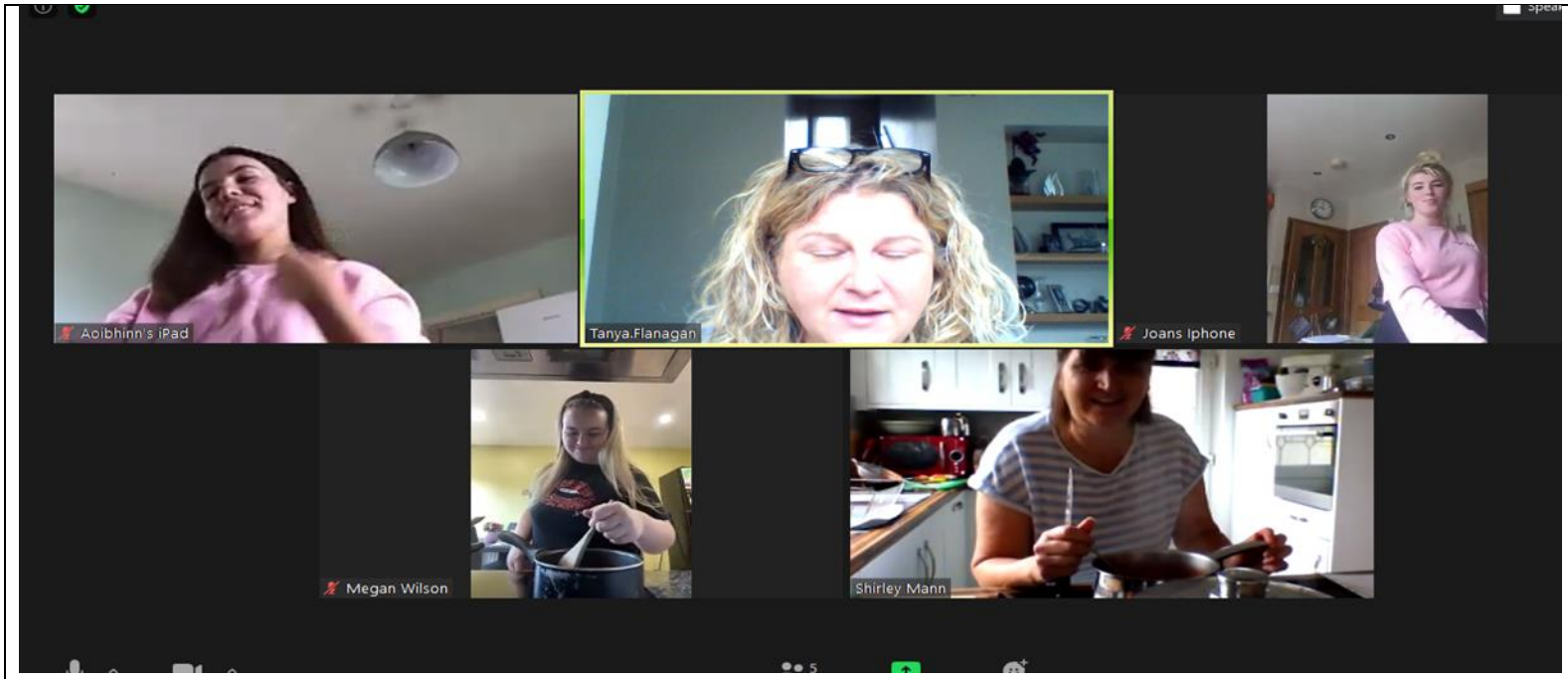
Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	95.0% (N= 978)	93.2% (N=815)	95.5% (N=620)	97.4% (N=602)
Hospitalization for Injuries	Five infants (0.5%) had 1 hospital admission due to injury/ingestion between birth and 6 months. No infants recorded 2 or more hospital admissions due to injury or ingestion between birth and 6 months.	Eight infants (0.9%) had 1 hospital admission due to injury or ingestion between birth and 12 months. No infants recorded 2 or more hospital admission due to injury or ingestion between birth and 12 months.	Eight infants (1.2%) were recorded with having 1 hospital admission due to injury or ingestion between 12 and 18 months. One infant (0.2%) was recorded with having 2 or more hospital admissions due to injury or ingestion between 12 and 18 months.	11 infants (1.8%) were recorded as having 1 hospital admission due to injury or ingestion between 12 and 24 months. No infants recorded 2 or more hospital admissions due to injury or ingestion between 12 and 24 months.
ASQ scores requiring monitoring (grey zone)				
ASQ scores requiring further assessment/referral	4 months: Communication: 2.4% (N=24) Mean 55.8 Gross Motor: 4.9% (N=49) Mean 55.0 Fine Motor: 2.3% (N=23) Mean 54.7 Problem Solving: 2.5% (N=25) Mean 56.1	10 months: Communication: 2.0% (N=17) Mean 54.9 Gross Motor: 14.9% (N=128) Mean 50.2 Fine Motor: 4.1% (N=35) Mean 55.6 Problem Solving: 4.0% (N=34) Mean 54.3	14 months: Communication: 4.6% (N=29) Mean 52.6 Gross Motor: 7.4% (N=47) Mean 53.3 Fine Motor: 3.9% (N=25) Mean 52.8 Problem Solving: 3.9% (N=25) Mean 51.9	20 months: Communication: 7.4% (N=44) Mean 50.8 Gross Motor: 3.5% (N=21) Mean 56.1 Fine Motor: 3.7% (N=22) Mean 55.1 Problem Solving: 2.5% (N=15) Mean 53.0

	Personal Social: 2.3% (N=23) Mean 55.6	Personal Social: 2.9% (N=25) Mean 53.5	Personal Social: 2.4% (N=15) Mean 54.9	Personal Social: 3.9% (N=23) Mean 55.3
ASQ-SE scores requiring monitoring (grey zone)				
ASQ-SE scores requiring further assessment/referral	**6 months:** 1.7% (N=17) Mean 8.0	**12 months:** 1.1% (N=9) Mean 8.3	**18 months:** 3.6% (N=23) Mean 11.9	**24 months:** 3.6% (N=22) Mean 12.0
Child Protection (please define for your context)				
Other (please define)				

Please comment below on your child health/development data:

Our data continues to show benefits in the five main areas of child development and in Social and Emotional behaviours. The low numbers of infants hospitalised due to injury or ingestion are also indicative of how improved, safe and supported parenting closes the inequality gap in child development, improves outcomes and is a protective factor.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts: The Central Team plan to expand the data collected to demonstrate impact and outcomes in the area of safeguarding. The family nurses are working with high levels of risk and intensity and it is important to capture information highlighting this. Data on IPV disclosure will also be collected to demonstrate identify and address Domestic Violence within our young client group. Families at risk of IPV share many characteristics with families at risk of poor child health outcomes. Analysis of data could show comparisons on this.
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program.





Clients are included at every opportunity. We have acknowledged how teenagers value peer influence and we have used this to our advantage. Recently we facilitated a zoom breastfeeding session in which 3 successful breastfeeding young mums shared their feeding journey with some antenatal mothers, in efforts to increase breastfeeding rates and optimized FNP outcomes.
Family Nurses Shirley Mann and Tanya Flanagan continued to facilitate Zoom Cook It sessions during Covid19 lockdown with excellent reviews from the clients. Ingredients were delivered to doorsteps and clients enjoyed the experience of cooking, fun and togetherness.

Understanding the impact of the pandemic has been a priority throughout the year and teams have reflected with their clients looking at both client and practitioner experiences. FNP teams remained resilient and creative in embracing new ways of programme delivery and thinking of new ideas to make things easier for clients. Supervisors from each team have shared some of the client feedback below:

'My Family Nurse was the only person outside of my home that I saw face to face. She had PPE on but I still loved seeing her coming"
"She made me feel safe when I felt so frightened"
"Some of the visits were done by video call and I looked forward to being able to ask questions about my baby. She kept me sane when things were hard"
"I wasn't on my own and it made things easier. I trusted what she said even when I was scared of Covid"
"I liked the virtual visits sometimes… but liked it better when she came to my house"

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	**0**	
Maternal death	**0**	
Other		

Any other relevant information or other events to report:

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

Briefly describe your system for monitoring implementation quality;
The QI process in Northern Ireland brings together those aspects of the programme that are required for safe, high-quality replication of FNP:

- **The core model elements** – ensure replication of the original research conditions.
- **Fidelity goals and measures** – evidence that the programme is being delivered to a high standard.
- **Clinical, Reflective, Safeguarding Supervision** - ensures safe delivery of a high quality service to clients and their families

Goals and Objectives for CQI program during the reporting period:

- Use ECHO NI to bring together FNP Nurses and Supervisors and provide opportunities for teaching through case presentations and training.
- To introduce the EPDNS and GAD7 Screening Tool and strengthen the Perinatal Care Pathway
- Complete the regional feasibility study of the augmentation and integration of an Intimate Partner Violence (IPV) innovation into existing practice into Northern Ireland.

Outcomes of CQI program for the reporting period:

- ECHO methodology has been used to support FNP programme delivery and service improvement, enhance the knowledge and skills of staff and provide an environment for collaborative reflective learning.
- EPDNS and GAD7 Screening tool have been implemented into FNP Visiting schedule in line with local and regional guidance. Data is being collected at local level at present.
- The preliminary analysis on the integration of IPV innovation into existing practice has been completed by Dr Emma Larkin and preliminary findings will be presented at a Conference: 4th European Conference on Domestic Violence online from Slovenia. The session will present findings from a service evaluation of the implementation of IPV innovation into practice in FNP Northern Ireland alongside findings from the parallel implementation of this innovation in FNP in Norway, England and Canada.

Goals for CQI in next year:

- Continue to use ECHO NI to bring together FNP Nurses and Supervisors and provide opportunities for teaching through case presentations and training. The FNP model fits well with ECHO in that it involves weekly team meetings and case based meetings to identify client challenges and solutions and provide peer support and learning.
- To use continuous quality improvement to monitor the ongoing implementation of the EPDNS and GAD7 Screening Tool and strengthen the Perinatal Care Pathway.

- Continue to progress work on Information system to improve the quality of the programme and maximise programme outcomes for clients

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

- Program innovations tested[1]:
  In June 2018, FNP NI commenced a regional feasibility study of the augmentation and integration of an Intimate Partner Violence (IPV) innovation into existing practice into Northern Ireland. The IPV innovation includes nurse and supervisor education and a clinical intervention (including a clinical pathway to guide decision-making) previously developed and tested for use with FNP clients in Canada and the USA by Professor Susan Jack (McMaster University, Ontario, Canada) and colleagues. The service evaluation has been completed by the FNP Health Intelligence Manager and FNP Research and Information Officer, in collaboration with Professor Susan Jack and preliminary findings will be shared in due course.

  FNP NI also presented preliminary findings of the NI IPV service evaluation at the following conference symposium: Adaptation, Implementation and Evaluation of Intimate Partner Violence Innovations for Home Visiting Programs in Europe: Practice-based evaluation of adapted IPV interventions (Larkin, E., Conway, S. & Webb, D), 4th European Conference on Domestic Violence, online from Slovenia, 13-15 September 2021. Presenters: Susan Jack, Ann Rowe, Tine Gammelgaard Aaserud, Emma Larkin, Sarah Tyndall, Deirdre Webb.

  The clinical lead has been involved in the international Reflective Supervision Project to develop a guidance document and Reflective Supervision Framework/model for NFP. This outlines the purpose, core standards, principles, and expectations; identifies recommended practice approaches; and provides resources to support successful implementation and evaluation'.

- Program innovations implemented:
  IPV has been implemented and incorporated into FNP visiting schedule.

  Reflective practice is used within reflective supervision which guides exploration, reflection and analysis of the content brought to supervision with plans developed and agreed as a result. It allows Supervisors to give attention to the emotional needs of the Family Nurse, how they have been affected by the emotional intensity of their work, and how to deal with these feelings constructively. The Formative/Educational function of Supervision within FNP focuses on developing skills, understanding and ability, by reflecting on and exploring the work of the person being supervised. This includes supporting the integration of different elements of the programme model.

- Findings and next steps:
  Share preliminary analysis and findings from IPV innovation.
  The central team to develop Data monitoring for fidelity in relation to Supervision.

Temporary Variances to CMEs

For each variance agreed please attach a report of the variance evaluation methods and findings to date in Appendix 2 to this document - **N/A**

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

Research and evaluation
Please tell us about any NFP related research and evaluation efforts currently being undertaken or planned in your country In order to demonstrate the value and impact of FNP in Northern Ireland further, we plan to discuss our revaluation findings with The Queens Nursing Institute. Measuring outcomes and improving impact is an essential part of service delivery in FNP. It is important that the work and study already completed is communicated effectively to strengthen the service, share FNP theoretical approaches and demonstrate the value of our evidence among strategic partners and the wider system in Northern Ireland.

PART FIVE: ACTION PLANS

LAST YEAR:

Our planned priorities and objectives for last year:

1. Implementation of the Learning from the intimate Partner Violence (IPV) Clinical Study
2. Implementation of EPDS and GADS7
3. Explore the options on the way forward with Information System

Progress against those objectives:

1. IPV innovation and implementation into practice has been completed. Preliminary findings have been shared at the Domestic Violence Conference.
2. Further training is planned using ECHO as a virtual platform. This model works well with FNP concepts. The aim is to use ECHO methodology to support FNP programme delivery and service improvement, enhance the knowledge and skills of staff and provide an environment for collaborative reflective learning.
3. The central team have had meetings with our colleagues in BSO and DXC to progress work on the Information System.

Reflections on our progress: Our progress in relation to our Information system has been hindered by changes in workforce dealing with our queries. This has resulted in a list of outstanding issues and actions. Dr Emma Larkin has spent a considerable amount of time on this work and it is hoped that this can be better progressed this year to achieve a system fit for purpose.

NEXT YEAR:

Our planned priorities and objectives for next year:

1. Further explore the options for development of the information system and to make data improvements to reflect the revised Annual Report template. This may need to include a scoping exercise looking at costs of migration to a new system.
2. Use ECHO NI to progress Quality Improvement Training using a virtual platform to bring together FNP teams for collaborative learning to enhance practice and service delivery.
3. Continue with Implementation of GAD7 and EPDS into FNP practice in Northern Ireland using a QI approach
4. Further exploration of the characteristics of clients declining the program and an understanding of their reasons for doing so.
5. Further clarification of client eligibility criteria in situations of limited capacity and exploration of the potential to offer the program more widely to women over 20 years leaving the care system

Measures planned for evaluating our success:

- Connections have been made with both BSO and DXC to progress plans to improve the Information system. The essential fix/update of the system to ensure it is fit for purpose will be the success.
- Evaluation is part of the ECHO model and will be completed at the end of each session. Results will be collated and a paper prepared evaluating the process.
- A new strengthened Perinatal Mental Health pathway will be developed using GAD7 and EPDS.

- Review client recruitment pathway and eligibility criteria to ensure those families who would most benefit from the programme are enrolled.

Any plans/requests for program expansion?
Following the recommendations of the Revaluation Report, the FNP programme has been expanded by 10 nurses, using Transformational funding, offering an additional 230 places on the programme.

Further funding was secured via the Delivering Care process and Trusts are in the process of recruiting an additional Family Nurse into each of the five FNP teams.

FEEDBACK FOR UCD INTERNATIONAL TEAM:

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

- Support during the Pandemic. This included taking part in the COVID-19 International Project which helped us share experiences and helped keep us connected during this unprecedented and challenging time.
- Regular meetings and updates on new innovations
- Information and support to Clinical lead
- Mentoring and guidance to Nurse consultant
- Facilitating the sharing of good practice between countries on particular topics.
- Sharing new NFP international research outputs from all countries via the website and through the international research seminars.
- Regular Clinical Advisory Meetings
- New content notifications on the International site

Our suggestions for how NFP could be developed and improved internationally are:
None

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

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

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

I agree to this report being uploaded onto the restricted pages of the international website [X]

I do not agree to this report being uploaded onto the international website [ ]

PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

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

- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- Completion of the COVID-19 project, in which resources and learning has been rapidly shared between countries and shared principles for continued use of telehealth within NFP/FNP have been developed.
- Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
- Access to the international website forum for discussion of issues with leads in other NFP implementing countries
- Development and dissemination of international guidance documents on program content and implementation that draw on the experiences of all NFP implementing countries.
- Sharing and updating the international data collection manual and program guidelines.
- Provision of the international Clinical Leads' Advisory Group meetings.
- Sharing new program innovations developed and researched by PRC and all implementing countries
- Developing additional opportunities for international collaboration and networking, such as the data analytic and research-leads forum, the PIPE education group and the international meetings regarding DANCE implementation and use of data.
- Continued access to expert consultation re IPV from Dr Susan Jack and learning from other countries adapting and testing the intervention
- Facilitating the sharing of good practice between countries on particular topics.
- Sharing new NFP international research outputs from all countries via the website and through the international research seminars.
- Promoting NFP internationally as an example of a program that ensures high quality replication in all contexts and maintains its international reputation for effectiveness and quality.
- Information and support to Clinical lead
- Mentoring and guidance to Nurse consultant
- Responses to ad hoc questions and requests for information, clarification, documents etc

Identified strengths of program:

- The high levels of strategic support and appreciation of the value the program brings to the NI system and families
- The maturity and expertise of the NFP workforce, leading to high quality program delivery, even during the very challenging period that this report covers
- The quality of leadership for the program – this has clearly inspired high levels of workforce commitment and personal investment in the success of the program in NI
- The quality of program data analysis, despite the challenges in terms of the Information System capabilities, reduced analytic capacity and competing priorities this year
- The strong partnership structures and working practices between services serving the FNP population
- The continued commitment to evaluate adaptations to the program
- The collaborative approach being taken to quality improvement and innovative use of the ECHO system to support continued practitioner engagement and learning

Areas for further work: • These were agreed as identified in the priorities and objectives for next year
Agreed upon priorities for country to focus on during the coming year: • As set out in part 5, with the addition of the areas for further work above, when capacity allows
Any approved Core Model Element Variances: N/A
Agreed upon activities that UCD will provide through Support Services Agreement: • Continued access to international community and 1:1 consultation for DW and support and guidance for SJ • Support as needed for the planned QI and developmental projects detailed in this report

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

Appendix 2: Evaluation of temporary CME variances

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

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

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