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**International Nurse-Family Partnership® (NFP)**


# PHASE THREE ANNUAL REPORT

**Phase Three - Randomized Controlled Trial (RCT).**
This phase is established to estimate program effects on outcomes of clear public health importance that align with the outcome domains in the original US trials and that address additional goals of that country. This work is designed to determine the added value of the program for the populations and contexts in which it is being delivered. The expected research methodology is a Randomized Clinical Trial (RCT) as this provides the strongest evidence of program impact. In some circumstances, it may not be feasible or appropriate to undertake an RCT (e.g. where the population size is too small to estimate benefits reliably or where there are serious cultural concerns). In these circumstances, consideration will be given to use of quasi-experimental designs. Countries are encouraged to conduct complementary qualitative studies, which can be helpful in understanding results of the RCT. During this phase, the implementing entity may seek approval to continue recruitment of clients in existing pilot and/or RCT sites until analysis and reporting of the RCT data are complete. Countries are expected to continue completing annual reports during this phase.

***NOTE:*** *Australia is not currently undertaking a RCT as part of Phase Three. The RCT approach was previously determined to be inappropriate in the Australian context. Australia is instead undertaking a mixed-methods Evaluation through an independent consultant which commenced in June 2021, with the Final Report due in mid-2024.*

**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.

**Additional Appendix:**
Australia has included in this report the *ANFPP National Annual Data Report 2020-21* (Appendix 4) which is prepared each year by the ANFPP National Support Service (NSS). This report presents information and data from ANFPP sites, including:

- a brief overview of the ANFPP including the data collection system
- a data summary from 2009-2021 on the women who have enrolled in the program to date
- a description of operational aspects of the ANFPP including program implementation and workforce
- data on ANFPP clients in 2020-21, including a descriptive analysis of client characteristics and program outcomes, including a comparison with national outcomes for Aboriginal and Torres Strait Islander mothers and
- conclusions and future directions for the ANFPP.

## PART ONE: PROGRAM OVERVIEW

Name of country: AUSTRALIA

Dates report covers (reporting period): JULY 2020 – JUNE 2021

Report completed by: Australian Government Department of Health

Date submitted: TBA

**The size of our program:**

| | Number |
|---|---|
| Fulltime NFP Nurses | 40 |
| Part time NFP Nurses | 14 |
| Fulltime NFP Supervisors | 10 |
| Part time NFP Supervisors | 2 |
| Full time NFP Mediators/Family Partnership Worker (FPW) | 39 |
| Part time NFP Mediators/FPW | 9 |
| **Total** | **114** |

- We have 13 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:8.6

- Current number of implementing agencies/sites delivering NFP: 13 sites
- Number of new sites over the 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: Please refer to section 2 below.

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

**License holder name:**

The Australian Government Department of Health (the Department).

**Role and Organisation:**

The Department, on behalf of the Australian Government, holds the sole Australian NFP license and provides funding, national policy oversight and management of the Australian Nurse-Family Partnership Program (ANFPP).

Within the Department's Indigenous Health Division, a dedicated team within the Maternal, Child and Youth Section (MCYS) has policy responsibility for the ANFPP. MCYS is also responsible for broader maternal, child and family health policy, including ear and hearing health, and has long term policy experience with the ANFPP and long-standing relationships with relevant government and non-government organisations.

The Department's key policy drivers in relation to Aboriginal and Torres Strait Islander health are the *National Aboriginal and Torres Strait Islander Health Plan 2021-2023* and its accompanying *Implementation Plan*; along with the *National Agreement on Closing the Gap* (National Agreement) including its seventeen targets, four priority reform areas and the Commonwealth's Closing the Gap Implementation Plan.

The MCYS has responsibility for driving outcomes against the *National Agreement Target 2 – Aboriginal and Torres Strait Islander children are born healthy and strong*. This Target is, by 2031, the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight is increased to 91%. The ANFPP is considered a key driver to contribute towards improving the birthweight of Aboriginal and Torres Strait Islander babies.

The Australian Government's Department of Social Services Community Grants Hub has responsibility for managing individual implementing site funding agreements.

**Description of our National implementing capacity and roles:**

1. Clinical Leadership:

- The ANFPP National Support Service (NSS) has high level clinical and content expertise working within the team. The NSS team is part of the Charles Darwin University's Molly Wardaguga Research Centre (College of Nursing and Midwifery).
- The NSS provides workforce training and professional support functions including refinement and continuous monitoring of the quality of the ANFPP to suit the needs of Aboriginal and Torres Strait Islander children and their mothers.
- Professor Sue Kruske is the National Director of the NSS and has a background in midwifery and child health nursing and has worked in the area of First Nations maternal and child health for more than 30 years.
- Associate Professor Sandy Campbell is the NSS Systems Manager and is an Aboriginal Public Health Researcher with Masters (ANU) and PhD (Uni SA) qualifications in epidemiology.
- Kym Cunningham is the NSS Clinical Lead and has spent the past 30 years as a registered nurse. She has more than a decade of experience in the ANFPP in Nurse Home Visitor (NHV), Nurse Supervisor (NS) and education roles.

In addition, the NSS engages external expertise as required such as from Professor Roianne West (CEO, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives – CATSINaM) for workforce, developmental psychologists on trauma informed care, and Indigenous specific child development assessment tools.

**Description of our local and national NFP funding arrangements:**

The Department of Health provides funding through the Indigenous Australians' Health Programme (IAHP) to support the ANFPP, including:

- Grant funding provided to individual ANFPP sites for staffing and ANFPP infrastructure (the majority of which are Aboriginal Community Controlled Health Organisations). Each organisation receives funding to reflect the size of the program delivered in that community;
- Funding for the procurement of the Charles Darwin University's Molly Wardaguga Research Centre to provide the ANFPP National Support Service role; and
- Licencing fees and procurement of the University of Colorado Denver for consultancy and infrastructure support for the program.

**Current policy/government support for NFP:**

The ANFPP contributes to the Australian Government's commitment to Closing the Gap in health, education and employment outcomes between Aboriginal and Torres Strait Islander people and other Australians. In 2008, the Council of Australian Governments agreed to six targets to address the difference between outcomes for Aboriginal and Torres Strait Islander people and other Australians in life expectancy, child mortality, education and employment. This included a commitment to halving the gap in mortality rates for Aboriginal and Torres Strait Islander children under five by 2018. Between 1998 and 2015, there was a significant decline (33%) in the mortality rate for Aboriginal and Torres Strait Islander children aged 0–4 and a significant decline (66%) decline in the mortality rate for Aboriginal and Torres Strait Islander infants[1].

In July 2020, the Australian Government signed a new National Agreement on Closing the Gap in partnership with the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian governments (Commonwealth, state/territory and local). At the centre of the National Agreement are four Priority Reforms that focus on changing the way governments work with Aboriginal and Torres Strait Islander people. These include shared decision making, building the Aboriginal and Torres Strait Islander community-controlled health sector, transforming mainstream organisations and improving and sharing access to data. The Agreement is supported by 17 targets, including a target to increase the proportion of Aboriginal and Torres Strait Islander babies born within a healthy birthweight range.

The Australian Government's investment in child and family health is guided by the *National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* and the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2021-2031*.

The National Support Service (NSS) was awarded a contract with the Department in early 2020 and took over operational responsibility in July 2020.

**Organisation responsible for NFP education:**

The NSS education team is led by Clinical Lead, Kym Cunningham, a registered nurse with post graduate qualifications in adult education. Kym also has extensive experience in the ANFPP including as a NHV, NS, nurse educator and now clinical lead. She leads a team of two clinical psychologists with expertise in perinatal mental health and trauma, two nurse educators, one of whom has worked as a nurse home visitor and the second an Aboriginal nurse with experience in the university sector. The final member, the FPW educator, has also worked in the program as an FPW, is studying a Bachelor of Nursing and is a strong community Indigenous leader. This team provides outstanding high-quality support and education to the sites.

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

The NSS sits within the Molly Wardaguga Research Centre at the Charles Darwin University. The Centre has assembled a multidisciplinary team of experts across Australia to address inequities in the first 2,000 days (pregnancy to age five), including Indigenous methodology and knowledge holders, and others with expertise in midwifery, nursing, inter-cultural communication, participatory action research, community development

[1] Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report https://www.niaa.gov.au/resource-centre/indigenous-affairs/health-performance-framework-2017-report

| |
|---|
| and investment, digital media, public health, health economist, sociology, anthropology, biostatistics, epidemiology, neonatology, implementation science, medicine, health services and translational research. |
| **Other relevant/important information regarding our NFP program:**<br>Nil. |

# PART TWO: PROGRAM IMPLEMENTATION

## Clients

**# of NFP clients participating in the program at any point over the last year:** for the 2020–21 period, 449 clients entered the program

- Current clients: Pregnancy phase (138/561) 24% at 30 June 2021 (time point)
- Current clients: Infancy phase (234/561) 42% at 30 June 2021 (time point)
- Current clients: Toddler phase (189/561) 34% at 30 June 2021 (time point)

Please note, there are three frequently used denominators referred to in this report: first, the number of active clients at June 30 2020-21 n= 561; second, the number of clients enrolled/accepted in 2020 n=449; and third, the number of singleton babies born in the program in 2020-21 n = 281. The denominator selected for use in each table is dependent on the information being presented.

## Nursing Workforce

- Average nurse caseload: _(48/561) 9.0

| | Nurses | SVs | Other | Total |
|---|---|---|---|---|
| # of staff at start of reporting year: | 54 | 14 | 44 | 112 |
| # of staff who left during reporting period | 23 | 3 | 8 | 34 |
| % annual turnover | 43% | 21% | 18% | 30% |
| # of replacement staff hired during reporting period | 24 | 3 | 12 | 39 |
| # of staff at end of reporting period: | 54 | 12 | 48 | 113 |
| # of vacant positions | Not available | Not available | Not available | Not available |

- **Reflections on NFP nurse/supervisor turnover/retention during reporting year**: The pandemic has provided many challenges for ANFPP teams across Australia. Sites have varied in the demands they have made from their teams. Some teams have been redeployed, others have allowed their staff to continue support via telehealth or electronic methods. The NSS has increased their availability of support to all sites.
- **Challenges with NFP nurse/supervisor recruitment**: Recruitment and retention is an issue in Australia and the reasons for this are multifactorial, including but not limited to:
  - Impact of the COVID-19 pandemic. Turnover was higher in 2020/21 compared to the previous year. 2019/20 reporting period covered 3.5 months of the pandemic from mid-March to 30th June 2020, whilst the pandemic impacted recruitment and retention for this entire reporting period.
  - Lower salaries in the ACCHO sector[2] compared to mainstream health[3]
  - Large variation in salary and other benefits across our sites. For example, some sites pay nursing staff at Level One practice nurse salary. It is argued that as staff in the

[2] https://www.fairwork.gov.au/employment-conditions/awards/awards-summary/ma000034-summary

[3] https://www.health.qld.gov.au/hrpolicies/salary/nursing

ANFPP work autonomously in women's homes, they should be both recognised for advanced practice and receive greater renumeration.

- High rates of workforce mobility in rural, remote and very remote areas, which can be difficult to mitigate.
- Unsuccessful recruitment; particularly due to the non-clinical aspect of the NHV role. Part of the NSS's contracted role is to assist ACCHOs to recruit staff; however, it is acknowledged that some ACCHOs would prefer to manage recruitment internally.
- Lack of ongoing job security; sites recruit mostly for non-ongoing roles ranging from 12-month arrangements to the life of the funding cycle. Some sites may offer ongoing contracts; however, these remain subject to funding availability.

Both the NSS and Department of Health appreciate that staff recruitment is an internal activity for program organisations. The strategies to improve recruitment and retention (as outlined below) are provided as good faith suggestions only. Strategies to improve recruitment and retention of ANFPP staff could include:

- Involving the NSS in the recruitment process at the site level.
- Involving FPW or client participation in the recruitment process.
- Review of position descriptions, with greater description of non-clinical role requirements.
- Review of salary range in recognition of advanced practice required to work effectively and autonomously in the program.
- Increased support and professional development opportunities from the NSS to support long term team members.
- Provision of Reflective Supervision education for NS to support the delivery of effective Reflective Supervision.
- Support from NSS to improve working relationships between the nurses and FPWs where required.
- Work strategically with DoH to facilitate agreement to longer term funding cycles for both NSS and ANFPP sites.
- NSS Offer exit interviews and surveys to better understand why staff are leaving.
- **Plans to address workforce issues:** The NSS is in the process of developing a briefing paper for CEOs to outline the issues and offer potential strategies that can be potentially used to improve recruitment and retention across the 13 Australian Sites.

**NFP education**

**The Australian NFP education curricula**

- The education curriculum includes program fidelity, theories, communication and reflection, program tools and scope of practice.
- Education curricula encompasses all three units of core education, post unit education on program tools including DANCE and PIPE (online education) and additional NS training.

**Changes to ANFPP education since the last report**

- NS Reflective Supervision training have been added.
- The mode of delivery of education has varied according to travel restrictions, including face-to-face and online delivery.
- Presentations in the core curriculum, including infant neurodevelopment, self-care, KMMS, the STAR framework (pilot phase), psychological safety have been added.

**Successes with delivery of core ANFPP nurse/supervisor education:**

- Psychological safety and trauma informed learning principles were integrated into online education delivery.
- High levels of learner engagement in education, despite the adaptation to online learning.
- High levels of positive feedback from learners about their education experience.

**Challenges with delivery of core ANFPP nurse/supervisor education:**

- COVID-19 travel restrictions have forced continual adaptation of education delivery to ensure educational requirements are met.
- Meeting the demands of new and established staff in the delivery of core education.

**Successes with ongoing (integration) ANFPP nurse/supervisor education:**

- Core education is contextualised to individual communities and integrated into learnings delivered.
- Site specific education based on the action points identified in the QSSA was developed and delivered to sites.

**Challenges with ongoing (integration) ANFPP nurse/supervisor education:**

Providing core education that aligns with program fidelity but is also responsive to the needs of individual sites and communities during the pandemic.

**Successes with delivery of ANFPP induction/ introduction, education and CPD for associated team members (FPW)**

- Training hours added to certificates of completion for core education to support associated team members to attain required CPD hours.
- FPW specific education development has commenced and Unit 1 FPW education has been delivered to remote workers with positive feedback on meeting the participants individual learning needs.
- Individual support offered during induction and core education to enhance the on-boarding process for new staff.

**Reflective Supervision**

**Successes with ANFPP NHV and FPW reflective supervision:**

- Reflective activities in NHV, FPW and NS Community of Practice meetings, including reflective skills practice, client case studies and communication skills education such as Motivational Interviewing skills are supported and prioritised.

**Successes with reflective supervision to our supervisors:**

- NS across multiple sites are currently engaged in fortnightly reflective supervision with the NSS Senior Practitioner. All NS have received formal training in reflective supervision, including a three-part training series covering critical reflection, cultural safety, trauma informed principles and reflective supervision practices.

**Challenges with reflective supervision to our supervisors:**

- Senior Practitioner position tasked with balancing the roles of reflective supervisor to NS, consultant/site support and educator to NHVs and FPWs.

**ANFPP Information System**

**High level description of the ANFPP information system, including how data are entered:**
There are no changes regarding data capture for the ANFPP since the last report, with 10 sites on ANKA and the 3 original wave 1 sites using Communicare.

**Commentary on data completeness and/ or accuracy:**
There are ongoing challenges related to having two information systems. Some program variables are different between the two systems, and others only exist in one system, making data aggregation unachievable, or resulting in loss or information due to aggregation. Data loss in aggregation contributes further to the amount of missing data inherent in the ANFPP data collection. In working towards improving the quality of the ANFPP dataset regarding data completeness and accuracy, the NSS is focusing on regular Data Quality and Completeness reports to continue the downward trend in missing data and data errors already noted over 2020-21. The frequency of distribution of the reports has been increased from 3-monthly (prior to fidelity reporting) to 6-weekly.

**Reports that are generated, how often, and for whom:**
Fidelity Reports are generated quarterly and provide information to NS, NHV and FPWs, ANFPP staff, and key stakeholders on program data. Our collection points are through Communicare and ANKA. Quality checks (Data Quality and Completeness reports) are completed 6-weekly and prior to fidelity reporting.

Following feedback from implementing sites via the Data User Group, the structure of the Fidelity reports was re-designed to improve presentation and consistency of fidelity reporting between ANKA and Communicare sites. In a further addition, quarterly program outcomes are being added in an appendix to the Fidelity reports in an incremental implementation process. The quarterly Fidelity reports are now linked closely to ANFPP QSSA (continuous quality improvement) activities.

| **Continuous Quality Improvement (CQI) Program** |
| --- |
| • Brief description of CQI processes:<br>  o Use of the Quality Site Self-Assessment (QSSA) as a tool to support sites to engage in a process of CQI.<br>• How we use qualitative and quantitative information as part of our CQI program:<br>  o We use the qualitative and quantitative information from the QSSA to support sites to meet the fidelity of the program.<br>• Successes/challenges with our CQI approach:<br>  o Continued use and success of the QSSA as a tool to support sites to engage in a process of CQI.<br>  o The use of a self-assessment process to support sites to identify their areas of success and potential improvement.<br>See also part 4 for details of CQI improvement program and findings. |
| **Any other relevant information:**<br><br>Nil. |

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

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

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 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<br>Monitored /assured by: (e.g. by signed informed consent) | 100% voluntary participation | Nil |
| 2. Client is a first-time mother | 100% first time mothers enrolled<br>Monitored/assured by: | 87% first time mothers<br>13% multiparous mothers including first opportunity to parent | Nil. Enrolment of multiparous mothers including those having their first opportunity to parent continues to be at the discretion of the program site teams. |
| 3. Client meets socioeconomic disadvantage criteria at intake | The eligibility criteria for inclusion in the program in our country are:<br><br>This includes the socio-economic criteria of:<br><br>Application of these criteria are assured and monitored by: | 100% clients enrolled who meet the country's eligibility criteria | Nil. All clients are pregnant with an Aboriginal and/or Torres Strait Islander baby when they enrol. |

| Core Model Element | National 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.<br>b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program.<br>c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier | a) 68% of NFP clients receive their first home visit no later than the 28th week of pregnancy<br>b) 77% of eligible referrals who are intended to be recruited to NFP are enrolled in the program<br>c) 26% of pregnant women are enrolled by 16 weeks' gestation or earlier | Timing of enrolment in the program and first home visits is often dependent on activities of referring organisations. Program sites work with referrers regarding timing of (early) referrals and eligibility of referrals. |
| 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 | Nil. |
| 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 benchmark set is:<br>_25_% visits take place in the home | 63% visits take place in the home<br><br>% breakdown of where visits are being conducted other than in the client's home:<br>ANFPP office - 884 (15%)<br>Car - 86 (1%)<br>Family or friend's home - 79 (1%)<br>Health facility (not a hospital) - 93 (2%)<br>Hospital or Health service or Clinic - 319 (5%)<br>Other - 684 (12%)<br>Work or School or Educational facility - | In some program sites, the woman's home is not always deemed to be the appropriate setting for successful face-to-face program delivery for a range of reasons including the number of others residing there. Women may have a preference, or requirement, for the visits to take place in a park, a coffee shop, in the car, on the veranda, or outside in the yard or another outdoor setting. |

| Core Model Element | National Benchmarks and how these are being monitored | Progress against Benchmarks | Challenges + suggested actions to address these |
|---|---|---|---|
| | | 61 (1%) | Nil changes proposed. |
| 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. | a) Length of visits by phase country benchmarks are:<br>• Pregnancy phase:<br>• Infancy phase:<br>• Toddler phase:<br><br>b) Client attrition by program phase country benchmarks are:<br>10% attrition in Pregnancy phase<br>20% attrition in Infancy phase<br>10% attrition in Toddler phase | • 100% of clients being visited on standard visit schedule<br>• Average number of visits by program phase for clients on standard visit schedule is Pregnancy: 5, Infancy: 13, Toddlerhood: 11<br><br>Length of visits by phase (average and range):<br>• Pregnancy phase: 60 minutes<br>• Infancy phase: 65 minutes<br>• Toddler phase: 60 minutes<br><br>Client attrition by phase and reasons:<br>30% attrition in Pregnancy phase<br>44% attrition in Infancy phase<br>26% attrition in Toddler phase | Nil? |
| 8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree. | 100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree.<br>Monitored/assured by (e.g., standardized job description);<br>Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc. | 100% NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree | Nil |
| 9. NFP nurses and NS develop the core NFP | 100% of NFP nurses and supervisors complete the required NFP educational | All core education attendance and progress are monitored through | Some delays experienced in early 2021 due to travel restrictions, all |

| Core Model Element | National Benchmarks and how these are being monitored | Progress against Benchmarks | Challenges + suggested actions to address these |
|---|---|---|---|
| competencies by completing the required NFP educational curricula and participating in on-going learning activities | curricula and participate in ongoing learning activities.<br><br>Percentage of NFP team meetings, case conferences and team education sessions are completed (against expected for time period) | internal systems. 100% of ANFPP NHV, FPW and NS currently working in the program have completed or are currently completing core education curricula.<br><br>Data analysis of team meetings, case conferences and team education session not available in this reporting period. | education has been adapted for online delivery until June 2022.<br><br>NS self-report that regular team meetings and case conferences have occurred, often via digital technology due to remote working conditions.<br><br>New options are being explored for a national approach to team related data collection as the current data system is not used consistently for this area of data collection by all sites. |
| 10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains. | Please complete the section at the end of this table*. | Please complete the section at the end of this table*. | Please complete the section at the end of this table*. |
| 11. ANFPP nurses and supervisors apply the | It is expected that ANFPP nurses and supervisors will apply the theories through | This CME is not directly measurable. However, these theories are | Nil |

| Core Model Element | National Benchmarks and how these are being monitored | Progress against Benchmarks | Challenges + suggested actions to address these |
|---|---|---|---|
| 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. | current clinical methods/delivery of the program. There is no specific benchmark for this CME. | incorporated across the training curriculum and provide a focus for Community of Practice meetings. | |
| 12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision | 100% of NFP teams have an assigned NFP Supervisor | At 30 June 2021, 92% (12/13) of NFP teams had an assigned NFP Supervisor. The 1:8 NS: team member ratio was exceeded at 6 sites. | Nil |
| 13. ANFPP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision. | No benchmark. | Quarterly program fidelity reporting is used to track program fidelity. In 2020-21 a robust program of Quality Site Self-Assessments (QSSA) has been established and implemented. | Nil |

| Core Model Element | National Benchmarks and how these are being monitored | Progress against Benchmarks | Challenges + suggested actions to address these |
|---|---|---|---|
| 14. High quality ANFPP implementation is developed and sustained through national and local organized support | Monitored/assured by (including other measures used to assure high quality implementation). | Regular exception reporting (Data Completeness and Missing Data Reports) is used to support program site program implementation and data quality. The CQI (QSSA) processes address local organized support at the program site level. | Nil |
| 15. ANFPP teams must employ Aboriginal and/or Torres Strait Islander FPWs to support delivery of the program and who participate in reflective supervision. | 100% of ANFPP teams employ Aboriginal and/or Torres Strait Islander FPWs to support delivery of the program and who participate in reflective supervision. | 100% of ANFPP teams employ Aboriginal and/or Torres Strait Islander FPWs. | Nil |

**Domain coverage***

**Please complete with your country benchmarks and average (for proportion of time spent within each domain during visits)**

| Domain | Pregnancy Benchmark (%) | Pregnancy actual (%) | Infancy benchmark (%) | Infancy actual (%) | Toddler benchmark (%) | Toddler actual (%) |
|---|---|---|---|---|---|---|
| Personal Health (My Health) | 35-40% | 33% | 14-20% | 17% | 10-15% | 15% |
| Maternal Role (My Child and Me) | 23-25% | 22% | 45-50% | 38% | 40-45% | 35% |
| Environmental Health (My Home) | 5-7% | 11% | 7-10% | 9% | 7-10% | 10% |
| My Family & Friends (Family & Friends) | 10-15% | 14% | 10-15% | 12% | 10-15% | 13% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Life Course Development (My Life) | 10-15% | 13% | 10-15% | 12% | 18-20% | 16% |

**Commentary:** (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
The environmental health domain benchmark is exceeded in the pregnancy phase. This may be attributed to the focus required to adequately support families to secure suitable and safe housing.
The maternal role domain benchmark has not been reached in pregnancy, infancy, or toddlerhood phase. Further analysis of this data is required, home visiting practices will be explored in Community of Practice meetings in Early 2022.

## 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/or add any additional text or diagrams in Appendix 1. Where terms used in the report template are generic, please specify how items are measured as necessary. Please explain any missing data or analyses.**

| **Characteristics of our clients at enrolment** | | |
|---|---|---|
| **Health, Social and economic Conditions at enrolment** | **Previous year(s) (n/%)** | **Current Period (n/%)** |
| Age (range and mean) | (13 – 43) 23 | (14 – 42) 23 |
| Race/ethnicity distribution | Indigenous: 88%. Non-Indigenous: 12% | Indigenous: 87%. Non-Indigenous: 13% |
| Home visits where father/partner is present | Data not available | 18% |
| Home visits where other family members are present: | Data not available | 22% |
| Income (please state how this is defined) | Not collected | Not collected |
| Inadequate Housing (defined as: in a group home/shelter or confined to an institution or homeless) | 293, 26% | 271, 10% |
| Educational Achievement | Secondary Only: 29%. Post-Secondary: 28%. Missing 42% | Secondary Only (Yr 10- 12): 27%. Post-Secondary: 26%. Missing 46% |
| Employment | 284, 30%. Missing 60% | 244, 34%. Missing 49% |
| Food Insecurity (please define) | Not collected | Not collected |
| Ever In the care of the State (as a child or currently) | Not collected | Not collected |
| Obesity (BMI of 30 or more) | 39, 24%. Missing 92% | 107, 24% Missing 76% |
| Severe Obesity (BMI of 40 or more) | 39, 0% | 107, 7% |
| Underweight (BMI of 18.5 or less) | 39, 15% | 107, 13% |
| Heart Disease | 207, 4% | 148, 5% |
| Hypertension | 207, 3% | 148, 4% |
| Diabetes – T1 | 133, 1% | 143, 4% |
| Diabetes – T2 | 133, 3% | 143, 0% |
| Kidney disease | 207, >1% | 148, 2% |
| Epilepsy | 207, 1% | 148, 2% |
| Sickle cell Disease | Not collected | Not collected |

| | | |
|---|---|---|
| Chronic Gastrointestinal disease | 207, 1% | 148, 2% |
| Asthma/other chronic pulmonary Disease | 207, 22% | 148, 24% |
| Chronic Urinary Tract Infections | 207, 6% | 148, 8% |
| Chronic Vaginal Infections (e.g., yeast infections) | 207, 13% | 148, 12% |
| Sexually Transmitted Infections | Not collected | Not collected |
| Substance Use Disorder | Not collected | Not collected |
| Mental Illness | 207, 33% | 148, 39% |
| Other (please define) | n/a | n/a |

**Please comment below on the vulnerability of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time.**
Aboriginal and Torres Strait Islander women referred to the ANFPP have varying levels of complexity/vulnerability and COVID -19 has presented further challenges to young women and families. Housing, access to community and health services, adequate financial support and complex relationships continue to be some of the chronic issues for ANFPP clients. Despite this, a record 140 clients have graduated from the program in this reporting period. This indicates that clients have been able to participate in the ANFPP until completion when access to other health and community services may have been very limited.

The ANFPP STAR Pilot Project commenced early 2021 with 2 sites. The Pilot Project will be completed by June 2022 with all current site staff from other teams scheduled to receive STAR education by the end of 2022. Feedback from pilot sites has been positive, with NS, NHV and FPWs all stating they see great value in the use of STAR to characterise and organise client strengths and risks, and found no barriers to the embedding of STAR into their practice. Both teams were supported through the online STAR modules and then used the STAR framework in a case conference of a current client and family.

| **Alterable Maternal Behavior/ program impacts for clients** (please complete for all the time periods where the data is collected) | | | | | |
|---|---|---|---|---|---|
| | **Intake** | **36 Weeks of Pregnancy** | **Postpartum** | **12 months** | **18 months** |
| Anxiety (n, % moderate + clinical range) | 215, (≥4, 30%), 0-9 | 93, (≥4, 20%), 0-8 | 169, (≥4, 22%), 0-8 | 64, (≥4, 27%), 0-7 | 39, (≥4, 26%), 0-7 |
| Depression, (n, % moderate + clinical range) | 215, (≥10&≤12) 5%), 0-27 | 93, (≥10&≤12) 1%), 0-17 | 169, (≥10&≤12) 6%), 0-24 | 64, (≥10&≤12) 8%), 0-15 | 39, (≥10&≤12) 13%), 0-18 |
| Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours) | 259, 39% | 148, 35% | 45, 46% | 116, 37%, | 91, 42% |
| Alcohol, (n, % during pregnancy, units/last 14 days) | 259, 8% | 148, 1% | 45, <1% | 116, 9% | 91, 16% |

| | | | | | |
|---|---|---|---|---|---|
| Marijuana, (n, % used in pregnancy, days used last 14 days) | 259, 5% | 148, 3% | 45, 0% | 116, <1% | 91, <1% |
| Cocaine, (n, % used in pregnancy, days used last 14 days) | Not collected | Not collected | Not collected | Not collected | Not collected |
| Other street drugs, (n, % used in pregnancy, days used last 14 days) | Not collected | Not collected | Not collected | Not collected | Not collected |
| Excessive Weight Gain from baseline BMI - Pregnancy, (n, %) | Not collected | Not collected | Not collected | Not collected | Not collected |
| Mastery, (n, mean) | Not collected | Not collected | Not collected | Not collected | Not collected |
| IPV disclosure, (n, %) | Not collected | Not collected | Not collected | Not collected | Not collected |
| | | | | | |
| | **6 Months** | **12 Months** | **18 months** | **24 Months** | |
| Reliable Birth Control use, (n, %) | Not collected | Not collected | Not collected | Not collected | |
| Subsequent pregnancies, (n, %) | 561, <1% | 561, 1% | 561, 2% | 561, 2% | |
| Breast Feeding, (n, %) | 314, 61% | Not collected | Not collected | Not collected | |
| Involvement in Education, (n, %) | 118, 21% | 123, 25% | 82, 26% | 87, 13% | |
| Employed, (n, %) | 130, 19% | 88, 19% | 60, 18% | 54, 26% | |
| Housing needs, (n, %) | Not collected | Not collected | Not collected | Not collected | |
| DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.) | Not collected | Not collected | Not collected | Not collected | |
| Father's involvement in care of child, (n, %) | Not collected | Not collected | Not collected | Not collected | |
| Other (please define) | Not collected | Not collected | Not collected | Not collected | |

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

Anxiety and depression are assessed in the ANFPP using the Edinburgh Postnatal Depression Scale or the Kimberley Mothers Mood Scale (KMMS). The KMMS was developed in the Kimberley region of Western Australia to be a more culturally secure approach to screening for anxiety and depression during the perinatal period for Aboriginal and Torres Strait Islander women. The number of women with perinatal mental health data at 36 weeks is impacted because these data are not recorded in the Communicare system used at 3 ANFPP sites. The available ANFPP data shows that the proportion of women who scored 6 or more on the anxiety subscale indicating possible anxiety symptoms decreased from 30% at intake during pregnancy to 20% at 36 weeks. In the postnatal period, the proportion of women who had possible anxiety symptoms was 20%, 27% and 26% in the postpartum period, when the child was 12 months, and when the child was aged 18 months respectively.

The proportion of women in the program with probable depression was less than 10%, except when the child was 18 months old where the reported proportion of probable depression was recorded as 13%. There is little comparative evidence on the prevalence of perinatal depression and anxiety among

Aboriginal and Torres Strait Islander women. A 2008 study in Townsville, Queensland screened 136 First Nations women and 16.7% were found to be at risk.

Cigarette smoking among Aboriginal and Torres Strait Islander women is high, particularly among women who live in remote areas of Australia. This is also reflected in the data collected by the ANFPP indicating tobacco control remains a high priority. The proportion of women smoking at timepoints throughout the program ranged from 35-46%. In 2020-21, reported alcohol use during pregnancy at 8% was higher at intake to the ANFPP than at 36 weeks gestation (1%). This is possibly related to early pregnancy alcohol use prior to pregnancy awareness. The reported use of marijuana was low at all timepoints and ranged from 5% at intake down to <1% in the postpartum period.

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

Qualitative feedback indicates an increase in clients' self-efficacy, confidence and ability to reach desired personal goals. The NSS is currently introducing the Growth and Empowerment Measure to measure the impact of the program on empowerment which will be included in future reports.

**Which are the areas of challenge?**

There has been a long history of poor data collection, monitoring and reporting. In the 18 months the NSS has been operational we have been required to review and modify the quality and relevance of our two data systems including implementing new data collection tools to robustly measure empowerment of mothers (Growth and Empowerment Measure), and early childhood development (PLUM and HATS).

Limited CQI processes also requires ongoing education and training for home visiting team members to continually improve the quality and completeness of the ANFPP data set.

| **Birth data** | | |
|---|---|---|
| | **Number** | **% of total births for year** |
| Extremely preterm (less than 28 weeks gestation) | 4 | 1% |
| Very preterm (28-31 weeks gestation) | 6 | 2% |
| Moderate to late preterm (32-36 weeks gestation)[4] | 25 | 9% |
| Low birthweight (<2500g) | 42 | 15% |
| Large for Gestational Age (LGA) (≥4500g) | 2 | 1% |

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

| | | |
|---|---|---|
| Other (please define) | | |

**Please comment below on your birth data:**

Preterm births: 12.5% (35/281) infants were born preterm in the 2020-21 reporting period. Preterm births for the previous three reporting periods (2017-18 to 2019-20) were reported as 13.1%, 13.6% and 8.3% respectively. Most preterm infants born in 2020-21 (71%) were between 32 and 36 completed weeks. However, at 71% (of all preterm births for the reporting period) the proportion of late preterm births (32-36 weeks) was lower than in the previous three reporting periods (88%, 93% and 88% respectively), meaning the proportion of extremely preterm and very preterm births was higher than previous years. Of mothers with data about smoking in pregnancy (213/281), mothers who reported any smoking in pregnancy were more likely to have a preterm baby (13.8%; 13/93) than mothers who didn't smoke (7.5%; 9/120) (p-value 0.06). For comparison, in national Australian data about women who had a baby in 2019 published by the Australian Institute of Health and Welfare (AIHW), of women who had an Indigenous baby in 2019 (includes non-Indigenous women), 12.2% (2,209/18,086) were born preterm, and of Indigenous women who had a baby in 2019, 13.2% (1,911/14,467) were born preterm.

Infant birthweights: The rate of low birthweight (<2500g) in the ANFPP in 2020-21 was 15% (42/281). Low birthweights for the previous three reporting periods (2017/18 – 2019/20) were reported as 12%, 15% and 13% respectively. The percentage of LGA (≥4500g) babies born in each of the reporting periods from 2017/18 – 2020/21 ranged from <1% to 2%. Of mothers with data about smoking in pregnancy (213/281), mothers who reported any smoking in pregnancy were more likely to have a low birthweight baby (20%; 19/93) than mothers who didn't smoke (7.5%; 9/120) (p-value 0.003). For comparison, in national Australian data about women who had a baby in 2019 published by the AIHW, of women who had an Indigenous baby in 2019, 10.6% (1,905/17,917) were born low birthweight, and of Indigenous women who had a baby in 2019, 11.7% (1,669/14,315) were born low birthweight.

| **Child Health/Development** | | | | |
|---|---|---|---|---|
| | **6 months (% of total)** | **12 months (% of total)** | **18 months (% of total)** | **24 months (% of total)** |
| Immunizations Up to Date | Not collected | 99% | Not collected | 98% |
| Hospitalization for Injuries | 0% | 2% | 1% | 9% |

| | | | | |
|---|---|---|---|---|
| ASQ scores requiring monitoring (grey zone) | 23% (04 months) | 20% (10 months) | 14% (14 months) | 36% (20 months) |
| ASQ scores requiring further assessment/referral | 8% (04 months) | 14% (10 months) | 5% (14 months) | 18% (20 months) |
| ASQ-SE scores requiring monitoring (grey zone) | No ASQ-SE grey zone available | | | |
| ASQ-SE scores requiring further assessment/referral | 2% | 8% | 0% | 0% |
| Child Protection (please define for your context) | Not collected | Not collected | Not collected | Not collected |
| Other (please define) | | | | |

**Please comment below on your child health/development data**

To date there has been no validated tool for use to assess Australian Indigenous child development. We are in the process of rolling out the ASQ Trak tool – a modification of ASQ 3 that have been validated in Aboriginal children in Australia. There are currently only 7 tools for the following ages: 2, 6, 12, 18, 24, 36 and 48months

ANFPP currently ask us to use ASQ3 at the following ages: 4, 10, 14, 20 months, therefore we are required to change this in sites that choose to use ASQ TRAK.

| **Additional analyses** |
|---|
| In 2020-21, the NSS completed a descriptive analysis of Multiparous and Primiparous women in the program, the results are available in the ANFPP Annual Data Report (page 14). The analysis was confounded by remoteness area. |
| **Client experiences** |
| **Quotes from recent ANFPP graduates**<br>**Jannali** |

"When I was in the program, I absolutely loved what everyone did - the nurses and the FPWs. I loved it. For me it was great. I had a great connection with them and knowing that the program was going to end soon, I was going to miss it because they were the only people that I could talk to. I thought this is great. This is so good for mums. They can help with so many things. And it's a struggle when mums don't reach out for help.

I thought this is a great way for me to help mums and I can be a very big inspiration to them, because I'm young, I've done all these things. Nothing was stopping me. And I can then show them and be a mentor for them. And then when they told me there was going to be a position soon, I was 'I'm gonna apply for that. I'll be great. I can't wait'. I was so excited, and I was over the moon when I heard that I got the job."
*(Jannali is now employed as a FPW at Rumbalara Health Service ANFPP site)*

**Emily**
"She (my nurse) was always supportive, and all the lessons and workshops they do with you - they teach you a lot about social, security, engaging with our child and things like that.
(The best thing about the ANFPP is) definitely the support; the support that they give you and how ongoing it is. They feel like family, like aunties. They just make a connection really quickly. I feel that's really important for Indigenous people to be able to make that connection.

Without the support that I received from ANFPP, I don't think I would have been able to achieve what I have. They helped push me, grow my mind set and believe in myself that little bit more. When you surround yourself with the right people and ask for that help and support, anything can be done."

**Bobbie**
"When we did the initial intake yarn (with FPWs), it felt like home. I hadn't met these two wonderful women before, but it felt familiar, and I knew I was going to be in good hands. I didn't even have to say much - they understood and held such a nice, safe space in that moment for me.

I had a lovely midwife/nurse journey with me throughout my pregnancy. I felt like the ANFPP nurse held my hand throughout the whole process. Although, if I said this to her - she'd say it was all me. But I honestly, couldn't have gotten through those times without her.
It was always about relationship - we just spent so much time yarning (talking) and it was what my anxious heart needed.

As I head into graduation, I'm finishing up the program with someone (a NHV) who I feel is just a best mate.
My ANFPP nurse will meet me literally wherever I'm at. If I'm in my house surrounded by toys or in the park chasing my overactive toddler, or is she's giving me a lift to therapy so I don't have to drive myself - Wherever I am at, I am met. It's been so nice.
It's so nice to be seen and for space to be held for me and my daughter – it just reminds you that you are not alone in this gig.

My ANFPP support crew have always been there throughout this journey of becoming parents and growing into parenthood. They were always providing advice, articles and any information we needed to help us, but most importantly just being there.

When I find people that speak to my soul – I like to keep them around. ANFPP people are good, generous, kind, compassionate people."

**Sentinel / Significant events that deserve review:**

| Event | Number | What was the learning? |
|---|---|---|
| **Miscarriage/fetal/infant death** | **10** | In the ANFPP data collection, 'child death' is recorded as a Reason for Leaving the Program in the category 'Miscarriage/fetal/infant death'. In 2020-21 a total of 10 women were recorded as leaving the program due to 'Miscarriage/fetal/infant death'. |
| **Maternal death** | **1** | In the ANFPP ADR, cells of less than five (particularly for potentially very sensitive data items such as maternal deaths, maternal incarceration) are reported as <5 to protect the privacy and confidentially of ANFPP clients and program sites. |
| **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;

Current site support CQI processes:

- Prior to each site visit, the NSS team attend the Site Quality Improvement Group (SQIG) meeting to review the contents of the Quality Site Self-Assessment (QSSA) form and the plans for the next 6-12 months (Appendix 3 - QSSA form). At these meetings, the NSS review the most recent Site Fidelity Report so the site support team can understand the strengths and challenges of the site. The most recent Client Completeness Report and Data Quality Report are also reviewed.
- At the site visit – using the QSSA processes and the Plan, Do, Check and Act (PDCA) methodology, the site support team collaborate with the site to identify priority areas for Quality Improvement and develop an action plan. Through the site quality meeting, progress against the action plan is monitored at 3-month, 6-month and 9-month intervals. Following each site visit, the site support team complete a post site visit report. The outcomes are then shared back at the SQIG review meeting allowing the education and data teams to formulate a support plan for the next 12 months.

Outcomes of CQI program for the reporting period:

- Improved CQI processes use a systematic approach to better support the ANFPP sites.
- Capacity building at NSS and sites through effective education regarding data collection – missing/incomplete data and new look fidelity reports.
- Effective feedback systems will be an integral part of the program cycle to promote learning and improve the quality of data collection and analysis processes.
- The new look Fidelity Reports ensure the site is implementing the program with fidelity to the Core Model Elements and meeting targets for clinical outcomes.
- Development of an education module on data and data collection is now included as part of the core curriculum and will enhance data quality and completeness.
- Transparency and 360 feedback to ensure clarity about importance of data collection.
- Effective collaboration between sites and NSS.

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

- Face to face QSSA meetings have proved to be an important factor in increased engagement between the NSS and Program sites in relation to data quality, data completeness and reviewing fidelity to the Core Model Elements. COVID 19 travel restrictions have prevented these meetings with some Program sites. These will be the highest priority site visits when interstate travel resumes in 2022.

Goals for CQI in next year:

- All sites will have a minimum of one face to face site visit annually.
- Review of previous years CQI priorities will support sites to do a 360 review of Program delivery in their community, and update/renew the new years' priorities.

| **Program innovations tested and/or implemented this year (this includes both international and local innovations)** |
|---|
| • Program innovations tested[5]: Nil.<br><br>• Program innovations implemented: Nil.<br><br>• Findings and next steps: Nil. |
| **Temporary Variances to CMEs** |
| For each variance agreed please attach a report of the variance evaluation methods and findings to date in Appendix 2 to this document. |
| **Additional Approved Model Elements (AAMEs)** |
| Please attach a summary of findings in relation to any Additional Approved Model Elements in Appendix 3 to this document. |
| **ANFPP Evaluation – Mixed Methods approach** |
| Research team and their institutions:<br>Poppy Wise – Director, Urbis (Project lead Urbis – Project Director)<br>Harpreet Kalsi – Director, Cox Inall Ridgeway (Project lead CIR)<br>Kaylie Harrison – Senior Consultant, Cox Inall Ridgeway (Senior cultural lead and consultation)<br>Christina Bagot – Associate Director, Urbis (Project Manager)<br>Abbey Wiseman – Senior Consultant, Urbis (Consultation and analysis)<br>Greta Newman – Consultant, Urbis (Consultation and analysis)<br>Madeleine Ridgeway – Research Analyst, Urbis (Consultation and analysis)<br>Dr Caroline Tomiczek – Associate Director, Urbis (Data lead)<br>Richard Gibbs – Director, Urbis (Lead Economist, Social return on investment)<br>Ryan Bondfield – Research Assistant, Urbis, (SROI Analysis)<br>Dr Ash Evans – Director, Taylor Fry (Data linkage lead)<br>Laura Dixie – Manager, Taylor Fry (Data linkage) |
| **Brief outline of research methodology:**<br>A robust evaluation of the ANFPP program is supported through numerous quantitative data sources, including survey data, program data and population-level data. These data sources need to be considered critically to ensure data adds value to the evaluation, while ensuring that no unnecessary burden is placed either on program participants or administrators. The evaluation methodology incorporates two periods of primary data collection and analysis: April to September 2022 (Round 1) and April to September 2023 (Round 2).<br><br>Findings from Round 1 will be reported in the Interim Report (due for completion in December 2022), while the final report will incorporate findings from both Round 1 and Round 2. These data collection periods were chosen to ensure adequate time for evaluation planning and |

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

primary data collection, and high participation rates (i.e. data collection was deliberately not scheduled over the summer holiday period, during the wet season or NAIDOC week). These rounds currently cover a period of six months, but that will be reduced to a much shorter period as fieldwork dates are firmed up.

The evaluation methodology combines the collection of primary qualitative data and quantitative data with the use of program data and population-level data sources. This approach simultaneously ensures that there will be enough evidence to draw conclusions and make recommendations, while minimising burden on program participants and frontline staff. Program data will be supplied by the NSS at least annually, but ideally on a more regular basis (quarterly). This data will be analysed and reported on in 2022 and 2023. However, given the importance of the program data to the evaluation, Urbis will undertake a data familiarisation phase to investigate the feasibility of these analyses. Linked data is likely to be available sometime in the middle of 2023.

**Details of progress to date:**

**Inception and planning:**

Two inception meetings were conducted with key Departmental staff.

Urbis, CIR and Taylor Fry mobilised our internal teams, including commencement meetings and the establishment of protocols for working together.

Key informant conversations (n=7) were held with Departmental staff, the NSS, international experts Dr Professor Olds and Gail Radford-Trotter, and representatives from the Department of the Prime Minister and Cabinet to explore existing Commonwealth Government guidance for SROI analyses.

**Evaluation strategy:**

The evaluation team conducted three online workshops with representatives from 10 of 12 partner organisations, the Department and the NSS. Feedback from all participants was collected by the evaluation team; via phone, email and written comments and incorporated into the revised strategy. Minor comments were also provided by Gail Radford-Trotter. The Evaluation Strategy was finalised based on feedback from the Department and the Evaluation Reference Group (ERG). The Evaluation Strategy documents the evaluation purpose, scope, key evaluation questions, stakeholder engagement plan and data matrix, including the KEQs, indicators and measures, data sources, methods and data collection instruments. The Project Plan has been incorporated into this document to provide a single reference document to guide the evaluation.

Discussion guides were also drafted for FPW, Program Managers/NS staff, ANFPP participants and their family/support person. A staff survey has also been drafted. These instruments have been reviewed by the NSS and circulated to the ERG members.

**Ethics applications:**

CIR led the development and submission of three ethics applications. Support letters have been provided by all ANFPP sites except Wuchopperen.

Central Australia Ethics Committee (CAHREC) and the Menzies AHREC provided in principal approval and have requested additional information on the comparison group and data linkage components. Minor amendments have also been requested for the Participant Information and Consent forms.

CIR is awaiting a response from Aboriginal Health and Medical Research Ethics Committee (AH&MRC).

CIR is currently confirming whether an application will need to be submitted to South Australian AHREC.

**Data linkage planning:**

- Taylor Fry has undertaken a range of planning and preliminary discussions, including engaging with staff from the NSS and Congress. In principal agreement for data linkage has been confirmed in support letters from sites. Technical feasibility application was submitted to AIHW in December 2021. Currently awaiting their response.
- Urbis/CIR are reviewing program data provided by the NSS Annual Report and exploring ethics approval for the NSS annual data.

**Communications with sites and other stakeholders:**

- CIR led preliminary engagement sessions with 11 ANFPP partner organisations to introduce the evaluation team, discuss the intent of the evaluation, hear their perspectives on the program and learn about the local context, including program participants and engagement preferences. These sessions were attended by the Program Manager, NS and other members of the team. Key contacts for ongoing communications were also confirmed. Currently scheduling a meeting with staff from Durri and Wuchopperen.
- CIR led a short presentation (online) at the conference to update sites on the evaluation progress, present the updated program logic, provide a timeline and key high plan for data collection in 2022.
- Ongoing engagement with the NSS through as needed meetings.
- Preliminary engagement interviews with Professor Olds and Gail Radford-Trotter, including feedback on the program logic.

**Governance and ERG activity:**

- WIP meetings were conducted weekly with Urbis/CIR to recap key activities over the previous week, emerging issues or risks for discussion and planned activity over the next week. These meetings are now held fortnightly, reflective of both Departmental and Urbis/CIR need.
- CIR led the establishment of the ERG and drafted the Terms of Reference. Representation from most sites and the NSS.
- Meeting 1 – 30 September 2021 – focus on evaluation update, reviewing Evaluation Strategy, program logic, discussion guides and the ethics process including support letters from sites as well as determining the Terms of Reference.
- Meeting 2 – 13 December 2021 – focus on evaluation update, finalising Terms of Reference, capacity building with sites, ethics update and adjustments to fieldwork scope and approaches.

**Expected reporting period and consultation with UCD prior to publication:**
Final Interim Report – 15 December 2022
Final Evaluation Report – 30 January 2024

At this stage, there is no plan for the report/s to be published. A consultation can be arranged with the University of Colorado, at both the Interim and Final Evaluation Report stages, as required.

# PART FIVE: ACTION PLAN

**LAST YEAR:**

**Our planned objectives for last year:**
The NSS took operations in July 2020 and has spent the first year reviewing and improving site support, reflective supervision, data systems, education content and CQI activities.

**Progress against those objectives:**
Significant improvement in engagement from teams across the country. High quality reflective supervision that now incorporates cultural safety and trauma informed care.

**Reflections on our progress:**
The NSS is very proud of its achievements.

**NEXT YEAR:**

**Our planned objectives for next year:**
Australia's key objectives for 2021-22 include implementing the expansion of the ANFPP to two additional sites, as per the Healthy Mums, Healthy Bubs budget measure, and extending the program for an additional three years to 2025. The extension involves renewing the NFP licence agreement with UCD, extending existing consultancy contract with the NSS and extending funding agreements with existing ANFPP sites.

The Department will continue to work closely with the Urbis consortium leading the ANFPP Evaluation.

Australia will also continue to consider program improvements and adjustments over the coming year, building on the priorities identified in the 2019-20 Annual Report such as data collection improvements, the involvement of fathers in ANFPP activities and maternal smoking rates.

**Measures planned for evaluating our success:**
Improved data collection
ANFPP Evaluation Progress Reports

**Any plans/requests for program expansion?**
As per the Healthy Mums, Healthy Bubs budget measure, Australia has Ministerial approval to expand the ANFPP to 2 more sites, yet to be identified.

The Department is working closely with the National Aboriginal Controlled Health Organisation (NACCHO), the NSS and other key stakeholders to identify potential new ANFPP sites. It is anticipated that at least one of the two new sites will be agreed, with contracts executed before 30 June 2022.

**FEEDBACK FOR UCD INTERNATIONAL TEAM:**

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

- monthly meetings with Gail Radford-Trotter and the NSS Clinical lead, Kym Cunningham continue to provide regular clinical and programmatic guidance and coaching in relationship to program leadership, curriculum, CMEs, international innovations, stakeholder engagement, implementation science, data reporting and CQI processes.

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

| |
|---|
| • More guidelines and support on measures of program impact from two of the three theories – attachment, self-efficacy. |
| **This what we would like from UCD through our Support Services Agreement for next year:**<br>See 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 | Y |
| I do not agree to this report being uploaded onto the international website | |

## PART SIX: ANNUAL REPORT FROM UCD

**Completed by UCD following annual review meeting**

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

- 1:1 International Consultancy with Clinical Lead
- Ad hoc guidance and consultancy as required
- Clinical-Advisory Group, Analytic, and Data Groups
- Specialist guidance and input to Evaluation Team by Dr Olds and International Consultant
- International Project (COVID and impact)
- Contribution and presentation to ANFPP Annual Conference

Identified strengths of program:

- NSS Leadership Team established and delivery of high-quality support nationally
- DoH commitment to the program demonstrated by support for NSS and planned expansion to 2 additional sites
- High uptake and receptiveness for the program by ANFPP clients
- Academic publications and close linkage with hosting University (Charles Darwin)
- Strong commitment to improving information system and its use in quality improvement
- Reflective Supervision becoming embedded nationally, with potential for shared learning across non NFP teams caring for women and children

Areas for further work:

- Improved enrolment to the program by 16 weeks
- On-going improvement of information systems, specifically addressing issues relating to missing data
- Nurse recruitment and retention; particularly Clinical Lead/NSS Leadership Team role in supporting recruitment process at a local level

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

- As above, plus;
- Further development and testing of Mastery tool (GEM)
- On-going support for Evaluation strategy
- Site expansion and planning organisational readiness
- Consider re-modelling of managerial support for FPW's

Any approved Core Model Element Variances:

- N/A
- Future discussions to focus on the possibility of Registered Aboriginal Health Practitioner proposal to deliver NFP in Darwin (Wurli) area (not discussed at Annual Review)

Agreed upon activities that UCD will provide through Support Services Agreement:

- Continued 1:1 International Consultancy with Clinical Lead
- Specialist input to new site expansion
- Ad hoc guidance and consultancy as required
- Clinical-Advisory Group, Analytical and Data Groups
- Specialist guidance and input to Evaluation Team
- International Project (tbd)
- Contribution and presentation to ANFPP Conference as requested

## 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:** |
| |

| **CME #:** |
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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:** |
| |

## Appendix 3: Additional Approved Model Element (AAME)

| **AAME agreed:** |
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| **CME 15:** ANFPP teams must employ Aboriginal and/or Torres Strait Islander FPWs to support delivery of the program and who participate in reflective supervision |
| **Reflections and findings in relation to use of the AAME** |
| The addition of CME15 has supported progression of role definition for FPWs. Although the ANFPP has always had the role of the FPW, the acknowledgement via the additional Approved CME15 has provided significant recognition of this integral role.<br><br>The role of the NSS in supporting the FPW workforce is considerable. Given the impact of colonisation and intergenerational trauma on Australian First Nations families, the need to support the First Nations workforce is significant. Supporting the First Nations workforce to work in systems entrenched in racism is also substantial. This work is currently not captured or discussed in any of our current reporting.<br><br>NS education in Reflective Supervision (including Cultural Safety) has been completed by all NS. A greater focus on cultural safety supports the provision of safe and culturally appropriate Reflective Supervision for FPWs. |