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International Nurse-Family Partnership® (NFP)

PHASE THREE ANNUAL REPORT

Disclaimer: *Please note transition from the National Program Center (NPC) to the National Support Service (NSS) occurred on 1 July 2020, immediately following this reporting period of July 2019- June 2020. Much of the content in this report is written by the former NPC and is not verified by the NSS. The NSS updated the data elements where possible. The NSS has also provided a short section at the end of the document to highlight key focus areas for the 2020-2021 reporting period.*

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.

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 this data is not collected in your country or is not able to be analysed at this time. Where terms used in the report template are generic, please specify how items are measured in your country. Where you have adapted your data collection schedule/timings or approach to accommodate local systems, please adapt the document as necessary to take account of this. If you have any questions regarding the content of this document, please do not hesitate to get in touch with your NFP International Consultant.

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.

PART ONE: PROGRAM OVERVIEW

Name of country: Australia

Dates report covers (reporting period): July 2019 – June 2020

Report completed by: Department of Health

Date submitted: 27 January 2021

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	41	41
Part time NFP Nurses	13	13
Fulltime NFP Supervisors	12	12
Part time NFP Supervisors	2	2
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	39	39
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	6	6
Total	113	113

- We have 13 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:7.3

- Current number of implementing agencies/sites delivering NFP: 13 sites
- Current number of NFP teams 13
- 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, through the Department of Health, is the license holder for the program.

Role and Organisation: National policy oversight and management of the program is the responsibility of the Child and Family Health Section, within the Indigenous Health Division, Department of Health.

Description of our National implementing capacity and roles:

License holder

The Department of Health (the Department), on behalf of the Australian Government, holds the sole Australian NFP license. Within the Department's Indigenous Health Division, a dedicated team within the Child and Family Health Section (CAFHS) has policy responsibility for the Australian Nurse Family Partnership Program (ANFPP). CAFHS is responsible for broader child and family health policy, 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 2013-2023* and the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023*; along with the National Agreement on Closing the

Gap including its sixteen targets and four priority reform areas.

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

Clinical Leadership:

- **Clinical leadership, support and guidance**

The ANFPP is made up of a collection of key stakeholders who provide strategic guidance and advice, clinical and cultural leadership, and implementation support and activities. Each stakeholder has defined roles and responsibilities to ensure the success of the program.

In the 2019-20 financial year, a contractor known as the National Program Centre (NPC) via ABT Associates was responsible for the coordination of the ANFPP (education support and data reporting). Transition from the former NPC to the current National Support Service (NSS) occurred on 1 July 2020, immediately following this reporting period of July 2019- June 2020. The following section outlines the key role and activities of the NPC, as reported by it in late June 2020.

The role of the NPC was to successfully manage coordination of the ANFPP across Australia. The NPC collaborated with partner organisations to achieve a sustainable, high-quality program. The NPC team aimed to ensure the ANFPP is delivered successfully to achieve improved outcomes for women pregnant with an Aboriginal or Torres Strait Islander baby (as well as their children and families more broadly). As above, this role has now transitioned to the current NSS.

The NPC had identified four dedicated areas of responsibility:

- **Strategic support**
  Provided strategic support by managing successful relationships with key stakeholders and partner organisations. Strategic support included program communication activities to enhance internal and external visibility of the program, collaboration with International societies through regular meetings and working groups to discuss program developments and innovations.
- **Workforce Development and Education**
  Responsible for delivering culturally safe core education to ensure staff have the skills required to deliver the program effectively and can progress to develop advanced skills. Partner organisations were supported to establish and sustain the ANFPP in their community and to deliver the program with fidelity. The goal of Workforce Development and Education was to develop a stable ANFPP workforce of highly skilled, advanced practitioners across all professional streams to achieve program outcomes.
- **Reporting**
  Responsible for providing regular and ad hoc reports to key stakeholders and meeting contracted reporting deliverables.
- **Quality**
  Responsible for establishing and maintaining quality frameworks and continuous quality improvement (CQI) processes and supporting Australian National Knowledge Access (ANKA) data quality.

The NPC provided clinical support and leadership to the ANFPP staff through a number of mechanisms, including:

- Community of Practice (CoP) meetings for all roles;
- reflective supervision for Nurse Supervisors;
- core curriculum training to all ANFPP staff; and
- facilitation of the Annual National Conference which was held on 23 – 25 July 2019 (which included a national CoP meeting, professional development opportunities and a data workshop). Note: the 2020 workshop was scheduled for after the Annual data report, and then delayed due to COVID-19.
- Online in interactive sessions were used for unit 1 and Dyadic Assessment of Naturalistic Caregiver-Child

Experiences (DANCE). Unit 2, 3 and NS education were conducted face to face.

ANFPP Leadership Group

The new Leadership Group was established in October 2019. It is made up of site CEOs, Professor David Olds, Gail Radford Trotter, and representatives from the Department of Health and the former NPC (now NSS). The group is responsible for the strategic direction of the ANFPP and providing oversight of implementation. While empowered to make decisions relating to their Terms of Reference, the group will remain an advisory body in relation to the Department of Health.

Over this period, key Leadership Group topics included:

- ANFPP governance
- NPC priorities for 2019/2020
- ANFPP evaluation process and progress
- ANKA update and consultation
- Core Model Elements (CME) 15 discussion
- Key findings of ANFPP Annual Data Report 2018/19
- Proposed format and dates of 2020 National Annual Conference
- Data Improvement strategies at NPC
- Transition process of NPC to Charles Darwin University

Implementing Sites CEOs' Group

This forum has transitioned to become the Leadership Group of the program – as above.

- **Data analysis, reporting and evaluation:**

The Australian National Knowledge Access (ANKA) database is the main data set used for data collection, analysis and reporting for the ANFPP. ANKA data is used to inform Quarterly Fidelity Reports from each ANFPP site and National Annual Reports. The data can be accessed by the Department of Health as the policy lead, as well as the coordinating centre the current NSS. Prior to the establishment of ANKA, extracts from the Communicare Clinical Information System were used.

Some of the key developments relating to data analysis, reporting and evaluation in this reporting period are outlined below:

National and Local Data Collection

A major review of ANKA was undertaken in October 2019, resulting in the ANKA 'Refresh' being rolled out in March 2020. Partnering organisations have continued to receive ANKA support through face-to-face training, as well as access to ANKA support. ANKA has been updated the incorporate additional functionality to record DANCE and Domestic and Family Violence (DFV) assessments. The Data Milestone structure for a Strengths and Risks Framework (STAR) has been developed on ANKA. However, incorporation of STAR will be aligned with the broader role out of the STAR project.

National Approach to Research and Evaluation

In March 2020, the Department commenced an open approach to the market to engage a supplier to undertake an evaluation of the ANFPP, utilising the evaluation design delivered to the Department by a consultancy consortium led by Urbis, in October 2019. The evaluation design involved consultation with a broad range of ANFPP stakeholders, including the University of Colorado. However, due to the COVID-19 pandemic, many organisations interested in applying were required to prioritise their response to COVID-19, and the Department decided to postpone the approach to market to ensure a fair and equitable approach for all potential candidates.

In September 2020, the Department approached the market for a second time and the tender for applications closed on 9 October 2020. The Department is currently assessing tender applications received and expects to finalise this process and engage an evaluator in January 2021.

- **Service development/site support:**

A number of developments were undertaken during this reporting period to ANFPP services and ANFPP site support, as outlined below:

ANFPP Cultural Framework

The NPC adopted the national *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health* as a primary driver to promote cultural safety within the program. The framework is intended to provide guidance for the entire Australian health system. The Cultural Respect Framework 2016–2026 also underpins the core principles applied to the ANFPP Performance and Quality Framework.

The *National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* and *Working and Walking Together: Supporting Family Relationship Services to Work with Aboriginal and Torres Strait Islander Families and Organisations* resource was also used by the NPC to ensure culturally appropriate professional practice and services for Aboriginal and Torres Strait Islander families within the ANFPP. By modelling the ideas and information provided in this resource, the NPC have been able to ensure the ANFPP core curriculum has a focus on cultural respect and a strengths-based approach to program delivery.

Workforce Development Program

The NPC worked with the Department to create Core Model Element 15 to recognise the unique role of FPWs in ANFPP and CME 9 was also adjusted to include the FPW. The workforce development and education team has been working to include these elements across the education program. The NPC has worked closely with Nurse Supervisors to establish a strengthened professional development and support program, and planned to conduct more regular face-to-face meetings with the national NS workforce.

Clarifying and strengthening the FPW role

An FPW workshop was held in February 2019, which brought together FPWs from around the country to explore the role, support workforce needs and embedding cultural safety. Bringing the team members together for education has been framed around the Nurse Home Visitor (NHV) role. With CME 15 and role description being finalised, it is timely to consult with FPWs to ensure that the education they receive supports them in their role to deliver the program. The workshop also unpacked the FPW learning needs, which supported the development of the FPW learning needs assessment document, which is to be used in the same way as the NHV learning needs assessment.

Further consultation is required to determine the nature of reflective supervision for FPWs. The intention was to explore this with the information gained from the FPW workshop at the NS face to face meeting in April. However, due to COVID-19, this consultation will be organised at a later date.

Review of education materials and curriculum

Several strategies were adopted by the NPC to ensure high quality education, learning, engagement and delivery. These strategies included CoP and innovative education delivery, such as transitioning to a new Online Learning Environment. The core curriculum had been reviewed to incorporate feedback, ensure that the cultural contextualisation was appropriate, provide new evidence and incorporated international

developments and enhancements. The curriculum review ensured education materials met the needs of Aboriginal and Torres Strait Islander staff. The review of the Home Visiting Guidelines (HVG) and Yarning tools ensured program delivery materials met the cultural needs of program participants.

- **Quality improvement:**

Please refer to Part 4 for detail on quality improvement.

- **NFP Educators:**

The ANFPP senior nursing leadership team, with support from CEOs, facilitates education for ANFPP nurses and FPWs. The Department also maintains general visibility of the education program, as the policy lead.

Senior Nursing Leadership

During this reporting period, the senior nursing leadership for the ANFPP at the NPC was provided by: NPC's National Program Manager and Nurse Educators who had qualifications in Nursing, Midwifery, Child and Family Health, Certificate IV in Workplace Training and Assessment, Reproductive and Sexual Health, Family Planning Educator, Immunisation Accreditation, Supervisor of Clinical Supervision, Diploma of Tropical Nursing, Master of International Public Health, Master of Health Science: Nursing Education, and Doctor of Philosophy by Research (PhD qualification held by past National Program Manager).

- **Other (please describe):**

Senior Nursing leadership was also supported by the CEOs, many of whom are senior Aboriginal and Torres Strat Islander leaders in their communities, with extensive experience in the delivery of primary health care. The revised governance structure included support from CEOs and Program Managers, who also hold health qualifications including Nursing, Midwifery, Child and Family Health, Social Work and Medical Practitioner.

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 16 targets, including a target to increase the proportion of Aboriginal and Torres Strait Islander babies born with a healthy birthweight.

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 2013-2023.*

[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

How our NFP supervisor and nurse education is organised: Please refer to NPC Core curriculum map in Part 2.
Description of any partner agencies and their role in support of the NFP program: This information is not available for the Phase 3 Annual Report, as it was not collected prior to the transition from the NPC to the current NSS.
Other relevant/important information regarding our NFP program: This information is not available for the Phase 3 Annual Report, as it was not collected prior to the transition from the NPC to the current NSS.

PART TWO: PROGRAM IMPLEMENTATION

Clients

# of NFP clients participating in the program over the last year: for the 2019–20 period, 468 clients entered the program

- Current clients: Pregnancy phase (%): 20%
- Current clients: Infancy phase (%): 48%
- Current clients: Toddler phase (%): 32%

% of those eligible clients offered the program who have enrolled over the last year: 77%

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

- Within this year the % of eligible women referred/ notified who were successfully enrolled onto the program was 77%

- Our reflections on this figure:

Over this reporting period, 77% of eligible clients were successfully offered the program, which is above the benchmark of 75%. This is consistent with the 2018-19 performance against this benchmark (77%).

Successes/challenges with receiving referrals

Successes reported by the NPC:

- The voluntary nature of the program ensures program participants are engaging willingly with the program. The differences between ANFPP and other maternal and child health programs are clearly articulated.
- Building strong partnerships and collaboration with stakeholders and referral agencies is important to expand referrals. Efforts to increase the ANFPP profile within the community e.g. attending community events, successful advertisement through social media, Community Reference Groups (CRGs) and awareness of initial program marketing materials have strengthened this pathway.
- Involving the FPWs improves communication and cultural safety, and enables trust to be built with clients and their families, particularly when there may be mistrust from the family around child removal, given the colonial legacy.
- A focus on keeping clients engaged during pregnancy supports their continual involvement throughout the infancy phase. Clients appreciate being kept informed about upcoming program activities e.g. Ages and Stages Questionnaire (ASQ) and Partners in Parenting (PIPE).
- Proactive client recruitment e.g. use existing client databases to actively identify and approach potential clients.
- Referrals continued to be received by sites during the COVID-19 pandemic, and these were managed appropriately in accordance with government COVID-19 movement restrictions and social distancing requirements. Sites often delivered their visits via a telehealth model to accommodate these requirements

Challenges reported by the NPC:

- How to share the details of the program to different levels of stakeholders and with communities e.g. focus on program intention to cross-refer to other services.

- New sites need time to understand their referral networks better.
- Lack of knowledge and misconception about the program e.g. a fear that ANFPP will overtake existing maternal and child health programs (delivered through the community or hospitals – although none are directly comparable to the ANFPP) and competition. Sites are providing in-service style information sessions at hospitals, Primary Health Networks (PHN) etc.
- Rapid staff turnover at referring agencies and staff turnover at sites can make relationship building challenging.

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: 5%
- % of home visits, where other family members are present: 9%
- How we engage fathers/partners/other family members in our program: All sites implement an inclusive approach to father and family participation, as detailed below. The Department would like to discuss options for increasing the engagement of fathers, partners or other family members in the ANFPP with the University of Colorado in early 2021.
- Our reflections on father/partners/other family members engagement:

Engagement of fathers

All sites actively promote a father inclusive practice approach to program delivery. The most successful activities have been group-based activities held at times suitable for fathers. Some sites have commented on the increase in participation of fathers in the program that have been present at birth. In some communities, local elders have been promoting the presence of fathers at birth, although traditionally birth has been considered Women's Business. Belly casting has also proved successful in increasing the participation and interest of fathers. At other sites, fathers are engaged at end of year group activities and strong linkages with men's groups within Aboriginal Medical Services are also promoted. Employment of a male FPW at one site has increased the involvement of fathers and provided a strong male role model. During this reporting period, a second site recruited a Men's FPW; but did not retain this FPW due to family commitments. The site is in the process of seeking a replacement for the role. There is interest with other sites to explore this role for Male FPWs.

The Department is interested in discussing options for an increased involvement of fathers in the ANFPP with the University of Colorado, noting the key role that fathers (as well as partners or other family members) play in a client's life course and decision-making, in addition to the father's role in the child's life more broadly.

Engagement of other family members

The home visiting team have an inclusive approach to family participation and this is supported by the increased interaction of the FPWs with other family members. This engagement of the extended family is individualised to suit clients' needs and requirements on a case by case basis.

Nursing Workforce

Average nurse caseload:

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	56	13	47	116
# of staff who left during reporting period	19	3	13	35
% annual turnover	34%	23%	28%	30%
# of replacement staff hired during reporting period	18	4	8	30

# of staff at end of reporting period:	54	14	45	113	
# of vacant positions	Not available	Not available	Not available	Not available	

- **Reflections on NFP nurse/supervisor turnover/retention during reporting year reported by the NPC:**
  - Some sites continue to face difficulties with staff recruitment and retention.
  - The home visiting environment is very different to the task-oriented hospital environments most nurses are used to; therefore, it takes time to develop new skills in home visiting and preventative healthcare in the setting of extreme vulnerability.
  - The high level of client vulnerability and complexity means crisis management may need to occur to enable program delivery. This includes tackling big issues across the social determinants, such as homelessness, food insecurity and financial problems.
  - Clients can be highly mobile and difficult to contact. They may disengage from the program as a result.
  - FPWs may share the same traumatic history as their clients.
  - Ongoing marketing and program promotion to improve the national profile is a challenge as promotion is conducted site by site. This also impacts recruitment if the program is not well known.
  - Multiple social and economic needs of individual clients can be difficult to manage, which can increase workloads and affect staff ability to obtain larger caseloads.
  - In some sites when a Nurse Supervisor (NS) or FPW are on leave or in training, client visits cannot go ahead, as two team members need to be present during visits.
  - The geographical locations of the ANFPP sites bring different challenges. Remote sites experience different issues to urban sites (e.g. some remote communities are only accessible by plane during certain seasons and have limited accommodation options for ANFPP program staff).
  - In moving to a telehealth model, some clients have limited access to telephone, in some cases the phone is not an individual's item but a collective commodity used by many people, and other clients don't have a phone that have video capabilities.
  - Restrictions in movement due to COVID-19 meant some remote communities could not be accessed for a period of time and clients may have had limited phone access.

- **Successes/challenges with NFP nurse/supervisor recruitment as reported by the NPC:**
  - Regular reflective supervision for all staff, as well as the development of a stronger network through face-to-face CoP has proved beneficial.
  - A trauma informed approach has been more broadly incorporated in the ANFPP education to better prepare home visiting staff for their roles within a complex environment.
  - Successful client recruitment can be attributed to greater linkages within the community, improved ANFPP education, expanded referral and service delivery networks and additional marketing and promotional activities.
  - The employment of a male FPW in one site has shown an increase in father involvement and provided a strong male role model for the serviced communities.
  - The ANFPP has assisted mothers having previously removed children return to their care.
  - Mothers monitored by child protection services have successfully been able to maintain custody of their infant while participating in the ANFPP.
  - Sites have reported that implementing the DFV Pathway and application of DANCE has enhanced program delivery.
  - Integration of the ANFPP into the broader health service has been a success, with greater focus on the program being a holistic program that complements other primary health care services.
  - Organisations understand and acknowledge the importance of the program linking with other health service they provide.

- Those sites able to use telehealth reported that for some clients they had improved regular engagement
- Use of telehealth enabled clients who had moved out of the referral area, or gone to stay on country, to stay connected to the program and even complete the program.
- Sites were able to adapt materials to suit telehealth program delivery and ensure clients stayed connected to the program during COVID-19 movement restrictions.
- Those clients due to graduate during COVID-19 movement restrictions were able to stay connected with the program until they were able to be transitioned and connected into follow on services.
- Even with some redeployment, sites were able to maintain their client numbers and most sites continued to receive referrals.

- **Any plans to address workforce issues:**

The NPC continued to receive feedback from newly recruited nurses that indicated that they felt well supported at their sites and personally welcomed by the NPC education team. Newly recruited nurses also indicated that they felt supported by individual follow-up during their education journey. Nurse Supervisors have commented on the benefits of the face-to-face CoP for building strong relationships, supporting each other, strengthening communication channels and sharing ideas and approaches with their peers. It was also used as an opportunity to provide professional development. The Department will work with the NSS to explore future plans to address workforce issues.

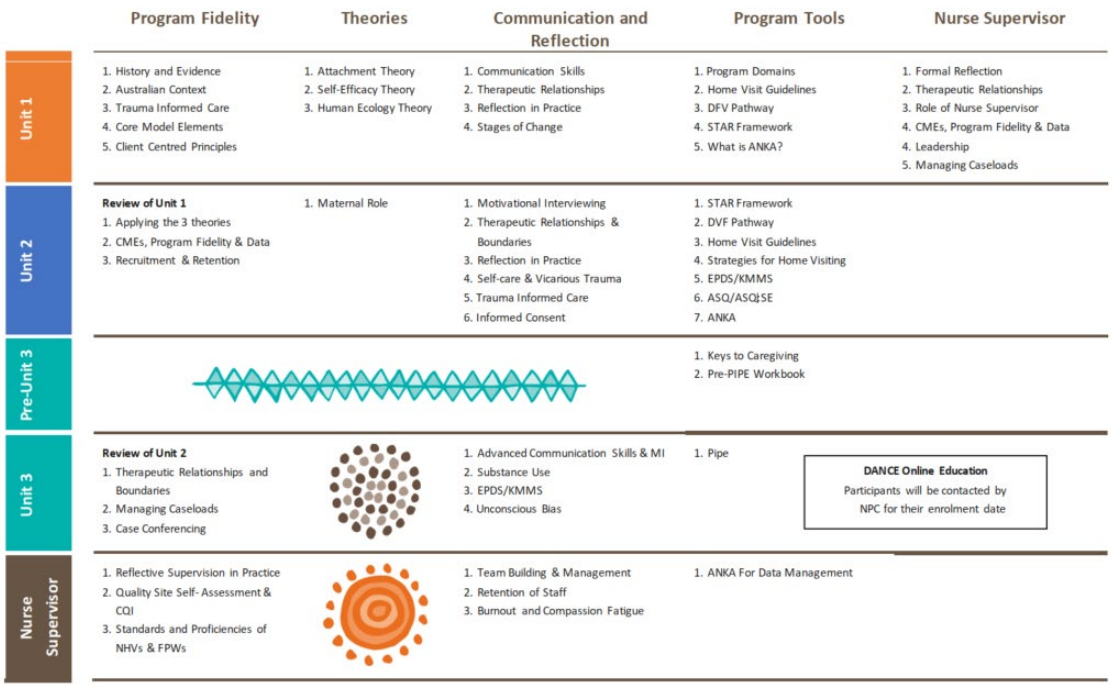
- **Continue to develop creative marketing and program promotion strategies.**

This area was not available for the NPC to provide comment.

NFP education

- **Briefly describe your NFP education curricula**

The NPC Core Curriculum for all ANFPP program staff was inclusive of Unit 1, Unit 2 and Unit 3 + PIPE Training. Additional training was scheduled for the Nurse Supervisors to ensure that staff management, supervision and team mentoring is covered within the Core Curriculum. Please see below the NPC ANFPP Education curriculum map (and provided as a separate attachment).



- **Changes to NFP education since the last report**

- The ANFPP Core Curriculum has been contextualised to ensure cultural safety and the inclusion of the relevant Australian Core Model Elements benchmarks, including the Family Partnership Worker role.
- Upskilling in Domestic and Family Violence pathway (DFV) training has been completed and is now embedded in the curriculum.
- Face-to-face Nurse Supervisor community of practice and professional development have been introduced.
- DANCE has been introduced and three training sessions were held during this reporting period.

- **Successes/challenges with delivery of core NFP nurse/supervisor education:**

The NPC were able to continue to provide core education to ANFPP staff during the COVID-19 movement restrictions. Adjustments were made to unit 2 and this was delivered virtually to ensure staff were able to start seeing clients.

- **Successes/challenges with ongoing (integration) NFP nurse/supervisor education:**

Site visits during this period were able to be tailored to specific site team's needs and enhanced education support was provided in collaboration with site NS. Many of the newly established sites were due to graduate their first clients; however, due to COVID-19, this was not able to happen as planned and will be completed when movement restrictions are lifted across the sites.

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

A key success has been the high rate of Aboriginal and Torres Strait Islander nurses employed in the ANFPP, which is significantly higher (13%) than the national rate of only 1.1%[2]. This rate is a positive for the program as it:

- builds and empowers the Aboriginal and Torres Strait Islander health workforce, a priority in Australia
- strengthens the cultural safety within the program.

Reflective Supervision

- **Successes/challenges with NFP nurse reflective supervision:**

Successes/challenges with delivery of core NFP nurse/supervisor education

Successes reported by the NPC:

The reflective supervision component in education has been strengthened throughout training for all staff and is providing greater clarity around definition and purpose.

Challenges reported by the NPC:

The FPW workshop identified that there is a mixed approach to reflective supervision for the FPW role. For example, some teams have group reflective supervision, some have the same as NHVs, some have reflective supervision through a senior FPW, some have an external cultural supervision, and some identified that they don't received any reflective supervision. Clarity around the ANFPP approach needs to be further explored with NS and implemented across sites to ensure consistency and compliance with necessary standards.

Successes/challenges with ongoing (integration phase) NFP nurse/supervisor education

Following NPC's involvement in the International Reflective Supervision Project and discussions with the International Consultant, it became evident the preparation of Nurse Supervisors for reflective supervision could be improved. A revised curriculum has been development with the following goals to:

[2] Australian Institute of Health and Welfare: Nursing and midwifery workforce 2015

- Support nurse supervisors in developing an understanding of their role specific to ANFPP.
- Support nurse supervisors to integrate and refine their knowledge and skills related to the ANFPP specific role.
- Support ANFPP nurse supervisors in developing and sustaining and effective workforce that achieves a high level of client outcomes through delivery of the ANFPP with fidelity to NFP principles and CMEs.
- Support ANFPP nurse supervisors in building strong nursing teams able to support their members in building/ maintaining expertise, skills and confidence in delivery of the ANFPP.
- Promote self-efficacy in ANFPP nurse supervisors in relation to their own continuing education and professional development.

Successes/challenges with delivery of NFP nurse reflective supervision

Successes reported by the NPC:

The reflective supervision component in education has been strengthened throughout training for all staff and is providing greater clarity around definition and purpose. Regular provision of reflective supervision to all Nurse Supervisors supports modelling and has assisted to increase confidence in their ability to support their staff with reflective supervision. The capacity of ANKA to collect data on reflective supervision is being enhanced.

Challenges reported by the NPC:

While nurses are familiar with the concept of reflection in practice as it relates to continued professional development (CPD) and ongoing registration, reflective supervision is not a concept most nurses are familiar with. Many new staff have never received reflective supervision before and feel ill equipped to provide it for staff. Reflective supervision has at times been one of the first things to drop off when organisations are under pressure e.g. issues with recruiting, large teams and lack of time etc. One of the challenges identified with introduction of CME 15 will be developing a model of reflective supervision for FPWs. Clarity around the needs of FPWs needs to be explored further.

- **Successes/challenges with reflective supervision to our supervisors:**

Successes reported by the NPC:

- Nurse Supervisors are currently receiving 1- 4 weekly reflective supervision sessions (depending on need) via Video Link and/or telephone.
- Nurse Supervisors are participating in monthly CoP teleconferences.
- Biannual face-to-face CoP between Nurse Supervisor and the NPC has been implemented. This has strengthened the relationship between the NPC and Nurse Supervisor. The October meeting also had a session with the Department of Health team, which was highly regarded by the NS group. NS's feedback was that they valued the opportunity to speak directly with the DoH team about the situation on the ground. The face to face meeting was adjusted to a virtual format for the April meeting and the DoH team were able to connect in.

Challenges reported by the NPC:

- NS working in the ANFPP are located across the country at 13 different sites; only two are located in the same city as the National Program Centre. Opportunities to meet face-to-face with Nurse Supervisors are restricted by distance and cost. This impacts on the ability to build trusting relationships between Nurse Supervisors and NPC staff; however, video link technology is being utilised for all reflective supervision sessions, which has proved beneficial.
- Staff shortages has created challenges around provision of regular reflective supervision by Nurse Supervisors; however, the NPC WDE team were able to provide support to teams to reduce this impact.

Any plans to address nursing workforce issues

The Department is planning to work closely with the NSS in 2021 to identify and address workforce issues or concerns, including approaching affected sites directly to recommend reaching out for

additional NSS support.

- **Successes/challenges with delivery of reflective supervision to our associated team members (Family Partnership Worker/Mediator) reported by the NSS**

The Department is planning to work closely with the NSS in 2021 to identify and address any concerns or issues relating to reflective supervision, including approaching affected sites directly to recommend reaching out for additional NSS support.

NFP Information System

- **High level description of our NFP information system, including how data are entered:**

There are no changes to report regarding how data is captured on 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 as reported by the NPC:**

With the focus on program outcomes, sites need to be encouraged to collect this data accurately and appropriately to ensure data completeness. Work was underway to develop and provide site access to client summary reports, socialise the data collection user manual, provide simulated ANKA training during the face-to-face education sessions, develop short instructional videos on ANKA use, add ANKA milestone matrix to education materials and develop a universal data repository. In addition, monthly data and information group meetings have been held. An ANKA super user group commenced to test developments prior to release. These activities aimed to improve the functionality of the ANKA system and its quality.

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

Fidelity Reports provide information to Nurse Supervisors, Nurse Home Visitors, ANFPP staff, and key stakeholders on program data. Our collection points are through Communicare and ANKA. Quality checks (exception reports) are completed monthly and prior to fidelity reporting.

Following feedback from implementing sites via the Data & Information Group, structure of the Fidelity Report was re-designed to improve presentation and consistency of fidelity reporting between ANKA and Communicare sites. The re-design is currently on hold during the transition period between the NPC and the NSS.

- **Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality as reported by the NPC:**

ANFPP National Knowledge Access (ANKA) System

ANKA refresh project: In September 2019, in response to feedback from users, NPC completed an internal review of ANKA and embarked on a refresh of the ANKA system.

The former NPC engaged an external ICT specialist support to help undertake the ANKA Refresh and to ensure the system fully meets users' needs. Client privacy and confidentiality was maintained throughout the process. Site representatives (from the Superuser group, Data & Information group and others who are interested) were incorporated in the process to advise, review and test planned changes to ensure that the refreshed ANKA platform met their needs. The NPC conducted the initial functional testing and then sites staff were involved in user testing (considerate of the burden on them).

The ANKA refresh project aimed to provide:

- Improvements based on user needs and advice
- Regular updates of phased releases through our Communications Manager
- Refreshed Support Centre information
- Advance advice of version update releases
- Version updates to ANKA

- Refreshed procedures
- Featured tutorials

The former NPC ensured sites were supported during these changes every step of the way as work was underway to improve ANKA usability, functionality and support. Sites were supported through this transition with access to Quick Reference Guides available for both the New OLE and ANKA, as well as new release notes for ANKA. Any questions were encouraged to be emailed to helpdesk@anfpp.com.au . User representatives from sites were being involved in the final user acceptance testing. Regular updates, final confirmations and reminders of cut-over times in the days leading up to the Go-Live were emailed to sites.

ANKA Refresh improvements reported by the NPC

- Improved menu navigation
- User adjustable Client Alias
- Updated Client Summary Page layout and navigation.
- Additional option in all data collection fields: no further data to be collected.
- Autosave functionality
- Additional Child Wellness Check options
- Updated Immunisation screens
- Additional External Services options
- Introduced live User Support options.
- Updated Team Activity functionality
- Introduced a Nurse Supervisor Dashboard
- Improved Quick Reference User guides

Continuous Quality Improvement (CQI) Program

- **Brief description of CQI processes:**

The NPC planned to enhance the continuous quality improvement process by using aggregated data to determine how the program goals are being met and to inform quality improvement strategies.

A Performance and Quality Plan was developed to implement the Performance and Quality Framework. The Quality Site Self-Assessment (QSSA) document was revised and Terms of Reference (TORs) developed for a Site Quality Improvement Group (SQIG). These documents guided Continuous Quality Improvement and identified the ways ANFPP stakeholders can contribute to Continuous Quality Improvement. SQIG was based on an international model. The group met several times during this reporting period on a monthly basis and provided clinical and professional analysis of data and clinical information by exploring all the sites that have been implementing the program to ensure license to fidelity and program outcomes are met.

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

The NPC used data to guide the program, inform continuous quality improvement, and demonstrate program fidelity. They also used it to access client outcomes, review clinical practice /reflective supervision, measure achievement of core program goals and guide the program by documenting the quality of service provision.

The Department is working closely with the NSS to gather, track and analyse fidelity report data provided by the ANFPP sites each quarter. This information will be used to identify trends in performance or flag areas of potential concern (such as workforce issues). If issues are identified during this process the Department will develop a plan of action and a way forward with the NSS and Department of Social Services.

- **Successes/challenges with our CQI approach:**

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

Any other relevant information:

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 Monitored /assured by: by signed informed consent	100% voluntary participation	Nil
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: referral data	100% (incl. first opportunity to parent and multiparous mums)	Nil
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: 100% are women pregnant with an Aboriginal or Torres Strait Islander child. This includes the socio-economic criteria of: women pregnant with an Aboriginal or Torres Strait Islander child. Application of these criteria are assured and monitored by: referral data and ensuring 100 % of mothers consented to the program are pregnant with a Aboriginal and/or Torres Strait Islander baby	100% clients enrolled who meet the country's eligibility criteria	Nil

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. 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	a) 87% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 77% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 25% of pregnant women are enrolled by 16 weeks' gestation or earlier	Client Referral pathways identified and reviewed through the Site Quality Improvement Group and QSSA processes implemented to ensure referrals are received as early as possible. The Department will continue to work with the NSS to improve progress against this benchmark.
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned an identified ANFPP nurse. The ANFPP Home Visiting team has a caseload range of between 15–20 clients. Technical, workforce, cultural and contextual guidance and funding considerations are considered in determining final caseload benchmarks appropriate for ANFPP. Client Retention: • Program retention is 60% or more through to the child's 2nd birthday as an average across partner organisations • ≥ 90% retention for pregnancy phase • ≥ 80% retention for infancy phase • ≥ 90% retention for toddler phase	100% of clients are assigned an ANFPP nurse. • In the 2019/20 reporting period program retention was 58% • 54% • 80% • 100%	Retention strategies for women in the pregnancy phase of the ANFPP needs to be explored via the SQIG meetings with individual sites. Inclusion of topics around program data, outcomes and CME benchmarks will be included in Community of Practice meeting agendas with NHVs, FPWs and NSs

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
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.	All clients are visited in the client's home as a minimum of once every four visits across the standard visit schedule (this equates to a total of 16 visits over the life of client involvement in the program, or 25% of completed visits). Home visiting teams acknowledge the importance of conducting visits in the place the client and her child sleeps most often on a regular basis throughout the program.	55% of clients were visited in their home. In some ANFPP sites, the home is not consistently considered the ideal place for home visits. Program content is often delivered in a car, on the veranda or in a suitable outdoor environment.	Nil COVID-19 caused the necessity to move to predominantly telehealth for program delivery, however nil problems without the social distancing restrictions of the recent pandemic
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard	National benchmarks for: a) Program visit dosage patterns in relation to client strengths and risks benchmarks are • Dosage: as per UCD Guidance Document, no benchmark will be set for expected number of completed visits. • Visit Schedule: as per UCD Guidance Document, the standard visit schedule will guide delivery of the ANFPP unless an alternative visit schedule is developed between a home visiting team and the client.	• 100% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is Pregnancy: 55%, Infancy: 63%, Toddlerhood: 46%	STAR framework will be introduced by June 2021

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	b) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase: c) Client attrition by program phase country benchmarks are: 10% attrition in Pregnancy phase 20% attrition in Infancy phase 10% attrition in Toddler phase	Length of visits by phase (average and range): • Pregnancy phase: 57 minutes • Infancy phase: 57 minutes • Toddler phase: 62 minutes Client attrition by phase and reasons: 39% attrition in Pregnancy phase 40% attrition in Infancy phase 21% 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. Monitored/assured by (eg standardized job description) 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.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on- going learning activities	100% of ANFPP nurses, Family Partnership Workers and nurse supervisors will complete the required ANFPP educational curricula and participate in on-going learning activities -	All core education attendance and progress are monitored through internal systems. 100% of ANFPP NHV, FPW and Nurse Supervisors currently working in the program have completed or are currently completing core education curricula.	Increased support and education to ensure regular reflective supervision for all team members. Data collection for reflective supervision will be reviewed with the data collection system update
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*.	Environmental health is a domain in which NHVs exceed the benchmark consistently across the pregnancy, infancy and toddlerhood phases. This can be attributed to the difficulties families experience in securing and keeping suitable and safe housing.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	It is expected that ANFPP nurses, and supervisors will apply the theories through current clinical methods/delivery of the program. There is no specific benchmark for this CME	This CME is not directly measurable. However, these theories are incorporated across the training curriculum and provide a focus for Community of Practice meetings.	Nil.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	A full time ANFPP supervisor can lead a team of no more than eight ANFPP nurses (including community mediators or similar positions where applicable) and a team administrator. The minimum team size is four ANFPP nurses with a half time supervisor	The 1:8 Nurse: Supervisor: Team ratio was exceeded at 5 sites.	Nil
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/ reflective supervision.	No benchmark. Monitored/assured by: Quarterly program fidelity reporting is used to track program fidelity.	Progress: More robust CQI activities are planned for 2021.	Nil.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
14. High quality NFP implementation is developed and sustained through national and local organized support	In principle, at least 85% of clients and their children should receive 100% of assessments and have their client record complete.	Monthly exception reporting is used to support Partner Organisation data quality which identifies where required actions have been missed (e.g. ASQ, and EPDS).	Nil.
15. ANFPP teams must employ Aboriginal and/or Torres Strait Islander Family Partnership Workers (FPWs) to support delivery of the program and who participate in reflective supervision.	100% of ANFPP teams employ Aboriginal and/or Torres Strait Islander Family Partnership Workers (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%	37%	14-20%	20%	10-15%	18%
Maternal Role (My Child and Me)	23-25%	22%	45-50%	41%	40-45%	38%
Environmental Health (My Home)	5-7%	10%	7-10%	10%	7-10%	11%
My Family & Friends (Family & Friends)	10-15%	14%	10-15%	13%	10-15%	14%
Life Course Development (My Life)	10-15%	14%	10-15%	13%	18-20%	14%

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

This area was not available for the NPC to provide comment.

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 – 42) 22	(13 – 43) 23
Race/ethnicity distribution	Indigenous: 89%. Non-Indigenous: 11%	Indigenous: 88%. Non-Indigenous: 12%
Father involvement	6%	5%
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)	279, 12%	293, 26%
Educational Achievement	Secondary Only: 37%. Post-Secondary: 29%. Missing 34%	Secondary Only: 29%. Post-Secondary: 28%. Missing 42%
Employment	264, 26%. Missing 61%	284, 30%. Missing 60%
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)	47, 23%. Missing 89%	39, 24%. Missing 92%
Severe Obesity (BMI of 40 or more)	47, 13%	39, 0%
Underweight (BMI of 18.5 or less)	47, 9%	39, 15%
Heart Disease	186, 10%	207, 4%
Hypertension	186, 3%	207, 3%
Diabetes – T1	89, 2%	133, 1%
Diabetes – T2	89, 2%	133, 3%
Kidney disease	186, 4%	207, >1%
Epilepsy	186, 2%	207, 1%
Sickle cell Disease	Not collected	Not collected

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Chronic Gastrointestinal disease	186, 1%	207, 1%
Asthma/other chronic pulmonary Disease	186, 24%	207, 22%
Chronic Urinary Tract Infections	186, 4%	207, 6%
Chronic Vaginal Infections (e.g., yeast infections)	186, 6%	207, 13%
Sexually Transmitted Infections	Not collected	Not collected
Substance Use Disorder	Not collected	Not collected
Mental Illness	186, 31%	207, 33%
Other (please define)		

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

This area was not available for the NPC to provide comment.

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)	140, (≥4, 33%), 0-9	21, (≥4, 33%), 0-8	84, (≥4, 44%), 0-9	34, (≥4, 41%), 0-8	19, (≥4, 63%), 0-8
Depression, (n, % moderate + clinical range)	140, (≥10&≤12) 11%), 0-22	21, (≥10&≤12) 10%), 0-18	84, (≥10&≤12) 12%), 0-21	34, (≥10&≤12) 15%), 0-19	19, (≥10&≤12) 11%), 1-23
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	85/222, 38%, 12	42/112, 38%, 9	-	30/89, 33%, 13	21/48, 44%, 12
Alcohol, (n, % during pregnancy, units/last 14 days)	Not collected	Not collected	Not collected	Not collected	Not collected
Marijuana, (n, % used in pregnancy, days used last 14 days)	Not collected	Not collected	Not collected	Not collected	Not collected
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

Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is 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, %)	225, >1%	177, 3%	119, 7%	97, 9%	
Breast Feeding, (n, %)	168, 64%	95, 62%	69, 50%	54, 50%	
Involvement in Education, (n, %)	127, 17%	87, 14%	62, 15%	61, 23%	
Employed, (n, %)	134, 13%	100, 20%	43, 44%	65, 40%	
Housing needs, (n, %)	140, 18%	103, 15%	67, 15%	65, 11%	
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 rates achieved in RCT, to equivalent populations etc)**:**

The NSS reports that there are significant problems with the current data systems that include both missing or incomplete data, as well as difficulties extracting data in a meaningful way. The NSS is working extensively to address these issues; but to date are unable to confidently provide comment on the impact of the program on client outcomes not already provided in this report.

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

Infants whose mothers received more than 5 visits during pregnancy had a low birthweight rate of 9%. Building the relationship during pregnancy supports engagement throughout the program and increases the likelihood of clients completing the infancy phase. This data highlights the importance of developing further strategies to increase the number of early referrals.

Utilising FPWs for reengagement visits and ensuring program participants are aware of services' open-door policies can improve client retention. One of the activities performed by FPWs is the initial consent visits. FPWs build trust and determine the most suitable nurse home visitor for each client in consultation with the nurse supervisor.

Which are the areas of challenge?

In Australia most women have their pregnancy confirmed by a suburban Family Physician (known as a General Practitioner of GP). The GP then refers the women to the local hospital who often do not see women until after 18-20 weeks. As many ANFPP referrals come from the local hospital midwives, the ANFPP

benchmark for referral into the program by 16 weeks can be challenging to meet. If participants are recruited later in their pregnancy, this reduces the time to build relationships with the home visiting team and to improve outcomes such as birthweight, and can also affect the retention rate. The Annual Data Report shows that only 26% of clients are referred by 16 weeks gestation. This is significantly below the acceptance target of 60% and highlights a significant challenge. However, the percentage of early enrolment has increased by 9% since 2017-18.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks gestation)	1	<1%
Very preterm (28-32 weeks gestation)	2	<1%
Moderate to late preterm (32-37 weeks gestation)	26	9%
Low birthweight (please define for your context)	46	15.5%
Large for Gestational Age (LGA) (please define for your context)	5	2.0%
Other (please define)		

Please comment below on your birth data:

This area was not available for the NPC to provide comment.

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	97.6%	Not collected	96.7%
Hospitalization for Injuries	0%	2%	1%	9%
ASQ scores requiring monitoring (grey zone)	Not collected	Not collected	Not collected	Not collected
ASQ scores requiring further assessment/referral	11% (04 months)	16% (10 months)	25% (14 months)	4% (20 months)
ASQ-SE scores requiring monitoring (grey zone)	Not collected	Not collected	Not collected	Not collected
ASQ-SE scores requiring further assessment/referral	3%	6%	9%	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

This area was not available for the NPC to provide comment.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts This area was not available for the NPC to provide comment.
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program. This can include collated client feedback, a case study or by clients providing video evidence etc. This area was not available for the NPC to provide comment.

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	Not collected	
Maternal death	Not collected	
Other	Not collected	

Any other relevant information or other events to report:

This area was not available for the NPC to provide comment.

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- Briefly describe your system for monitoring implementation quality;

National Quality Improvement Framework

Following the implementation of ANKA, a comprehensive review of the Data and Monitoring strategy was undertaken by the NPC. The Data and Monitoring strategy was merged with the Quality Framework into one document titled the 'Performance and Quality framework' which aims to:

- identify areas for improvement;
- support data collection and reporting against key outcome measures;
- generate outcome reports on aggregated data to track program outcomes;
- support the Continuous Quality Improvement process in all aspects of the program including education, program delivery and NPC performance; and
- promote ANFPP through relevant conference presentations and publications.

In 2018-19, a detailed Performance and Quality Plan was prepared to implement the performance and quality framework. The plan identified areas of improvement and potential actions to ensure continuous quality improvement in all aspects of program delivery. It provided a suite of activities and tools to ensure effective performance management and continuous quality improvement.

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

This information was not available from the NPC.

- Outcomes of CQI program for the reporting period

This information was not available from the NPC.

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

This information was not available from the NPC.

- **Goals for CQI in next year reported by the NSS:**

  - Ensure national conference aligns with ANFP program aims and provides a forum to make suggestions and identify opportunities for improvement regarding data collection and program practice.
  - Maintain key program management tools to manage risks and issues, and program quality.
  - Conduct quarterly meetings/visits with all program sites to support CQI activities that improve program effectiveness.
  - Facilitate data workshops during the virtual conference 2020 aimed at improving content and presentation of data in the quarterly (fidelity) reports.
  - Strengthening CQI processes is linked to improved data quality and fidelity reporting. Site visits and regular meetings focused on CQI activities will be important for strengthening relationships and CQI processes. NSS will offer Quarterly Site meetings (yearly visits).
  - Hold fortnightly SQIG meetings with each site participating twice per year to review progress and support with site specific CQI activities.
  - Re-establish Data Working Group and ensure genuine collaboration with site representatives.

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

Program innovations tested[1]:

Strengths and Risks Framework (STAR)

- STAR to be integrated into revised Home Visiting Guidelines, DFV resources and ANKA.
- STAR will be embedded into core education.

Dyadic Assessment of Naturalistic Caregiver-Child Experiences (DANCE):

- ANFPP has implemented DANCE.
- Two DANCE champions provide support to staff completing DANCE training or using DANCE.
- The DANCE training can be renewed online which will be helpful given the geographic diversity of sites in Australia.

Home Visit Guidelines Contextualisation project

- The Home Visit Guidelines V4 are available on the OLE incorporating finalised feedback from the field.

Domestic and Family Violence (DFV)

- The adaptation and contextualisation of the DFV materials was completed and is embedded in the curriculum.

Program innovations implemented:

The program pivoted to a predominately telehealth model. Telehealth had not formally been introduced to ANFPP but was rapidly implemented to support the program during the COVID-19 pandemic. Majority of sites were unable to conduct site visits but were able to connect with clients through telehealth.

- Introduction of telehealth in response to COVID-19, sites were provided with guidance documentation to support implementation along with site-based workshops to support staff implementation.
- Adjustment of Core Education – unit 2 adapted to a virtual format to ensure new staff can deliver ANFPP to clients.
- ability to identify telehealth visits due to COVID-19 in the data.
- Improvements to the DFV data collection enabled ability to identify who was using violence (sites have reported client using violence) and the actions taken to support the client.
- Development of FPW needs assessment.
- Implementation of smoking cessation online education package.

Findings and next steps:

The STAR guidance document was reviewed outlining specific tools for Australian context and STAR project plan identified.

Trauma-informed Care and practice has been incorporated into the broader curriculum with online module in Unit 1 and face to face session in unit 2.

ANKA refresh released enhancements to the usability of ANKA, NS reporting abilities and ensuring identification of missing data.

The National Support Service (NSS) priorities over the next reporting period:

NSS has identified a number of areas that need attention and intends to undertake future reviews whilst continuing to deliver key activities.

A summary of key focus areas in the 2020-2021 financial year are as follows:

Stakeholder Engagement:

Improve engagement of the leadership group by shortening meeting time to one hour; providing briefing papers on all matters of importance one week prior to the Leadership Group meeting; and seeking the support of the rotating chair to encourage communication and participation by CEOs. Engagement of site staff will also be enhanced by restructuring the delivery of the monthly Community of Practice meetings.

Data Systems and Reporting:

The vision is to build and maintain a high quality ANFPP dataset that fulfils end-user needs in Australia (ANFPP program sites, Department of Health, NSS internal requirements) and internationally. Key focus areas include:

1. Data accuracy, reliability and data completeness,
2. Data collection of items that fit the ANFPP purpose e.g. empowerment (mastery),
3. Timeliness and relevance of datasets and
4. availability and Accessibility of the dataset by the end users.

These key areas will be achieved through the following key projects:

- The new Data Quality Reports deal with data errors and the new Data Completeness Tool provides sites with an opportunity to complete data fields identified as missing
- New Look Fidelity Report
- Reconvene the ANFPP Data User Group
- Communicare Forms Project to update the communicare forms and produce an updated formal definition of the ANFPP program dataset
- Developing and delivering data education for program sites
- Strengthening site visits and CQI processes
- Utilising OLE as a role as a data education and data sharing mechanism for the program
- Exploring data collection extension to fit ANFPP purpose for example empowerment/mastery and child development.

Workforce Development, Education and Site Support:

The vision of the NSS Education Team is to have a robust, culturally safe, highly skilled, effective and consistent ANFPP workforce. The NSS Education Team is committed to fostering trust, connection, partnership and growth within the relationships we build with each other, our stakeholders and the staff in ANFPP sites. In working toward this vision between January 2021 and July 2022, the NSS Education Team will focus on the following four key areas:

1. Clarify and strengthen the cultural safety of ANFPP standards, tools, practices and education content
2. Improve the knowledge and skill level of ANFPP staff
3. Enhance processes for the recruitment and improve strategies for the retention of the ANFPP workforce
4. Create and maintain relationships between the NSS, ANFPP staff, non-ANFPP staff at sites and our NFP international societies

These key areas will be achieved by focusing on the following key projects:

- Strengthening Core Education through revision of content of Unit 1, 2 & 3, creating new education modules on Data collection, RS, introduction of STAR and Kimberley Mums Mood Scale' (KMMS) and exploring the use of ASQ-TRAK.
- Ongoing Professional Development & Site Support and
- Continuous Quality Improvement

Please see 2020-2021 NSS Curriculum map below for further details:

There are new education sessions on Psychological safety and self-care, Cultural Contextualisation, Trauma informed care and compassion fatigue introduced to support team members to remain highly functional in their roles in the ANFPP. A focus on addressing the previously identified gaps in reflective supervision including education, mentoring and skills development has been embedded in regular NSS activities such as Community of Practice meetings, RS for all Nurse Supervisors.

Reflective supervision for all Nurse Supervisors is available with highly skilled and experienced NSS team members including Clinical Psychologists, Clinical Lead and FPW Educator. Team based group supervision is available when requested to support teams in complex situations i.e. when supporting a mother/family who have experienced a loss.

Reflective supervision training for all ANFPP team members will be commenced in 2021 to ensure a greater understanding of the requirements and benefits of Reflective Practice in the ANFPP. FPW educator is available for reflective supervision with FPW and team leaders as requested by individual teams. The 2020-21 ANFPP Education Curriculum is provided below and as a separate attachment.

2020-2021 ANFPP Education Curriculum

Nurse-Family Partnership

Australian Nurse-Family Partnership Program

	Program Fidelity	Theories	Communication and Reflection	Program Tools	Scope of Practice
Unit 1	1. History, Evidence and Australian Context 2. Trauma Informed Care 3. Core Model Elements 4. Client Centred Principles	1. Attachment Theory 2. Self-Efficacy Theory 3. Human Ecology Theory	1. Communication Skills 2. Therapeutic Relationships 3. Reflection in Practice 4. Stages of Change	1. Program Domains 2. DFV Pathway 3. Home Visit Guidelines and materials 4. STAR Framework (2021)	1. Roles in the ANFPP (2021)
Unit 2	**Review of Unit 1** 1. Applying the 3 theories 2. CMEs and Program Fidelity 3. Data collection in the ANFPP	1. Psychological Safety and self-care in ANFPP 2. Maternal Role	1. Motivational Interviewing 2. Therapeutic Relationships and Boundaries 3. Reflection in Practice 4. Trauma Informed Care	1. STAR Framework (2021) 2. DVF Pathway 3. Home Visit Guidelines 4. Strategies for Home Visiting	1. Learning and Development plan (2021) 2. Cultural contextualisation in the ANFPP
Pre-Unit 3				1. Keys to Caregiving 2. Pre-PIPE	
Unit 3	**Review of Unit 2** 1. Therapeutic Relationships and Boundaries 2. Managing Caseloads 3. Case Conferencing	1. Neurological Development in the Infant	1. Advanced Communication Skills and MI 2. Compassion fatigue why you matter in the ANFPP	1. DFV pathway 2. PIPE 3. Perinatal Mental Health and Screening - EPDS/KMMS 4. ASQ/ASQ:SE and ASQ-TRAK	1. Learning and Development plan review (2021) **DANCE Online Education** Participants will be contacted by NSS for their enrolment date
Post-Units				1. DANCE online education 2. DANCE monthly integration webinars	
Nurse Supervisor	1. Reflective Supervision in Practice 2. Quality Site Self- Assessment and CQI 3. Standards and Proficiencies of NHVs and FPWs		1. The many hats of a Nurse Supervisor 2. Team Building and Management 3. Retention of Staff 4. Burnout and Compassion Fatigue	1. Data Management	1. Supporting teams with Learning and Development plans

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

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

RCT or equivalent commissioned Research
Research team and their institutions: *Not known at this time.*
Brief outline of research methodology: *Not known at this time.*
Details of progress to date: In March 2020, the Department approached the market to engage a supplier to undertake an evaluation of the ANFPP utilising the evaluation design delivered to the Department by a consultancy consortium led by Urbis, in October 2019. The evaluation design involved consultation with a broad range of ANFPP stakeholders including the University of Colorado. However, due to the COVID-19 pandemic, many organisations interested in applying were required to prioritise their response to COVID-19. The Department decided to postpone the approach to market to ensure all organisations had the ability to apply. In September 2020, the Department approached the market for a second time and the tender for applications closed on 9 October 2020. The Department is currently assessing applications received and expects to engage an evaluator in January 2021.
Expected reporting period and consultation with UCD prior to publication: Not known at this time.

PART FIVE: ACTION PLAN

LAST YEAR:

Our planned priorities and objectives for last year:

- Support for all sites to implement and deliver the program, targeted to each site's specific phase of implementation.
- Ongoing workforce training for current and new program staff.
- Finalising a design for an evaluation of the ANFPP.
- Complete the Request for Tender for the ANFPP Support Service.
- Engage an evaluator to conduct the evaluation of the ANFPP.
- Finalising, monitoring and updating of program materials.
- Developing and implementing strategies to improve early referral rates for clients and healthy birthweight outcomes.
- Aligning program outcomes to the priorities raised through the Closing the Gap refresh agenda and next iteration of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

Progress against those objectives

- NPC provided specific support to sites to implement and deliver the ANFP Program.
- The evaluation design was completed and a tender to engage an evaluator is currently underway.
- The Charles Darwin University (CDU), Molly Wardaguga Research Centre was successful in obtaining the National Support Service (NSS) tender.
- Despite the challenges the Australian COVID-19 response presented, CDU successfully completed a five month transition from the NPC into the National Support Service role.
- Ongoing work within the NSS to strengthen the ANFPP data systems to better identify areas of improvement to enable sites to develop strategies to improve outcomes for their clients.
- On July 2020 the National Agreement on Closing the Gap was signed by the Coalition of Aboriginal and Torres Strait Islander Peak Organisation and Australian Governments that include 16 socio-economic targets that include outcomes and indicators. The ANFPP links to Outcome 2: Children are born healthy and strong; Outcome 4: children thrive in their early years; through linkages and referrals made by Nurses the program can influence Outcome 12: children are not overrepresented in the child protection system; Outcome 13: families and households are safe. The document can be found at www.closingthegap.gov.au
- The Department is working in partnership with Aboriginal and Torres Strait Islander health experts to develop a refreshed 10-year National Aboriginal and Torres Strait Islander Health Plan. The Health Plan will provide a single, overarching policy framework for Aboriginal and Torres Strait Islander health to drive progress against our Closing the Gap commitments. It is anticipated that development of the refreshed Health Plan will be completed by mid-2021.

Reflections on our progress:

- Minor priority changes due to the COVID-19 pandemic meant the ANFPP evaluation tender experienced a delay. The Department advised the UCD of the change in priorities to allow all potential tenders the opportunity to apply.

NEXT YEAR:

Our planned priorities and objectives for next year:

- Support for all sites to implement and deliver the program, targeted to each site's specific phase of implementation.
- Engage an evaluator to conduct the evaluation of the ANFPP.
- Increased focus on site performance and sites engagement with the program.
- Increased focus on data collection and undertaking tracking and analysis of fidelity report data.
- An increased focus on maternal smoking and a clear plan for how the program will contribute to reducing these figures.
- Utilising the Leadership group to explore
  - induction training and support for newly recruited Nurses
  - reflective supervision for Nurses and Family Partnership Workers
  - Nurse supervisor and Nurse ratios factoring in Family Partnership Workers.

Measures planned for evaluating our success:

- All 13 sites are fully operational and appropriately staffed to support the growth of client numbers and effective delivery of the program.
- An evaluator has been engaged and has begun the evaluation of the ANFPP.
- A clear understanding of site performance and any areas of concern or additional support required.
- Fidelity report data and performance/progress reports show strong performance and engagement with the program.

Any plans/requests for program expansion?
Not at this point in time.

FEEDBACK FOR UCD INTERNATIONAL TEAM:

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

- Support and participation on the ANFPP National Support Service (NSS) tender.
- Support and guidance for the NSS and the NSS Clinical Lead.
- Support and feedback on the Evaluation design.

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

- Australia would be interested in working with the University of Colorado to explore options for increased engagement of fathers, partners or other family members in the NFP program. An increased participation of these support networks would acknowledge the complex social and familial aspects to pregnancy, birth and new motherhood.

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

- Continual engagement and support through the first stage of the evaluation.
- Providing technical advice for the ANFPP Evaluation tender process.
- Continual direct guidance and clinical support for key personnel within the National Support Service.
- Continual 1:1 Mentorship with Clinical Lead.
- Contribution to the 2021 Annual National Conference.
- Supporting the Data Team to ensure a high functioning and well utilised data collection system.

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

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: • Advice and guidance to Clinical Lead throughout the year since appointed through mentoring and consultation calls • Support to consider strengthening the role of FPW, A review of CQI processes in monitoring site implementation, inclusion of STAR and Reflective Supervision into the program delivery • Collaborative planning and delivery of the 'Virtual 'conference on NFP Data for new NFP nurses and mediators • Responses to ad hoc questions and requests for documents etc. • Access to NFP International website and resources, Clinical Advisory Group, COVID-19, International Research and Analytical Group COVID-19 working group and other International collaboration. • Involvement in DOH ANFPP National Support Service (NSS) tender. process • Support and feedback on the Evaluation design.
Identified strengths of program: • Strong and rigorous DOH process for appointing NSS • Appointment of a highly skilled team based in Charles Darwin University (CDU) Molly Wardaguga Research Centre, closely connected to the populations served, with strong Leadership and an international, reputation in research. • A team with direct experience of NFP program delivery and with members from the Aboriginal and Torres Strait Island community NFP serves • Clearly identified priorities for improvement and action plans outlined and in progress; developed in conjunction with the NFP workforce • Reflective Supervision being developed further to reflect Australian context and embedded in practice • Review and overhaul of NFP Information system in conjunction with end users (NFP Teams) • The early employment of CDU Academics to explore elements of the program to enhance program delivery • Continuity of excellent care throughout COVID-19 • Leadership group. New format working well
Areas for further work to be discussed via The Leadership Forum: Parental smoking and pre-term and low birthweight

• Partner and Family Involvement in program delivery. Sharing with others Australian experience and learning from others
Agreed upon priorities for country to focus on during the coming year: • Nurse attrition; undertaking an internal reflection process and then looking to learn from other implementing countries with similar challenges. • Information System and Data collection and the promotion of further ownership of NFP data by nurses and sites. • Continued support for site development and QI processes through forging closer links with sites and teams to identify and support local priorities • Further utilization of Leadership Group to support high quality Implementation
Any approved Core Model Element Variances. As there was no time for discussion at The Annual Review regarding any ongoing evaluation of these , we would appreciate an update at a later date; Ideally to be decided at the next Leadership meeting. CME#9 Family Partnership worker CME#2 Multiparous women eligible for program CME#15 FPW Authorized additional Model Element role supported by Supervision and Education
Agreed upon activities that UCD will provide through Support Services Agreement: As listed previously and agreed ; • Continual engagement and support through the first stage of the evaluation. • Providing technical advice for the ANFPP Evaluation tender process. • NFP Research Seminars led by Dr Olds • Continual direct guidance and clinical support for key personnel within the National Support Service. • Continual 1:1 Mentorship and support with NFP Clinical Lead. • Contribution to the 2021 Annual National Conference. • Supporting the Data Team to ensure a high functioning and well utilised data collection system. • Ad hoc guidance and access to NFP information as required

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