LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL

Evaluation of the Integrated area-based Health Systems for children and young people in Out of Home Care Mallee

Progress report 2
May 2021

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Acknowledgement

We would like to acknowledge that we are on Country of First Nations peoples. We acknowledge the beautiful and unique Country, waterways and animals of these landscapes. Elders of these communities and their Ancestors are the continuing traditional custodians. We acknowledge their living culture and their continuing roles in the life of these communities.

Table of Contents

Executive summary

In September 2019, La Trobe University was approached to conduct an evaluation of the Integrated area-based Health System (IHS) project in the Loddon Mallee. The aim of the IHS project remains solidly on improving health outcomes of children and young people in Out of Home Care, extending beyond a narrow focus on medication use. The evaluation would span the initial two years of a 10-year project design, testing and assessing developed Theory of Change frameworks, accompanying Plan-Do-Study-Act cycles, and a series of distinct system elements (nine in total). Each system area is focussed on improving and streamlining access to relevant healthcare assessments, engagement of healthcare professionals, and preventing hospital admissions. An initial focus on medications as a determining criterion for project eligibility was abandoned around August 2020. At that stage it became clear that identifying eligible children and young people were more challenging than anticipated. The scope was broadened to trial existing systems and pathways for children and young people in Out of Home Care accessing healthcare services in general.

Integration of care and systems is a challenge at the best of times, particularly the range of different legislative requirements and frameworks to work within. COVIC-19 added an additional disruption, whilst conversely, twenty months into the project, a series of not just challenges but also enablers surfaced.

The dedication of professionals in designated roles to carry the IHS project forward is a key driver for progress made and maintaining momentum. Obtaining relevant health information from child protection practitioners remains a challenge. This can include a seemingly simple task of locating a Medicare number to complexity around consent and sharing sensitive health information. Health needs for children and young people involved with statutory service delivery and case managers' perceptions of best practice needs further development. Despite these challenges, impromptu work-around solutions to, for example, engage carers and young people in the project are appearing. It does not mean these solutions can be elevated to systematic responses. They do provide informative data elements that could be captures as part of a series of PDSA cycles. Unfortunately, the actual development and operationalising of PDSA cycles has suffered and in turn, impacted on capturing valuable project-related information to inform the efficacy, optimal mechanisms, and effectiveness of proposed change. With only four months left as part of the original project timelines, it is time to engage other stakeholders into the project, in formal and informal capacity, to test project enablers and change makers. This could include potential funding providers for

continuation of the project to ensure its implementation and accompanying measures are properly tested to prove impact.

Finally, equally important is the need for lateral thinking for engaging partners like Department of Education and the broader Out of Home Care service sector, to ensure that children and young people receive maximum support and opportunity to access health services and relevant professionals, create broader system integration, and improved health outcomes for children and young people in the Mallee region.

Recommendations

This part consists of two distinct lists of recommendations, one containing new recommendations, current as of 1 May 2021 and one providing an overview of the previous list of recommendations (progress report 1, October 2020), and their respective status updates.

Status of recommendations from 1st progress report dated October 2020.

Recommendations reported in first progress report, accompanied by current status quo, seven months later:

1. Regular collection and provision of data to inform project progress (for example, as part of Plan Do Study Act (PDSA) cycles), can also constitute a 'performance indicator', adopting it as an integral part of existing reporting systems.
   => <u>Outcome to date</u>: Some information has been gathered, with system 4 providing the most information and content to date. This recommendation is carried across to this report, with focus on collecting relevant information as part of new PDSA cycles to be implemented and operationalised.
2. Ensure stronger governing focus of Clinical Advisory Group (CAG) and reduced operational focus. Interweaving PDSA and data cycles, and particularly regular discussion of the *study* element, will facilitate stronger focus on oversight and guidance.
   => <u>Outcome to date</u>: This has not happened yet. Due to lack of PDSA cycles developed and opportunity for studying results, as well as infrequent occurrence of CAG meetings. Recommendation is carried across to this report.
3. Targeted resourcing of critical systems enabler at 'coal face' of the project (I.e., administrative support for sourcing relevant client-related information for adding to referral form) to better streamline and expediate CYP accessing the project.
   => <u>Outcome to date</u>: HEAC role has been used as support for gathering client-relevant information and as conduit between Health Navigator and child protection staff. Formalisation of role and embedment in project has not occurred. Inclusion of newly developed Child and Family hub in Mildura may act as a substitute for this resourcing requirement.
4. Stronger involvement and identification of external stakeholders relevant for longevity of project (from a funding point of view, but also extension of system changes across sectors, for example, child and maternal health, Department of Education (DET).

=> Outcome to date: Soft engagement has occurred with some potential stakeholders by Project Coordinator. Formal inclusion and agreed engagement strategy and approach has not been articulated for assessing relevance and effectiveness.

5. Immediate provision of mentoring and education to child protection staff in relation to health systems, IHS project and critical importance of a shared responsibility in terms of successful implementation.

   => Outcome to date: Happens ad hoc and infrequent. Often learning is by virtue of being reminded of project requirements and requests for information by Health Navigator or HEAC. No systematic approach to education or mentoring for child protection staff regarding importance of health assessments and minimum data set required.

6. Consider impact of Flinders University's project (data algorithms) on progress of the Integrated Health Systems (IHS) project in relation to time allocated to provision of data requested, and diversion of focus.

   => Outcome to date: Data algorithm project appears to have shifted its focus and no longer hinders IHS project's progress and focus.

7. Greater involvement from management of auspice organisation in providing guidance and direction to role of Health Navigator.

   => Outcome to date: Involvement from line manager of auspice organisation with role of Health Navigator appears more deliberate, intent and structured. Direct line management responsibility has changed to the newly created position of Clinical Operations Manager (early May 2021), who will be invited to become a member of both governance structures.

8. Engage Centre for Excellence for Child and Family Welfare to promote project whilst creating momentum for the project's findings and recommendations by lobbying for an advocacy role to enable real system change.

   => Outcome to date: This has not happened yet. Recommendation to be carried across for tabling at CAG meeting and discuss relevance with remaining time left in the project.

9. Delay finalisation of project evaluation due to impact of COVID-19 and in recognition of slow uptake of referrals, with six to nine months, dependent on necessary approvals and by formal mutual agreement between Sunraysia Community Health Services (SCHS) and La Trobe University.

   => Outcome to date: Has not been finalised or agreed upon yet. This ties in with decision around end date of project trial (scheduled for around November 2021), subsequent steps, and wrap-up of governing structures, dedicated roles, formal notification to project stakeholders, and warm hand-over of CYP within the project and their carer.

10. Ensure reporting mechanisms (frequency, content, directionality, level of detail) are conducive for capturing relevant project elements and quality improvements.

    => Outcome to date: Reporting, in particular informal information provision, has improved since the last report. With scope expansion, function change, role sharing (HEAC and Health Navigator, in particular) and identification of external stakeholders – soft engagement-, unreported and undocumented engagement and information sharing occurs steadfastly, which is a natural by-product of a project of this size. Focus will need to continue to be on ensuring critical elements are shared, reported and recorded.

11. Provide clear parameters around role and function of Health Navigator, including delineation between role of Health Navigator and Health Coordinator, as well as unambiguous and function-specific deliverables and expectations.

    => Outcome to date: With the introduction of the HEAC role as conduit between Health Navigator and child protection staff, and in a supporting role for the Health Navigator in terms of engaging with external OoHC case managers, the specific role requirements of the Health Navigator have diluted further. Expectations regarding role-specific outcomes appear not delivered. This is partly due to lack of autonomy and authority when engaging with child protection staff and OoHC case managers.

12. The pivotal role of the Health Navigator requires considerable leadership and support in order to position the project well for reaping maximum success. Initiation of a Community of Practice for practitioners in similar roles across the state may be a helpful peer support mechanism.

    => Outcome to date: No follow-up has occurred regarding exploring external (peer) support options for the role of Health Navigator. To negate disenfranchising, relevant support mechanisms are needed to empower current incumbent.

13. Amend project plan following broadening of scope as matter of priority.

    => Outcome to date: Project plan has not been amended since recommendation. Recent developments regarding inclusion of local paediatrician and other healthcare professionals co-located in Child and Family hub in Mildura, may present additional project amendments for inclusion.

14. Consider development of a position statement regarding how the project and its stakeholders conceptualise health. Does the role and experiential element of wellbeing warrant formal inclusion, and how does it extend to First Nations worldviews?

    => Outcome to date: This has not been considered or formally addressed yet. Communication was sent by Susan Webster – Honorary Research Fellow- on 6 November regarding need to discuss, which hasn't been followed up. Despite the project moving into

the final stages, conceptualising health in a formal manner remains vital for project extension (in whatever capacity) or replication.

Recommendations as part of 2nd progress report (May 2021)

An overview of a new series of recommendations provided at the 15-month mark, to accompany the previous set of recommendations, is listed here:

1. Ensure relevant and timely information is relayed to all stakeholders through open lines of communication via formal and informal communication channels (e.g., emails, weekly touch-base opportunities, governance meetings) to maintain momentum.

2. Prioritise stakeholder engagement and involvement of local and regional partners to strengthen the integration of system opportunities and involve new local service providers.

3. Place stronger emphasis on incorporating and prefacing learnings from other (similar) health integration projects like Hume Moreland and consider inviting key stakeholders to (part of) planning session.

4. Proactively explore referral pathway opportunities for children and young people through the Child and Family hub in Mildura, which could act as a conduit for accessing healthcare assessments in lieu of uncertainty as to future role of Health Navigator role for remainder of project. This includes:

    a) Capture conversations and negotiations in relation to process and decision-making around children in scope.
    b) Development of a flowchart to structure updated system pathway for young person in OoHC entering the hub.
    c) Articulation of a plan regarding (warm) handover of existing 10 children accessing the project trial.
    d) Agreement on realistic and practical timelines.
    e) Forward planning to ensure strengthening of system integration beyond the end date of the project trial.
    f) Communication strategy for engagement with local GPs and General Practices.

5. Review and define series of optimal and suboptimal outcomes as part of two-year trial phase of the project. This should be, based on progress so far, partnership opportunities, broader sector engagement, and project extension opportunities. This enables:

    a) Joint agreement on set of acceptable and mutually beneficial outcome indicators to measure progress against.
    b) Development of outcome indicators for next iteration of the project that are useful and relevant.

6. Design a specific PDSA cycle to capture the Health Education and Consultation (HEAC) role as part of the project. This will also assist to:

    a) Provide transparency around resource allocation towards this role.
    b) Ascertain financial status quo of the project, including commitment of resources. to specific roles and functions that need to be accounted for in the overall feasibility of the project.

7. Design of output and outcome overview as per original evaluation plan, developed by DHHS, by evaluators, with the idea to:

    a) Table at remaining governance meetings for information purposes.

8. An outstanding recommendation from the first progress report is the identified need to define the collective understanding of 'health and wellbeing', to ensure cultural relevance, humility and appropriateness. The recommendation carries over to this progress report and remains salient now the project moves into the next phase where stakeholder engagement widens, and eligibility criteria will be critical elements to structure access and referral pathways.

List of abbreviations and key terms

CAG	Clinical Advisory Group
CFSS	Child and Family Service System
COM-B	Capability Opportunity Motivation – Behaviour
CRM	Client Record Management
CP	Child Protection
CYP	Children and Young People
DET	Department of Education
DHHS	Department of Health and Human Services[1]
DFFH	Department of Families, Fairness and Housing
EIR	Essential Information Record
HEAC	Health Education and Consultation
HREC	Human Research Ethics Committee
IHS	Integrated Health Systems
LAC	Looking After Children
LTU	La Trobe University
OoHC	Out-of-Home Care
PCG	Project Control Group
SCHS	Sunraysia Community Health Services
ToC	Theory of Change
ToCA	Theory of Change Analysis

[1] Department of Health and Human Services had a name change to Department of Family, Fairness and Housing, as of January 2021

Outline of the commitment and project purpose

The purpose of the evaluation of the Integrated area-based Health Systems project for children and young people (CYP) in Out of Home Care Mallee (OoHC) undertaken by the Department of Families, Fairness and Housing (DFFH; Previously Department of Health and Human Services, DHHS), Population Health and Wellbeing Mallee, and Sunraysia Community Health Services (SCHS), is for systems learning and improvement. It echoes the project's purpose, designated in the original business case as being:

> *To oversee Mallee Child and Family Service System quality governance including the establishment of quality structures, systems and processes that will promote a quality culture and will support the achievement of improved outcomes using a systems level approach.*

The goal of the project is to inform future directions for systems development and provide information to strengthen future funding applications to support ongoing quality improvement approaches in health service design and delivery for CYP in OoHC in the Mallee area across nine service systems of interest for CYP in OoHC:

1. Identifying and monitoring children in OoHC for whom a medical practitioner prescribes medication[2];
2. Collecting and maintaining child health records in OoHC including systems for the sharing of child health information between DHHS Mallee Child Protection and OoHC Placement Support;
3. Referring children and young people from OoHC to SCHS;
4. Clinically assessing child health needs;
5. Developing and implementing health care plans and reviews;
6. Healthcare delivery to children from OoHC at SCHS, including ways of supporting carers to manage children's medication;
7. Referral by SCHS to other health service providers;
8. Tracking children's actual receipt of health care services;
9. Monitoring carer and child experiences of health system accessibility, quality and effectiveness.

La Trobe University project team

[2] Since the scope extension regarding eligibility of CYP for the project as of August 2020, focus of project is no longer solely on children's medication.

Since the last progress report, a change in personnel has occurred within the La Trobe University project team. Due to personal circumstances, Dr Bonnie Giles had to take a leave of absence. Ms Emma Gordon has since joined the project team (Dr Modderman and Dr Vogels) and focussed on thematic coding of the first round of semi-structured interviews held late 2020.

Ms Emma Cordon

Emma has a Bachelor in Psychological Science (Hons) from Deakin University which she completed in 2019. As part of her thesis, Emma undertook a collaborative research project with the Monash Centre for Health Research and Implementation (MCHRI). She has a keen interest in facilitating behaviour change at the population-level and is especially interested in knowledge transfer/implementation science. Emma enjoys working with multi-disciplinary teams, and brings considerable experience working with qualitative and quantitative data sets in the context of rural and regional health. Emma is living in rural Victoria and involved as research assistant with various projects within the La Trobe Rural Health School.

COVID-19

Despite considerable relaxation of restrictions since the onset of the COVID-19 pandemic occurring from early 2021, effects as a direct result of the pandemic still abound in May 2021. Despite the allowed return to 100% office attendance by public government staff in April, the previously identified co-location of the Health Navigator with child protective services did never eventuate. One of the immediate results was a continued unawareness of child protection frontline staff in relation to the purpose and value of the project and limited engagement with the Health Navigator.

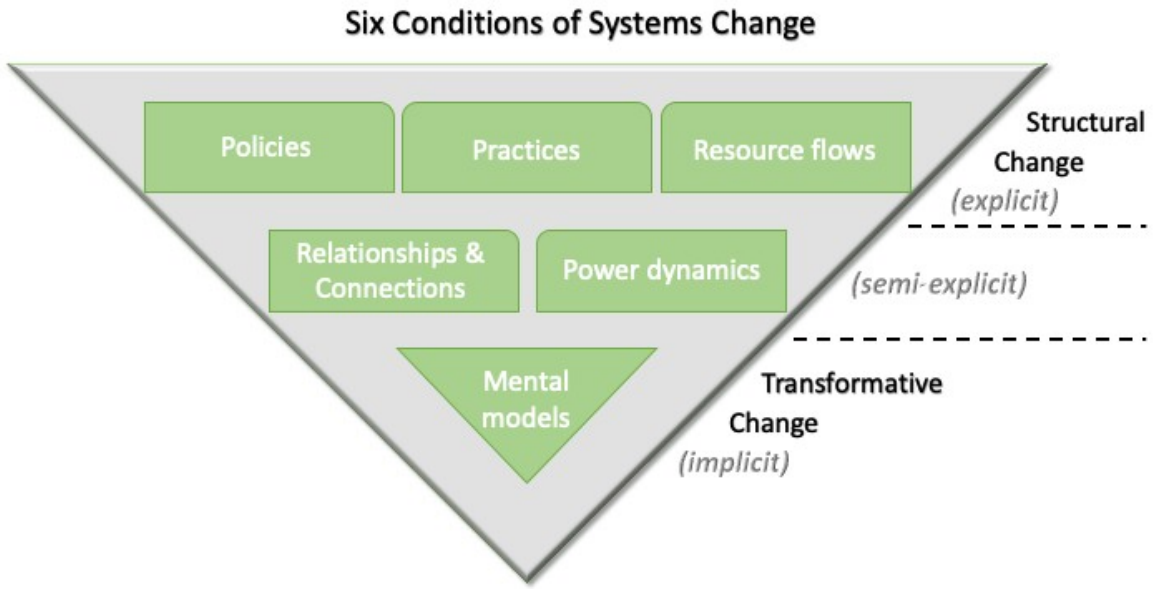
Project stocktake as of May 2021

The remainder of this report will provide an overview of progress made since the last progress report in October 2020, including critical time points, key enablers and challenges, and other observations worthwhile reporting. Areas reported on in the previous report have been updated and amended, wherever and whenever relevant.

Progress and detail have been added and specified in the context of the identification of ten children within scope, and possibly eligible to participate in the project, a critical milestone achieved by 23 February 2021.

Change

The Integrated area-based Health Systems project positioned change to be about people, values, and organisational culture. To that extent, the project evaluation set out to capture change by identifying and subsequently populating six distinct indicators amounting to systems change. These indicators comprise three subsequent layers to culminate in transformative change. A visual depiction of achieving systems change is displayed in the diagram below.



A series of related transformative change elements will be discussed in more detail, dependent on their applicability over the last six months (Nov 20 – May 21).

Policies

No policy changes have been made over this last reporting period November 2020 to May 2021 that may directly impact the project.

Practices

Practices have not changed particularly. The collection and recording of additional health-related information of CYP in scope of the project by child protection staff, is not systematically happening. Upon being reminded by line management or Health Navigator, some improvements have been

observable, but unfortunately nothing systematised or continuous, becoming part of everyday practice. Existing systems and legislations trump opportunity for targeted information gathering.

Resource flows

The roles of Health Navigator, Health Coordinator and Project Coordinator have been three key resource flows instigated with the commencement of the project. The resignation of the Health Coordinator not soon after the evaluation of the project commenced, and absorption of this role by the Health Navigator has resulted in a change in financial resource availability, but also a need for increased physical resourcing (in the form of providing relief for the Health Navigator undertaking a dual role).

Some resource flows are difficult to capture or fully surface, let alone making them explicit. The importance of *explicitly* allocating or compartmentalising resources for the benefit of the project should not be underestimated. It sends a clear message to stakeholders involved. An example is the support provided by the HEAC role, who steps in with the collection of information and liaises between child protection staff and the Health Navigator. At the same time, this person attends PCG meetings and undertakes considerable leg work on behalf of, or in lieu of the Health Navigator. The 'system work-around' HEAC role has an important function as the incumbent has access to critical software systems where certain information is stored, is located near or with child protection staff, and acts as a conduit between other project staff. Of note is the apparent floating nature of the HEAC role, in that the current incumbent appears to go back and forth between her substantive role and support for project members as required. Who eventually decides engagement and to what extent remains unclear.

Power dynamics

The purpose of this section and the element of power dynamics is to move beyond the singular concept of power imbalance. As a starting point, it is critical to identify that there is a genuine willingness to work together, as well as a shared commitment to working towards achieving positive outcomes for CYP within scope of the project, including carers and guardians. The dedication to achieving an improved integration of systems and *ways of working and knowing* as a mechanism to do so, is less clearly present, particularly regarding finding system loopholes, appreciating and accounting for cultural differences, or exploring practical system changes (easy wins) to facilitate

better integration. Considering the above, possibly more implicit than semi-implicit, power dynamics can readily be observed since the project's commencement. Mostly, these relate to the requirement to change routine and stepping back to reflect on the high-level project deliverables and outcomes. Firstly, some power dynamics appear due to legislative requirements accompanying the work of the child protection workforce, a determination to adhere to guidelines and protocols, and given structure to ways of working, recording information, as well as restrictions imposed because of system access. As a direct result, lack of access equals suboptimal provision of information and subsequent frustration because progress is hampered and delay unavoidable.

Secondly, there are power dynamics relating to culturally specific approaches, ways of working, ways of knowing and how we interpret the concept of health. Implicitly – perhaps subconsciously-, a bias towards western worldviews guides most of our collective thinking and operating, with the examples of how we define and approach health and wellbeing, and how we engage, essential to the project.

Thirdly, there are power dynamics between and within existing governance structures, for example who holds consent and who will release 'consent'. Governance structures between health settings and human service settings differ and impact on relationships and what is identified as a priority.

Fourthly, being a place-based project in a regional and rural area, existing relationships and understanding the 'lay of the land', provides a sound base for strengthening partnerships and forging respectful relationships. There is a reduced presence of personality-driven power dynamics in small rural places like the Mallee region as partnerships demand continuation once the project finishes.

Finally, the overlay of COVID-19 restrictions and its direct impact on power dynamics, cannot be underestimated. Access to buildings, places of work, team members, imposed social restrictions and uncertainty as to the future impact of the pandemic on work, personal life, and social connections.

Relationships & Connections

Relationships have strengthened over the course of the project. Naturally, some more than others, dependent on opportunity and frequency of engagement. Once individuals got more comfortable with one another and video-conferencing was accepted as the sole mode of engagement during COVID-19 lockdowns, conversations started to flow more freely and regularly. Email conversations have added to the sense of connection and involvement. The sense of belonging to a group of people who have a collective mindset of making a positive change for a marginalised group of CYP and their carers, acts as a catalyst. Conversely, a by-effect of COVID-19 restrictions was a shared

sense of deflation, not being able to meet with people, carers, young people and other stakeholders to strengthen relationships. Not being able to physically spend time together during planning sessions, team meetings and case plan meetings for a period of 12-16 months, has hindered relationship building.

Of note is the observation that staff's reliance and determined adherence to protocols, guidelines and existing processes -amid times of uncertainty- this challenged finding a way forward together. This resulted in some tense conversations and frustration. Similarly, because of not being able to meet face-to-face, some difficult conversations were avoided or delayed. The resulting quality and reciprocity of relationships took longer to mature, possibly because of relaying solely on communication via email and videoconferencing.

Simultaneously, communication via online modalities has facilitated initial relationship building and set the tone for lines of communication, not necessarily in a systematic manner. At times, not all stakeholders were involved in email conversations, or found out about decisions and actions through different channels, or with some delay.

In terms of contents, relationships have been professional and respectful. Individuals are encouraging, courteous and inquisitive during governance meetings, bound by their respective roles, functions and organisational parameters and structures. People become creatures of habit, and accustomed to ways of working. It has meant that people were not often challenged to step outside of their comfort zone.

As discussed in the first progress report, the phases of team development apply equally well to both CAG and PCG governance structures, and have moved organically through *forming*, *storming* and *norming*. In particular the PCG, simply due to its more regular occurrence, has arrived in the norming phase (relief, lowered anxiety, members are engaged and supportive), moving towards *performing*, where interdependencies are forged, and the ability to effectively produce start to become visible. Relationships and connections observed during governance meetings and other formal engagement appear respectful, warm and with good intent.

Connections have been flagged as critical elements of ensuring sustainability of the model, enabling the integration of a responsive area-based health system. Connections are being forged and will more prominently appear when the group of stakeholders is expanded to include a broad range of stakeholders from the Child and Family hub, OoHC organisations, and Maternal and Child Health, hospital settings, General Practice, and the Department of Education.

A major determinant for level and quality of relationships and connections is the fact of living and working in a small rural area. It has meant that people engage in a professional and respectful manner, because reputation is critically important for current and future partnerships and relationships on both a personal and professional level. More recently, the project team has come

together with renewed energy, inspired by the prospect of the Child and Family hub progressing the integration element of the project, bringing together CYP, professionals, carers, and practitioners, to support CYP entering the project. New stakeholders have been identified and will be contacted to broaden the project's reach and making it sustainable beyond its trial phase. The one-stop-shop model of care may be the conduit to further systems change beyond relationships and connections towards becoming truly transformational.

Early indicators of the inception of a potential mental model occasionally surface, focused on broadening stakeholder engagement and exploring integration across a range of service domains and levels (Department of Education, Maternal and Child Health program, Child and Family hub). Whereas a first indicator of a mental model in development has not been identified yet, evaluation progress to date can identify a critical first one, from which others can follow:

- Child protective services case managers *systematically* identifying a child within scope, and follow-up actioned with Health Navigator (or other identified person as part of the newly established OoHC clinic in the Child and Family hub) for organising a meet and greet.

Change as measured by extent of integration

To capture and conceptualise the change required to ensure system integration to improve outcomes of CYP in the Mallee area in relation to their healthcare, one of the main objectives for the evaluation is mapping the extent of system integration at the two-year touchstone. The approach to understanding the context in which integration takes place follows that of Ling and colleagues (2010) who undertook a study in the United Kingdom in relation to integrated care systems.

In developing an analytical framework for conceptualising integration, two classifications relating to function and structure are employed. In essence, integration occurs at three levels: (1) micro-level, (2) meso-level, and (3) macro-level. The table below provides further detail around these three different levels and some related examples.

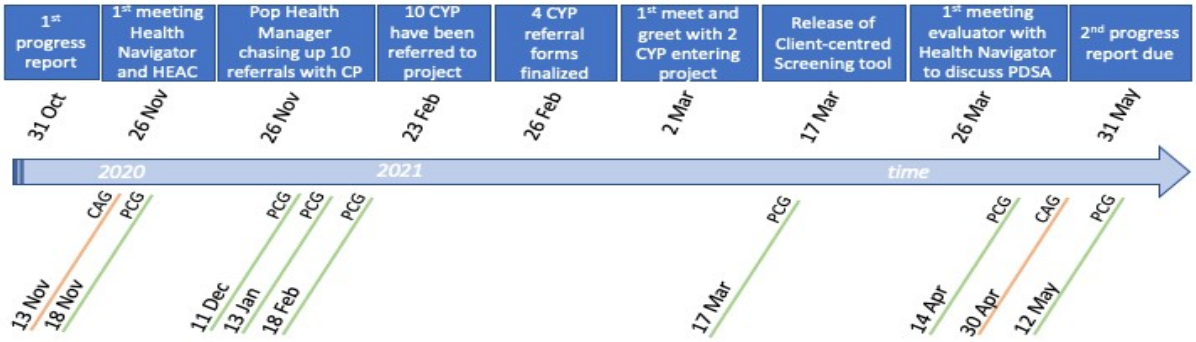
Level	What	Example	Current status
Micro	Promote integration amongst individual practitioners within a single organisation.	• Health Coordinator and Health Navigator developing referral form for project. • Child protection staff aware of the IHS project and its goals and objectives • Health Navigator developing client centred screening form.	• Integration of health and wellbeing as a core objective for children and young people involved with statutory child protection service delivery is not evident. • Referral form remains complicated with areas of information not traceable in child protection reporting systems.
Meso	Promote integration among practitioners working in different organisations. This may include co-location of services	• Health Navigator physically spending time three days per week at Child Protection. • Child protection worker contacts the Health Navigator to discuss possible referral.	• At meso level the integration between practitioners has not evolved due to the health navigator not being able to spend time within the child protection office (COVID-19). • Health is not a main priority for current service delivery in the out of home care domain.
Macro	Promote integration designed to facilitate organisation-to-organisation working, e.g., across different sectors. This includes pooled budgets, structural changes to facilitate work across two or more organisations	• Health Navigator being employed 2 days per week at DET for implementing system learnings. • 0.1 EFT allocated in budget for role of Health Navigator across range of services.	• At the macro level systems integration has not occurred. There is communication and awareness due to the CAG and PCG, but it is not operational in the sense that is it facilitating structural changes.

A further analysis of function and structure is undertaken as part of the living document analysis. As per the original proposal, the second living document analysis will occur at the 24-months' time point, at the conclusion of the project. The element of structure is referenced in the semi-structured interview analysis though, as are some other evaluation framework elements.

Relevant project timelines

In the diagram below, a visual overview can be found of critical touchstones from an evaluation point of view since La Trobe researchers were contracted for the evaluation. Governance structures were well in train once La Trobe researchers started attending meetings and commenced drafting an

evaluation framework, collating evidence for the living document analysis (forming the baseline for the evaluation) and acquainting themselves with relevant stakeholders involved in the project.
Of note is a first formal mention during the 12 May 2021 meeting is the transition to the Child and Family hub in Mildura, gradually replacing role of Health Navigator. A detailed overview, including formal (warm) handover of CYP in project to the hub, updated referral process, flowchart, and communication strategy (for local GPs and General Practice), will need prioritisation, well before 30 June 2021, the day the Health Navigator's role ceases.



The change trajectory of the project has seen many twists and turns since its inception. The resignation of the Health Coordinator in the early stages during a time that the implementation of that role had many question marks and unknowns, had a profound impact on the subsequent stages. Possibly more profound than initially anticipated.
For example, the apparent benefit of the Health Coordinator function comes to light now, where eligible CYP and their carers need to find their way through the process of identifying health assessments, a person responsible for organising assessment, information provision, and practical support has to be identified, and pieces of missing information of the young person's health history need to be collected and recorded. At the same time, the Health Navigator taking on the role of Health Coordinator is complex, confusing, and counterproductive.

Similar to the first progress report, this report should be read with the critical time points visualised above in mind. The regularity of CAG and PCG meetings can be seen as enablers for the maturation of the project and resulting change. The occurrence of CAG meetings therefore reduced due to lack of reviewable progress with PDSA cycles. The absence of a dedicated individual taking carriage of

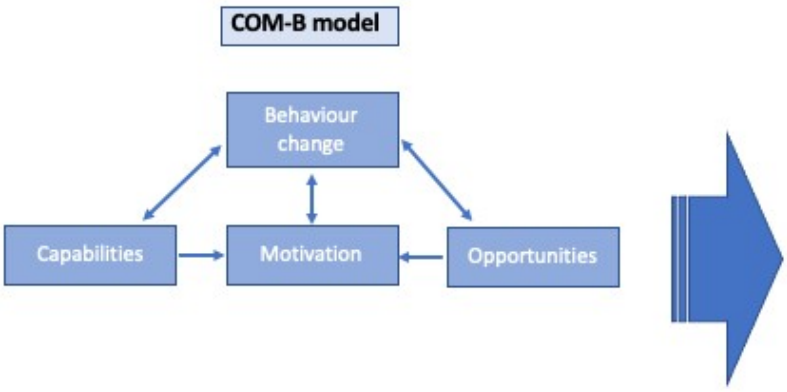
development and operationalising PDSA cycles, has significantly delayed progress and momentum regarding populating the Theory of Change: the backbone and key change framework of the initiative.

The first two years of the initiative should be seen as the steppingstone for the remaining eight of a 10-year project. Robust data collection systems and processes are essential ingredients for the further embedding and sustainability of the project in terms of facilitating integration. System-specific data related to resources, enablers, barriers, behaviour change, partnerships, function and structure will need to be defined, identified and captured to inform and guide the project's direction during the next phase.

COM-B TOC analysis (ToCA) progress

The Theory of Change analysis (ToCA) is heavily dependent on implementation of a series of PDSA cycles, including review and update for improving applicability (fit for purpose). As of May 2021, only one basic PDSA cycle has been developed and used by the Health Navigator.
As described in the previous progress report (Nov 2020), most interventions involve changing the behaviour of target populations, institutions or other intermediaries. The COM-B model is a particular version of a behaviour change ToC. The primary premise is that behaviour (B) occurs as a result of interaction between three necessary conditions: capabilities (C), opportunities (O), and motivation (M).

As the below diagram displays, motivation is influenced by both opportunities and capabilities and brings about behaviour change but can also be influenced by the resulting behaviour change. In other words, the feedback loop exists from behaviour change to capacity change. If behaviour change is seen as limited, there may be a need for more capacity change work.
A benefit of the COM-B model is that it maps a clear story: outputs (or activities) reach intended audiences and lead to changed capacity of those audiences, which consequently leads to a change in their behaviour. Direct benefits ensue, which over time lead to enhanced wellbeing (impact).

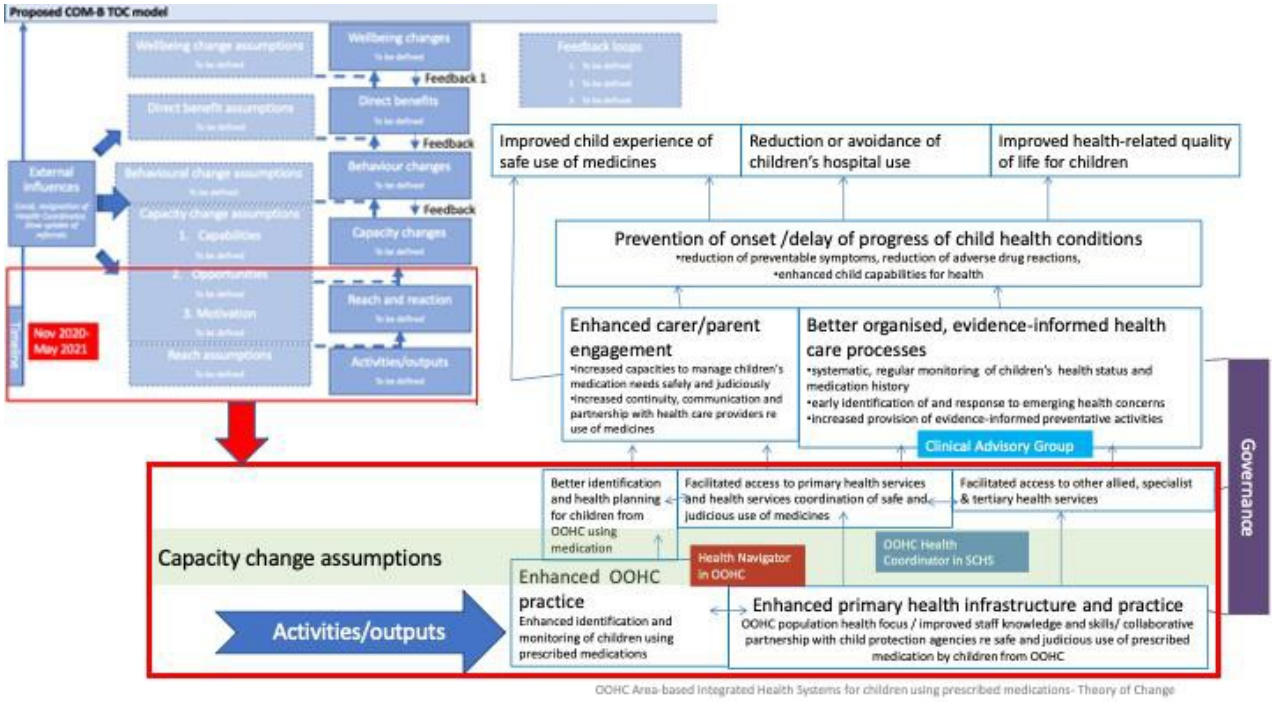


COM-B component	Types of intervention
Capabilities	Education Training Modelling Enablement
Motivation	Persuasion Modelling
Opportunity	Incentivisation Coercion Restriction Environmental Restructuring Enablement

A comprehensive overview of examples and corresponding behaviour changes (in the broad sense of the word) related to Capabilities, Opportunities and Motivation, is presented in Appendix x. The table was presented in October 2020 and has been further populated with information that has become identifiable (observable, more particularly) during the last six months, working up to the second progress report.

Despite delays to the effectuating of PDSA cycles (linked to individual system elements one through to nine) the following steps have been undertaken since the previous progress report, in relation to the ToCA:

1) Development and detailing, with some initial data collected for, system number 4.
2) Tabling of draft ToC during PCG meetings as standing agenda item, from July 2021 onwards, following the face-to-face planning session (tentatively scheduled for July 2021)
3) Initial recording of activities, as well as early identification of reach and reaction, for feedback and further population at governance meetings.
4) Development of series of recommendation, embedded within this report, to enable a more nuanced and realistic approach to change, based on what has been learned so far and the project's status quo, six months before the formal finish date.



In appendix 1, a series of ToCA indicators is listed, structuring the approach for mapping reach and reaction assumptions. An adaptation of these indicators has been applied to the proposed project's ToC model, as per the figure above. This includes, activities mapped underneath the headers of (1) Enhanced OoHC practice, and (2) Enhanced Primary Health infrastructure and practice, and their corresponding capacity change assumptions. In the table below examples of practice enhancements are summarised, including reach and reaction assumptions. These examples will need review by both governance mechanisms to ascertain agreement before finalising entries. Regardless, a learning that pops out from the reaction phase is the need for increased stakeholder engagement, casting the net wide, to improve understanding and awareness of project and its deliverables.

	Enhanced OoHC practice		Enhanced Primary Health infrastructure and practice		
	Enhanced identification	**Enhanced monitoring**	**OoHC population health focus**	**Improved staff knowledge and skills**	**Collaborative partnership with child protection agencies**
Activities	Regular meetings between CP staff and Health Navigator	Regular catch-ups with carers and case managers	*None observed*	Regular tabling of project and deliverables at CP staff meetings	Regular meetings with OoHC agencies (case managers), involving Health Navigator
	Securing support from HEAC to assist with information gathering			Supported information collection and data entering in relevant forms by Health Navigator	
Reach	CP frontline staff	CYP	Population Health manager DFFH	Paediatrician	CP frontline staff (case managers)
	CP leadership team	Carers of CYP	Population Health project officer DFFH	CP frontline staff (case managers)	CP leadership team
	Kinship carers in Mallee region	CP frontline staff (case managers)	CP leadership team	OoHC case managers	Population health team DFFH
	OoHC organisation staff	Case managers of OoHC organisation involved	CP frontline staff	Health Navigator	Health Navigator
	HEAC	PCG meeting	OoHC organisation staff	HEAC	HEAC
	Local GPs	CAG meeting	HEAC	SCHS staff	Child and Family hub staff
		Local GPs	Health Navigator	Child and Family hub staff	Health Navigator line manager
			Paediatrician	Health Navigator line manager	
			Child and Family hub staff		

Reaction	Apprehension with CP staff and OoHC staff Support from CP leadership team	Sense of confusion as to responsible person or entity Uncertainty regarding what monitoring entails	*None observed*	Appreciation of relevant staff but inability to commit time Unawareness of targeted staff regarding opportunities and skill acquisition opportunities	No capacity to commit time to engagement in systematic way. No clear appreciation regarding benefits and value of project

	Enhanced identification	**Enhanced monitoring**	**OoHC population health focus**	**Improved staff knowledge and skills**	**Collaborative partnership with child protection agencies**
Reaction	Uncertainty with kinship carers Unawareness of GPs and their practice staff	Willingness to improve efficiencies but unsure how Lamenting absence of systems or structures to capture relevant information and systems to record			Hesitation of CP staff, SCHS and OoHC organisations to forge stronger partnerships Sense of competition rather than opportunities for improving outcomes for CYP in OoHC
Capacity change assumptions	Greater interest of relevant CP staff Less time- consuming data gathering and reporting More streamlined process for data collection, data entry and sharing	Increased efficiency in terms of data gathering Greater overview of status quo across region Opportunities for improved resource allocation Better and earlier identification of areas in need of attention	Aligned information collection processes Better understanding of co-morbidities and health priorities Improved focus on health needs of CYP in OoHC Smarter collection of information needs in terms of frequency and longevity	Better equipped staffing teams Improved staff efficiency and time management skills Reduced duplication More intelligent task operationalisation	Advanced care pathways of CYP in OoHC Increased efficiency in identifying health checks Increased data sharing opportunities More efficient resourcing of staffing teams due to partnership arrangements

		Improved data recording and analysis	Stronger data source identification	Improved autonomy with CP	
		Stronger engagement and connection with carers and CYP		Strengthened decision making processes	

In line with Braithwaite's (2018) applied approach, change should be nuanced, involving strong feedback loops to build momentum for change. At present, feedback loops – via governance structures and other meeting opportunities, both formal and informal- are well used and adequate tools for communication, strengthening the usefulness of individual model elements (Capabilities, Opportunities, and Motivation). It is important for all these discourse mechanisms to continue and constitute valuable feedback loops. It appears that existing relationships and professionalism have matured to a level that constructive and strength-based feedback can be shared and acted upon within the existing governance structures. This finding is also supported by the analysis of the CAG and PCG meeting minutes, presented further below.

Despite a lack of tangible information captured through a series of PDSA cycles to inform the Theory of Change analysis, the COM-B model continues to be a most useful mechanism for illustrating pertinent change-related elements, and therefore an optimal 'goodness-of-fit' model for analysis purposes. Once the first few PDSA cycles are more consistently operationalised, and reviewed for quality purposes, data for the COM-B ToC analysis will be more readily accessible and matured to enable a more comprehensive analysis.

Integrated Health Systems project staff

Three critical roles have been flagged at the commencement of the project as critical success factors (enablers). These were the roles of Health Navigator, Health Coordinator, and Project Coordinator. At the 15 months mark of the evaluation, this group has expanded with two additional functions, described below.

Health Navigator

This role has continued to be of critical importance to the progress of the project, in conjunction with the responsible manager within the child protection program. Navigating the system, an intricate part of this role, posed considerable challenges early on, comparable to a 'Mallee triangle'. In summary, following agreement on children and young people being within scope of the project, eligibility and progression to access relevant health checks and assessments hinged on communication and sharing of information between the Health Navigator and child protection frontline staff. Possible diffusion of responsibility for contacting relevant carers and professionals with the addition of an external third party (OoHC service provider), hindered further by the lack of awareness of the time-critical nature of the project, amidst a plethora of competing demands. This was exemplified by an email conversation between the Health Navigator and Project Coordinator

around role clarification, following entry of a third party (external OoHC provider) posing questions around coordinating responsibilities.

Health Coordinator

As discussed previously, the relevance of this role cannot be underestimated. At the same time, this project has shown that the recruitment to this role and its actual benefit and application are most prominent currently, where the first few children and young people have progressed from the eligibility stage to intake. Staggering of recruitment in future iterations or similar projects elsewhere to similar roles is a key enabler for success.

Project Manager

This role continues to be instrumental in keeping governance structures operational and bringing relevant stakeholders together. Over these last few months, many informal conversations have been held, with the project manager as the key driver and attendee for many.

Auspice organisation – responsible manager

Progressed quite organically, it is worthwhile mentioning here that some roles have been instrumental in maintaining momentum of the project. Without necessarily much tangible progress outcomes, they warrant mentioning. This should be prefaced by stating that the opportunities associated with the Family and Child hub present a momentous forward leap for operationalising the Theory of Change underpinning the project, but also working towards actual integration of services to benefit CYP and carers.

The role of the supervising manager (and in this instance, the organisation auspicing this project) should not be underestimated and receive more attention. Whether it is allocating sufficient resources, or articulating more stringent role expectations, generating a clearer understanding of the critical role of this supporting function for the project's successfulness. SCHS has seen some managerial and function changes, which have posed its own challenges to a project of this nature, where relationships extend across the sector and lines of communication are mostly short. Identification of key personnel for developing the groundworks for the remainder of the project will therefore be important for the broader stakeholder group.

Health Education Assessment Coordinator

This role was initiated around the time of considerable delay regarding uptake of the project and children in scope following broadening eligibility scope. In first instance, the role was identified as providing support to the Health Navigator. The role and specific functions associated with the role were never articulated in detail, which has led to confusion about reporting lines, authority and engagement. It resulted in the role becoming floating throughout the project and sporadic attendance at governance meetings.

CAG and PCG meeting analysis June 2020-April 2021

The aim of reviewing the CAG and PCG minutes is a better understanding of progress made across the nine identified systems described in the original project brief. Minutes from June 2020 to April 2021 were reviewed for the purpose of the 2nd progress report. Minutes are considered a formal reflection of conversations, decision mechanisms and action recording across the course of the project.

CAG	**Jun 2020**	**Jul 2020**	**Aug 2020 Planning Session**	**Sep 2020**	**Oct PDSA cycle workshop**	**Nov 2020**			**April 2021**
PCG	**Jun 2020**	**Jul 2020**	**Aug 2020 Planning Session**		**Oct 2020**	**Nov 2020**	**Jan 2021**	**Feb 2021**	**Mar 2021**

The CAG and PCG meeting minutes reflect a new phase in the project, the various stakeholders are familiar with each other, there is regular attendance of key stakeholders and initial system challenges are known; the storming phase has subsided. There is a shared understanding that expectations and organisational structures put pressure on finding common ground that enable regular health checks for children in out of home care. The 'who is responsible for what change' remains somewhat unclear. Formulating challenges in PDSA cycles for the purpose of clarity (steps) and measuring change does not evolve in an approach that can solve system challenges.

Conversations around system challenges, in particular regulatory (legislative)-driven, increase in frequency and become more direct. There is less of a tendency to avoid the difficult conversation.

In June 2020 there are intentions for the Health Navigator to work with child protection staff to collect information that will support the referral process. Contact with case managers is established and there is confidence about moving forward with referrals in both CAG and PCG meetings. There is debate which children are eligible for the project with little appetite to open scope to case contracted children and young people. Robust debates focus on the aim of the project and concerns are raised that an overemphasis on eligibility criteria may cause to losing children in the system. Commitment is expressed to the guiding principle that once a child is identified, they remain in focus of the IHS project, no matter what their placement journey will be. In July 2020 it is evident that some child protection workers do not provide the Health Navigator with the information required for a referral, framed as a *communication blockage* in the CAG meeting. In the PCG meeting concerns are raised about the amount of information that needs to be shared by child protection workers to support an initial referral. There is an identified need to continually promote the initiative and explain the short- and long-term benefits to child protection staff. The Health Navigator is scheduled to present to the team and the need for additional administrative support is raised. Health assessments and data collection are experienced as a continues barrier between child protection and community health services.

June 2020, the referral form is completed and on the SCHS MasterCare client system with one child referred. There is a flowchart request to enable better understanding of the referral process, also for evaluation purposes. In September 2020 there are nine referrals and Dr Webster created a PDSA cycle to capture essential child identification data. There is no further clear action on developing robust PDSA cycles to monitor various moving parts of the IHS project. Child protection PCG members note that in the LAC documentation most of the service involved with OOHS are not health professionals which is seen as a challenge for project progress. The overall objective, for a child in OOHS to have a completed health assessment in the last 6 to 12 months, seems somewhat lost in the project progress.

Between July 2020 and January 2021, the PCG discussed the possibility of the DHHS Health and Education Administration Coordinator (HEAC) to have a role in the project as admin support person. The child protection operating environment is challenging, and staff is stretched to meet the demands by COVID-19 and this is impacting on project progress. November 2020 it is evident that the HEAC role does not have the required access to collect information from the Essential Child

Information, however, does have the capacity to initiate the referral within kinship care. There is much discussion without the HEAC person having a clear role within the project until In January 2021 when the PCG decides that HEAC person in DFFH can take on the role of continue health information collection support for the remainder of the initiative.

A core questions that remains on the CAG and PCG agenda is consent for various changing circumstances that children in OOHC face. In the PCG there is confusion around who should obtain consent and the role of the health navigator. Child protection can assist depending on the legal order and authority of approval and has influence in this space but there is little commitment from frontline staff to move forward. September 2020, the Health Navigator is collecting child protection documentation however the LAC and EIR reports do not have the required health information and frequently miss Medicare numbers. The BCHS consent form is shared with the PCG in November 2020 as an example of consent to share health information.

In reviewing CAG meeting minutes, it is evident that the project focussed on system 2 - Collecting*/maintaining health records, including sharing health info between DHHS/OOHC placement support* and system 3 - *Referring from OOHC to SCHS.* The PCG minutes also prioritised system 2 and 3 and moved into system 4 -*Clinically assessing child health needs* January 2021. At the start of the new year, the four existing children in the project can commence health assessments with SCHS confirming that a new paediatrician is starting in February 2021 which will support health check-ups for children part of the IHS project.

Semi-structured interviews

Over the months September and October 2020, a series of semi-structured interviews were conducted. A total of six interviews were held by Dr Vogels and Dr Modderman via MS Teams and Zoom (note that approval was sought through the HREC at La Trobe University for these interviews to be held via videoconferencing platforms). Participants of these interviews are listed in the table below, by their position within the project and their host organisation at the time of the interview.

Position	Organisation
Project Sponsor	DHHS
Project Manager	DHHS
Health Navigator	SCHS
Academic Advisor	Melbourne University
CAG member	Priceline Pharmacy
Principal Practitioner CP	DHHS

Interviews took between 45 to 60 minutes and were recorded for transcription purposes (verbatim-audio only). Data analysis followed an iterative process (Braun & Clarke, 2008) undertaken by an experienced qualitative researcher and research assistant (CM & EC). The approach used inductive thematic analysis which allowed themes to emerge from the data, (Braun & Clarke, 2008). In performing thematic analysis, all interviews were read several times and annotated by one researcher (EC) and coded line by line and assigned initial codes made as descriptive of the stakeholder's experience of commentary as possible. This includes line-by-line reading, and extraction of key quotes and text segments related to the questions posed within the interviews (Ezzy, 2013). Nvivo software was used to facilitate coding and analysis of the transcribed data. An initial coding framework from the interview was developed and presented back to the broader research group for input and refinement. Coded data extracted from the interviews was largely semantic (e.g., limited physical presence due to COVID-19 restrictions). Following coding, themes were identified to best capture important aspects of the data that spoke to the research question:

> *Explore the initial experience of key stakeholders in the Integrated area-based health systems project for children and young people in out of home care in the Mallee area.*

Ensuring anonymity is challenging when drawing on a small cohort of research participants. For this reason, the quotes that are included in the paragraphs below do not refer to the position of the participant.

Stakeholders' experiences of the Integrated area-based Health System project: interviews with key stakeholders

Understanding stakeholders' experiences informs future directions for systems development and supports ongoing quality improvement approaches in health service design and delivery for children and young people in out of home care in the Mallee area.

The objectives were to understand (1) the barriers and enablers of the project; (2) experiences of partnerships and collaboration within the project; and (3) the possible changes amongst the system and behaviour of participant stakeholders.

Findings

The thematic analysis identified six key themes (with some of them having sub-themes) reflecting the overall experience and feedback of the Mallee IHS project since its inception. Findings have been

grouped underneath the overarching themes, gleaned from the overarching evaluation framework. Findings from the interviews have been reported underneath these six themes. Quotes are reported to give content to the themes and insight into.

Theme 1: Enablers -Stakeholder and community engagement -Eligibility criteria and increased referrals - Clinical input	Theme 2: Barriers - Difficulty with referral process - Covid-19 restrictions -Limitations of child protection system and operating model	Theme 3: Partnerships -Stakeholder and community engagement, rapport building - Communication andconsultation
Theme 4: Behavioural change	Theme 5: Structure -Service structure changes - Organisational changes - System changes	Theme 6: Resources

Theme 1: Enablers

Stakeholder and community engagement

Enabling factors included meaningful stakeholder engagement and strong community connections. One participant noted the key strength of the Mildura site was in its network of professional connections who shared a willingness to cooperate and collectively improve the health outcomes of CYP in OoHC.

I think one of the things that has stood out for me in this Mildura site has been, in comparison to other sites that I'm familiar with, the things that are strengths for them are that people - professionals are well connected locally. Everyone knows everyone or knows of everyone. That is a strength when they are willing to co-operate which I have unfailing heard people are willing to co-operate. I'm sure there are tensions between organisations and there are failures. But as a general impression I have heard and witnessed in meetings that involve several agencies people coming with genuine intent to the table to say we share a desire to do better in this space.

Meaningful engagement with executive roles was considered vital in ensuring the project maintained specific performance targets and feedback. Participants also noted that learnings from

the interim report should be disseminated widely to area directors and key stakeholders. Several participants felt that this knowledge sharing should also extend to the broader service system, potentially facilitating new lines of thinking to enable shared resources.

I think too, whether it's towards the end of this year or early next year, it's really critical to start thinking about how we engage the broader service system in some of our learnings, maybe after the interim report. Because there have been times where, even early on, where there was some interest from external stakeholders of sharing in resources, particularly from the early child maternal health programs within local government. They have a challenge with underspend when they have the resources in certain aspects. So I'm keen, as one example, to engage and think about the broader stakeholder group.

Establishing and building trusted relationships with children and families was identified as a necessary enabler to the program's success.

For me, the first time a child from the program comes into the building, my place of work and hopefully from our conversation here, hopefully if the navigator comes and introduces the family…..I think that would be a win. I think supplying them their - early on wins, I think the return of that family or the client will really be I think almost more important.

My employer sees a benefit of that repeat client. That repeat client is a benefit. Anyone can have one interaction but it's the return for more interaction which actually tells you that you're doing a good job. Or that growth in interactions with more people. I can have as many paper forms to fill out as possible but if - well, let's go with something that's directly related to what I do. I can have as many people in my clinical intervention program that I have in the workplace but if I'm not actually dealing or talking with those enrolled people, well the number is meaningless.

Eligibility criteria and increased referrals

A key enabler emerged with the broadening of the eligibility criteria. For many participants, the subsequent increase in referrals was considered significant, providing many avenues for contribution, feedback and shaping the future direction of the program.

I think now that the change of scope has been endorsed, that the doors are open and really looking to see with interest what happens next.

Participants felt that this change of scope and increase in referrals provided immediate feedback on barriers allowing the program to progress. Many of the participants also viewed the increase in referrals as an enabler for the process to provide meaningful support for the child and family. Specifically, the referral process was viewed as a way in which to address carers' needs over time:

In my experience they've been hampered in even thinking about carer needs because they've not actually had any cases (referrals) yet. So that exposure to individual carers and their stories and their needs will bring a greater appreciation of carer issues It won't be until they meet with those carers, they have time to spend with them, they rarely reflect on the impact of a carer's health and the child's health and the struggles that carers have in caring for these children that they will begin to develop their own ideas about ways forward with carers.

There were mixed views on the consistency of the current referral process. One participant experienced disappointment as four referrals came through in quick succession only to find they were not in scope. Another participant did not regard it essential for referrals to be complete before processing given the possibility of a client not progressing with the application.

….sometimes we've got a child's name and a school and we need to go out and see what's happening for that child I just – yeah, I don't think that should be a barrier at all. I think that some of that information can be collected along the way and will have to be collected along the way. It's never either been collected before or potentially gone amiss or whatever it is. Yeah, no, I just think that if we can identify that they are eligible for the project and we know that we've got consent. Because the other issue being we might send four weeks getting the referral right and then we go and spend some time [unclear] spend some time giving the carer some more information about the project and they might say, no, not doing this.

Clinical input

Providing clinical input to the referral process was described by stakeholders as an important factor. It was viewed as essential in terms of providing robust feedback to the PDSA cycles regarding clinical/health assessments and for ongoing participation in the program. Several participants raised the value and importance of the Health Navigator role. A clinical background allowed the Health Navigator to bring a valued, health lens which supported and enhanced service delivery experience and brought with it a level of respect for the health advice provided.

…absolutely we need somebody who knows that system in and out. Just like anybody entering the child protection system would need somebody on the inside to know the system well. So for me they're critical roles. There's no point giving a child protection worker (in) the role and saying, here, go and navigate the health system. It needs to be somebody with an understanding of the system. I think the idea of somebody with a clinical background is just an additional impact for our kids…. particularly for carers.

Theme 2: Barriers

Difficulty with referral process

For most participants, a common barrier emerged during the initial stages of the project. This was described as a frustrating experience and related to the delays experienced in the referral process. Health data/information, system access and structures were identified that made engaging in the program difficult.

Interviewees described a lack of system access to (child protection) health data, an over reliance on child protection personnel to provide missing health data to complete referrals, and a general lack of health data available. In addition, the eligibility criteria were narrow and restricted the number of applicable clients. Barriers to the referral process had been anticipated, however the reality of navigating a system that did not focus on health was considered a significant learning.

…In a very unexpected way to the people involved on the ground where it all hiccupped was that the referrals didn't come through from community services. Now I predicted that they would be slow, not that they would be non-existent. There was a disconnect between people's expectation about that and the reality. I don't believe COVID actually had anything to do with the slowness of referrals because it's been my experience in any other site that that is a major undertaking to get community services on board and willing to bring forward - willing and able to bring forward children because they're not asking about health. They don't collect data about health. It's not their priority. So they're not putting time into health.

COVID-19 restrictions

Establishing and building key relationships during the COVID-19 restrictions was identified as challenging and often unattainable. This impacted the key role of Health Navigator who had planned to physically sit in the DHHS (child protection) office and work alongside personnel.

The plan was for me to sit at DHHS three days a week and at Sunraysia one day a week. I had started doing that for two or three weeks before COVID, the restrictions to work from home. So, in that process I had really just started learning about how the navigator role might fit in DHHS, in looking at the health needs of children in out-of-home care.

For others, the restrictions impeded planning sessions. It was felt that the collective aim of the project was lost and highlighted the need for in-person meetings to build necessary, strong relationships amongst key stakeholders. This linked to the shared sentiment that COVID-19 restrictions and other unforeseen challenges will continue to arise and an acknowledgement that various ways of moving forward to overcome challenges are necessary.

I think that's caused some problems. So I think it's about what can we do? I mean COVID is COVID and restrictions are restrictions and we can't stop that. But I think recognising it and acknowledging it is one thing to start with. Then thinking about how we can actually overcome that.

In another instance, COVID-19 restrictions were attributed to a loss in crucial systems thinking, especially as newcomers joined the project.

But that was all of course not possible. I think they really suffered from that because I'm aware that for practitioners who are not used to thinking in terms of systems or quality improvement or quality issues that the framing of their work is quite [unclear]. The terminology I use is a mystery, without good explanations in case studies and workshopping. So I regret that I haven't been in a position to support the project with that sort of development. I've witnessed the lack of that.

Limitations of child protection system and operating model

Participants noted that the child protection system had its limitations and felt frustrated that there was no dedicated resource to focus on health outcomes.

I think I've had about five or six different people that have been the main point of contact for me; I've lost track. So that's been difficult. If the department had the one person, that would be really good. I think if anything, I think it's just been highlighted the need, and that the case manager, that they don't have the capacity or the health background and the health literacy to be able to focus on that sort of stuff.

This presented a challenge for completing referrals in the absence of health data within the system. It was felt that the child protection service traditionally does not embrace system-level change. Instead, it was acknowledged that the day-to-day constraints of their work focused on the immediate needs of children and families in crisis. A willingness to bridge the gap between the child protection operating model and addressing the health needs of children was identified to ensure the longevity of the program.

I don't' think we can underestimate the importance of investing some resources into this space, purely from the learnings that come from internally with child protection saying, maybe we can do things differently. Just simply dedicating the resources and having a lens over a critical aspect of your work, is really important. Because it takes away from the day to day operational, and totally understand that a lot of the work with this complexity, don't have the time to do this. So I think it's really integral from that point of view.

Several participants described their surprise when revealing a lack of health-focus within the Looking After Children (LAC) framework and its non-mandated use amongst frontline child protection staff. This was linked to an absence of a dedicated health policy for children involved with statutory services.

I go back to surely there's enough evidence to suggest that there needs to be a policy. Actually, that's probably one assumption I did have, which I was very surprised was absent, was you're looking after children, a LAC framework, which is all about the health. I made the big assumption that all Child Protection practitioners, it's mandated you go through that training and it's part of your inductions. It's not the case. I find that a little bit surprising, but not in a way if you don't have a dedicated health policy for children in care, it's a probably a reflection of that.

I didn't know they were one and the same until it's – so I sort of learned these things along the way, that LAC and EIR are the same thing, and they're the clinical guidelines that the department has set out as the bare minimum that every child in out-of-home care should have in regard to their health needs. I do think that it misses the wellbeing side in the project here.

Theme 3: Partnerships

Stakeholder and community engagement, rapport building

Establishing and building collaborative partnerships was identified as a positive and pivotal experience for most interviewees. For many, connecting through the PCG and CAG had been an important pathway to established, respected partnerships.

Facilitator: *……but you were saying the partnerships in the PCG and the CAG are being established as we speak?*

Interviewee: *No, I think – they seem quite well established, actually. I know I sort of came into the group thinking, oh the – they – there's quite some good established partnerships in here. So it was just coming in and fitting in with them, I guess. Yeah, I think that the way that the groups have formed – those groups have formed, the collaboration there seems to be really respectful and really good. Everyone's got something – an area of expertise that they bring. So I think that collaboration is really good*.

Sometimes, stakeholder engagement was hampered. The delay in referrals was a strong, recurring theme and one interviewee expressed clear concern about the future of the CAG.

I think that the clinical advisory group have suffered from having no meaty work to do, in that their most interesting role is to respond to the clinical issues that arise directly from cases. Because we haven't had cases, they haven't been able to do that. So they've got a high level of interest. They're fairly committed but they can't continue indefinitely having nothing substantive to get their teeth into.

However, the strength of program partnerships was credited for enduring challenges.

In terms of any other thoughts, no, I'm really happy - I've never really been terribly concerned. Maybe there was a little bit there for a while, and….. are we going to get any referrals through? There was a bit of frustration, as you could see….and somewhat confusion… But I'm very pleased from a partnership perspective, we've maintained respected continuity with Child Protection, definitely maintained that with Sunraysia Community Health, and it certainly has informed the other investments we've got, briefly with the Mallee Population Health team.

Developing broader stakeholder engagement was described by some participants as an important factor in supporting often complex relationships and needs of children and families/carers. Support from the education system (including both schools and kindergartens), maternal and child health,

and other community health services were highlighted as untapped knowledge on children's health and wellbeing.

I think Maternal and Child Health is very relevant. I think schools are. I think schools are incredibly relevant. Children are there for a big part of everyday. So the health and wellbeing stuff at the school in particular I think are very important in this role. They're probably two that immediately come to mind. There are I guess the other community service organisations that we work with in respect of the children and services that they offer. Whether or not the carer advisory group, where kinship support can be offered to people, whether or not that would be something. I guess I've always been a bit concerned that there's not enough carer support available, like carer to carer.

Communication and consultation

Maintaining stakeholder engagement over the long term was identified as a challenge. There was recognition that regular communication and consultation with stakeholders was necessary. Feedback and transparency were identified as key elements necessary to keep stakeholders engaged and invested.

I see the challenge of keeping the people that are in the project invested in the project as another challenge. That's not just saying the people that are so to speak directly related into the project, such as the people on the clinical advisory group or the other groups that are running concurrently with this project. But also the individuals in the - the case managers and the people on the ground. Keeping them involved. I think there probably needs to be a way of giving feedback to them about yes, that referral for child X was done and this is what has happened from that referral and this has been of a benefit.

Stakeholders joining at different times and at different levels of project understanding contributed to the need for clear, informative communication channels.

I think in the early stages, and I suppose because I'm on a clinical advisory group, I don't see a lot of the behind the scenes kind of things that are going on. I'm not saying that I should see what is going on behind the scenes. But maybe an awareness of what is going on behind the scenes is helpful and keeps people invested in the project. Or would keep me further invested within the project, as I've probably alluded to early on. I was struggling to see where my position was.

The CAG was described as an important forum in which to raise questions and seek clarification. Participants felt free to openly discuss issues and raise queries without issue.

.. I just think the nature of those meetings are very respectful. So I haven't seen anything that's been brought up and taken the wrong way or anything like that. So it doesn't sort of lead me to feel nervous about it. I feel quite open to saying what I think in those meetings will be helpful.

Theme 4: Behaviour Change

Participants described how the systems-level thinking influenced the way they engaged with stakeholders and the project. Participants often framed their actions and intent in terms of the project aim: to improve health outcomes for CYP entering OoHC. Participants appeared motivated and aware that they had the chance to improve children's health outcomes by changing their own behaviour within the project. In some cases, the system-level thinking promoted the opportunity to approach difficult issues and decouple individual blame.

I need to exercise a fair level of diplomacy which I certainly try to do without shying away from the difficult conversations. There are many of those in this space. I think people accept now that I will enter into those difficult conversations or ask difficult questions but they're not personal to individuals. They're about the great issues that everyone is grappling with.

In one scenario, changing the nature of stakeholder engagement to build rapport and share health information was described. New software was reported as being installed to facilitate the capture of this health data.

Facilitator: *..I think it has merits. I guess also to have a trusted healthcare professional in your life, regardless whether it's a GP, or a paediatrician, or a pharmacist, in an already quite volatile, stressful situation, I think that has tremendous benefits.*

Interviewee: *They can also be more frank. You become more comfortable. You become less guarded. You can actually say things and you have less fear of being judged for those. I think that also comes from the health professional being educated or trained or aware even, just aware, of the issues at hand. Because for me, when a prescription comes in, I have no idea whether that patient is in out of home care or what their home life is or whatever else is happening in their life.*

Including medical. I only see a single prescription which is a single snapshot on a single issue in that child's or in that individual's life.

In another case, a key Health Navigator role had the potential to build health knowledge capacity amongst child protection personnel while working *in situ*.

So what I hope and I always hope this when we have new projects and we have specialist workers sitting alongside our workers is that capacity building. So I hope that having – if we get a chance to do a bit of work alongside Sharon it will build some capacity within child protection and the care teams to have a much stronger lens on health. So that would be a good short-term impact because obviously anything that we put in place will need to go through a process and will be a longer term option. So that's one of the things I'm hoping to get out of this. So better understanding of different health systems for care team members, child protection, and a better ability or understanding of how to navigate those systems.

Participants spoke about the need to disseminate project learnings on a regular basis to ensure sustained stakeholder engagement. It was also noted that distributing the interim report amongst a broader stakeholder base versus the common practice of issuing a final report on project completion to key stakeholders enhanced the longevity of the program. It was also considered an effective way to identify new stakeholders with which to align future resource capacity. For most interviewees, a whole Theory of Change model enabled a new way to respond to systemic challenges. In one case, a lateral problem-solving approach produced an alternative to navigating a difficult service operating model barrier.

I think whilst there are challenges in the CP space, I think there could be some interesting opportunities in terms of whilst you can't make quick significant structural changes because of the operating model, what benefits may be for that broader stakeholder engagement, service engagement, from a whole theory of change model. For instance, whilst we know now you can't go and employ a nurse and drop him or her into child protection. However, those resources exist anyway, with other agencies, other health providers. So I'd like to think with these learnings, we could potentially line up and realign resource capacity.

This shift to thinking in terms of system-level change was also described by another participant in broader terms.

I think maybe the project will show the ability from the wins and the learnings that we have for child protection, to maybe think out of the box in terms of, maybe let's trial this particular role, or maybe shift the dedication of a resource to here, rather than just going down your traditional operating model, and maybe becoming a bit blinkered. So rather than completely trying to solve the problem, maybe think a bit laterally in terms of allocation of existing resources rather than banging your head against a wall, trying to get a policy change, or a recruitment through, look at the existing resources that you have and maybe take a different perspective.

There was a recurring concern that there was a gap in newcomers' understanding of the project purpose and the higher system-level approach the program was taking had not been effectively communicated. It was suggested a standing item be re-tabled at a future CAG or PCG meeting for realignment.

Interviewee: *No, I think I've covered everything. I've certainly had a - as I've raised, a growing concern that I see it at the moment becoming very much an operationalised project and perhaps we're losing sight of the purpose of it which is about the system issues. That you know, it's not just to churn kids through and get them better health outcomes. That's part of it but it's about changing the system so that going forward that can be the case for children. So for me, that's something that I've had some growing concerns about.*

Facilitator: *On that then, do you think that's something we - or that might be able to be tabled at a CAG? To see where we - how we might change that if at all possible? Or a PCG or do you think it's…*

Interviewee: *Yeah, maybe. Maybe we could. Yeah, maybe we could. Yeah. I think a way of doing that is revisiting what the project is about to be honest. I think that covers off on it. I think that's just that reminder for everybody around - and particularly for - and I think it would be really helpful for Sharon. I think for people like Jacqui and people like that, who have come into it late and haven't been there for the full journey, I think it would be helpful for them too. So I think it's about getting everyone on the same page again.*

Theme 5: Structure

The key theme of structure encompassed changes to organisation, system, or service structure. Each of these sub-themes are detailed with supporting quotes below. In most cases, change was limited or speculated based on learnings due to emerge from the interim report. Participants spoke about the lengthy process of establishing a business case (on 12 months), but many maintained this was a positive and sturdy approach that consolidated the key structure around systems intending to be tested. It was also lauded to have produced the solid foundation for a place-based program.

Service Structure Changes

For most participants, the complexity and multi-layered nature of the program was underestimated. This was often described as frustrating and identified the most common barriers: delayed referrals, system limitations and COVID-19 restrictions. However, the general consensus was that the project had merit and targeted a long-known gap in healthcare for CYP in OoHC. One participant maintained the challenging journey to operationalising the program was worthwhile. They reported the process had secured significant service structure changes and established a solid, place-based program relevant to the Mallee region.

I think we've - while I think I know that there were lots of frustrations along the way because of the time that it was taking to get it to a stage where it was actually operationalised, but in hindsight, I actually think that's probably not been a bad thing. Because I think it's enabled us to really develop something that is place based. That is relevant for the Mallee and fits within the Mallee Child Protection Program more so and the partnership with Sunraysia Community Health. So I think while at times I really felt the frustration that it was taking so long to get to where we're employing staff and getting things happening, I think that that probably hasn't hurt. To really give that good foundation to actually build on.

Broader stakeholder engagement and potential resource alignment was described by several participants. Often this was linked to learnings disseminated in the interim report which could lead to further stakeholder engagement and the potential to align resource capacity (e.g. maternal health, schools and kindergartens).

… it's really critical to start thinking about how we engage the broader service system in some of our learnings, maybe after the interim report. Because there has been times where, even early on, where

there was some interest from external stakeholders of sharing in resources, particularly from the early child maternal health programs within local government. They have a challenge with underspend when they have the resources in certain aspects. So I'm keen, as one example, to engage and think about the broader stakeholder group, just so we're not coming to an end of a two-year project which has a 10-year theory of change behind it, and then starting to engage. Think of that broader theory of change and engagement as well.

Organisational changes

Participants felt that in its current form, child protection services were often compelled to focus on daily operations. For many, this highlighted the need for greater involvement and accountability from the child protection program regarding the collection and focus on health information.

Facilitator: *What do you see the role as child protection - I guess particularly now early on with the change in scope - what will be the role of child protection in this space early on with the opening of scope?*

Interviewee: *Really, the role is exactly the same as it was previously. There are some systems - really most of them - in those nine systems of interest - that cannot operate without active involvement and accountability exercised by child protection. The first thing that's required of them is fidelity to their own policies and procedures about collecting health information about children and their own procedure about ensuring that children have a detailed health assessment. So they have to collect that baseline information that's in the essential information record, their Medicare number, allergies, medications, those kinds of things.*

Others supported organisational shifts in the management of the program, given the nature of the child protection workload and priority structure.

…But I think the rest of the structure is probably okay. I think it's good that it's not totally managed by Child Protection because I just don't think it would occur. Because they're too busy with everything else, it would just get put on the back burner. So I think having it managed by Population Health who view things through different lenses to what Child Protection do I think is really helpful. Really helpful. So I think that allows for some robust conversations and there's strength in that model.

System changes

The preference of upfront investment into resources, especially in the child protection space rather than relying on *in situ* Health Navigator and Health Coordinator roles to facilitate system integration, was explored. It was found that a fundamental difference in the executive functioning of both arms of the health department would make this challenging in its current state.

Even with that, with community service organisations being involved, with child protection, executives being involved, people felt on the ground that there was insufficient engagement with the child protection workforce in those early days. I agree that that's a gap. In an ideal world you would do both rigorously and deeply and simultaneously. But in the ideal world you've have the executive arm of both sides of the department with shared goals, clear accountability, expectations down to staff and really good alignment. The reality is that's not the case from head office down. They're like two different countries, health and child protection.

Theme 6: Resources

The Health Navigator role was considered crucial to building health capacity within the child protection service and was a frequent theme raised amongst participants.

So what I hope and I always hope this when we have new projects and we have specialist workers sitting alongside our workers is that capacity building. So I hope …. it will build some capacity within child protection and the care teams to have a much stronger lens on health. …. So better understanding of different health systems for care team members, child protection, and a better ability or understanding of how to navigate those systems.

Several participants spoke about the need for a dedicated, health-focused resource in child protection services to support the Health Navigator role.

If the department had the one person, that would be really good. I think if anything, I think it's just been highlighted the need…that they don't have the capacity or the health background and the health literacy to be able to focus on that sort of stuff.

I think something like some admin support, if possible, in Child Protection to actually gather that information quickly. I think it would get Child Protection on side. I guess more committed to the project. I think it would make [the Health Navigator's] life easier.

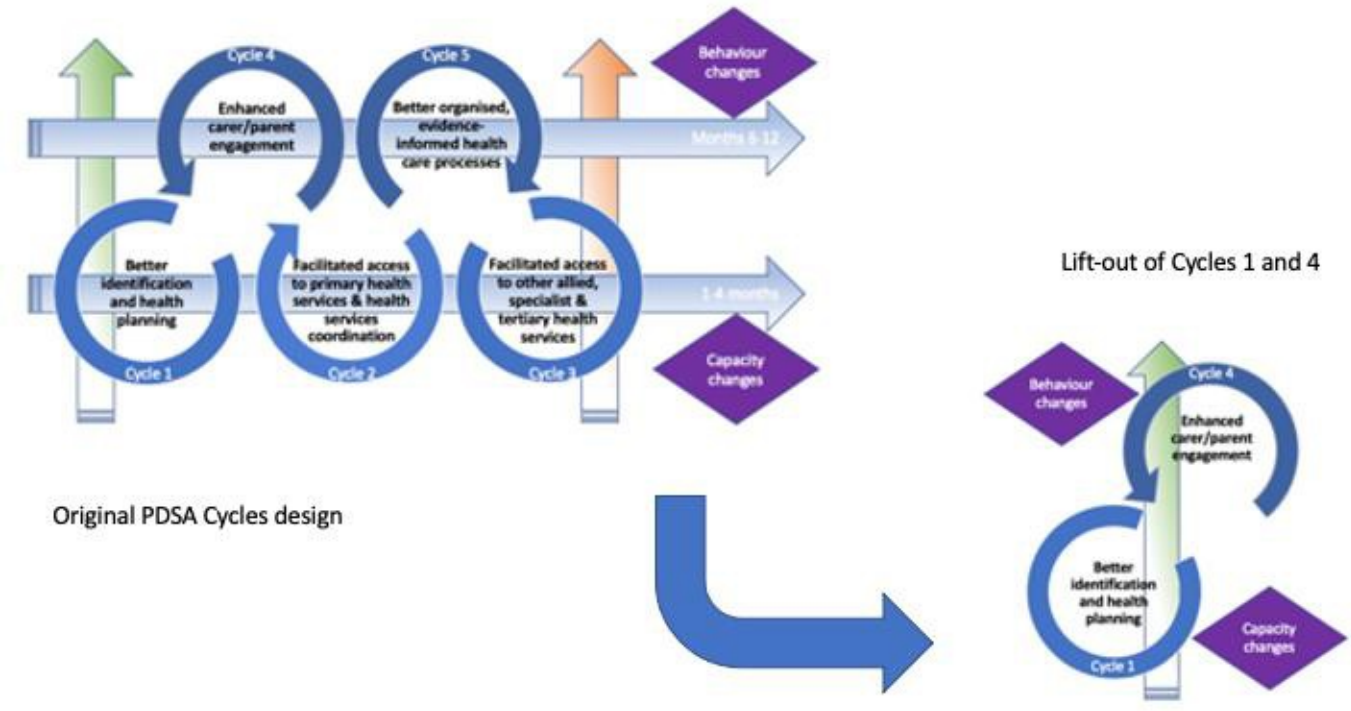
In some cases, concern was expressed for the wellbeing of the Health Navigator. It was acknowledged that the status quo was not sustainable. Supporting the Health Navigator in a higher level, systems approach was suggested to work through recurring challenges.

I think we need someone to actually support her and help her to take a deep breath and keep reminding her about what this project is about. That in fact, if you weren't feeling frustrated then in fact there wouldn't be the need for a project.

To add richness to the information collected and stories shared, but also to enable comparison of the themes identified and discussed, a second round of interviews will be conducted between June and October 2021. This next round of interviews will involve individuals who have participated before, invited to reflect on the project's maturation, whereas others may be able to assess where the project is at, looking forward to the next phase.

PDSA cycles

A visual overview of the proposed structure to applying a series of PDSA cycles to individual project cycles can be seen in the figure below. This proposal was initially put to the CAG for consideration and potential adoption by project team members for operationalising.



Progress to date in relation to the use of PDSA cycles to inform the ToC, is the development and ad hoc use of PDSA cycles relating to Cycles 1 and 4 in the original PDSA cycles design. A visual overview of both cycles is displayed above, and progress made against both cycles will be discussed. As planned, indicators related to Cycles 1 and 4 could be observed in close succession, the first series to provide examples of capacity and behaviour changes.

Cycle 1: Better identification and health planning

Considerable emphasis has been placed on improving communication between hild protection frontline staff and the Health Navigator. Occasional support provided by the HEAC position, has enabled traction to occur in terms of collating and recording relevant health data for a child in scope of the project criteria. The impact of COVID-19 and the resulting inability of the Health Navigator to spend face-to-face time with child protection case managers to discuss the project and remind staff of the importance of collecting certain pieces of health information (Medicare card number, for example) has significantly hampered influx of children and young people potentially eligible for the project. The occasional presence of a third party involved with the young person (external OoHC case manager, for example), has resulted in increased confusion around follow-up and further dilution of responsibility when it comes to allocation of tasks. Moreover, health-related information of the CYP could be scattered across multiple services, programs and software systems. This remains an area for attention, reiterating findings from the first round of semi-structured interviews.
The Health Navigator and Health Coordinator have developed additional checklists to collect and record relevant information of the CYP that is not systematically captured elsewhere (bits and pieces are recorded on different software systems, or in hard copy files). The development of a health assessment checklist is another example of a quality improvement to more systematically capture relevant information (Appendix 4). This checklist is only used sporadically, usually during the first meet and greet with the parent/carer, once a young person is eligible for the project (see also cycle 4).

Cycle 4: Enhanced carer/parent engagement

Cycle 4 has made an initial start with engaging carers as part of the process to obtain relevant health-related information to identify outstanding health checks or assessments. At the moment, the Health Navigator has taken a lead role for this work, co-organising meet and greet sessions with carers, in conjunction with case management from child protection or alternative OoHC provider. It is anticipated that future engagement with carers will benefit from this early contact made by the Health Navigator, creating a connection and building relationships. A more collective effort, and

realisation by child protection staff and case managers from OoHC providers of the importance of early introduction of carers and guardians of children in scope to the Health Navigator and the project, may enhance engagement; a critical base element for operationalising system integration, and ensuing mental models.

Governance structures

Governance structures in place at the commencement of the project remained in place at the time of the second progress report. In principle, the PCG and CAG meetings take place monthly, (refer to critical touchpoint diagram before), with the PCG usually preceding the CAG. Upon the identification of the first four children in scope for the project, around the time of the first progress report release, a decision was made to use CAG meetings as the mechanism for PDSA cycle reviews and have reporting timelines captured within the specific cycles to account for this. It has meant that CAG meetings, as can be seen in the overview of meeting occurrences, have not been held regularly due to the lack of PDSA cycle data for review and discussion. A hiatus of a few months occurred, with a first CAG meeting scheduled again in May 2021, during which PDSA progress rather than review was tabled for discussion, as well as other agenda items requiring strategic input and guidance.

The irregular nature of the CAG meetings has meant that the development of PDSA cycles hasn't eventuated to the extent that was predicted in the previous report. Representatives from the La Trobe University evaluation team attend both these meetings to provide an update on evaluation progress. Despite a suggestion that was made at the October (2020) PCG meeting to invite a carer representative to future meetings to rekindle the important carer voice to the project, this hasn't occurred as yet. Similarly, the recorded action to explore involvement of other relevant stakeholders in the project and their formalised participation as a project stakeholder on the PCG, is an ongoing area for attention. Broader stakeholder engagement would strengthen the applied ToC, encouraging integration at the macro-level (between organisations, across sectors).

Planning session

A future planning session is scheduled for July 2021 following the final version of progress report number 2 (this report), for discussion of recommendations, and an opportunity to convene to discuss next steps as part of the final stage of the project.

Meeting attendance

Members of the research team (CM and/or WV) attended majority of the CAG and PCG meetings. In their role as embedded evaluators, they would present on progress, provide suggestions for consideration (e.g., PDSA cycle content, planning meeting content, project referral amendments) and participated in project-related discussions. By taking a reflective stance, querying decisions and clarifying processes, focus maintained on system-related improvements rather than role-specific functioning.

Next steps of project evaluation

The evaluation for the final phase of the project involves elements that report on accumulated material over the life course of the project, whereas other elements are specific to the final stage, providing a 'point in time' overview. The living document analysis, for example, spans the collection of material collated over the course of the initiative, whereas the output and outcome review here constitute an end-point assessment.

The La Trobe research team works from the assumption that the project trial period will finish in November 2021. In no particular order, the final report will include the following elements.

Model sustainability

The original business case lists a key deliverable as *Modifications to initiative based on evaluation findings*, preceding the sustainability-phase of the trial initiative. Loosely translated, the evaluators propose that the revision includes the involvement of the staffing team at the Child and Family hub in Mildura working in partnership to progress referrals for CYP in OoHC in need of health assessments and support. A comparison of project progress including outcomes associated with a more structured involvement of the operating model of the hub, will provide great insight into sustainability of the model moving forward. Critically, it promises to be a key success factor for the element of integration as part of the project.

Finalised ToCA

This element of the evaluation will primarily focus on the applied ToCA framework (COM-B) and its related findings and outcomes, as well as a description around its 'goodness-of-fit' to an initiative of this sort.

Thematic analysis of semi-structured interviews

A series of interviews will be conducted between June and October 2021, coinciding with the formal end date of the two-year project. This will enable comparisons of material obtained from interviewees regarding the project's progress and traction, as well as new insights provided through this second round of interviews.

System change

The six conditions of system change model will be fully populated with data available, describing and discussing the extent to which change has worked its way through the various layers towards becoming implicit (summum).

Living document analysis

A summary will be provided of the analysis of relevant documents and information sources having been made available to the research team against the nine systems of interest.

Output and Outcomes data

In Appendix 5, an overview is provided of outcome and output indicators listed in the evaluation plan developed by DHHS, providing an evaluation requirement for the final report. The caveat being that information will be provided for as much as it is readily accessible or available. Some manipulation may need to occur to some of the indicators to make it more relevant, better aligned with the changes made to the scope of the project, including eligibility criteria (e.g., *cumulative record of all children in kinship care in Mildura with prescribed medications* will need to be *cumulative record of all children in kinship care in Mildura*). Linking this to the topic of model sustainability, it may be useful to extend this indicator to include *source* and *entity responsible.*

Reference list

Braithwaite, J. (2018). Changing how we think about healthcare improvement. *BMJ*; 361, 2014.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Ezzy, D. (2013). *Qualitative analysis*. Routledge.

Appendices

Appendix 1. Draft COM-B TOC model and proposed criteria for ToC analysis

Appendix 2. Overview of COM-B interventions, including examples and identified behaviour change (May 2021)

Appendix 3. Client-centred screening tool template

Appendix 4. Health Assessment checklist

Appendix 5. Overview of data output and outcomes for final evaluation report

Appendix 1. Proposed criteria for ToC analysis and draft TOC COM-B model

Proposed criteria for ToC Analysis	
Overall criteria	
Understandable	Is the logic and structure of the ToC clear?
Agreed	To what extent is the ToC agreed or contestable
Level of effort	Are the activities and outputs of the intervention commensurate with the expected results?
Criteria for each result	
Well-defined	Is the results statement unambiguous?
Plausible timing	Is the time frame for the result reasonable?
Logical coherence	Does the result follow logically from the previous result? Is the sequence plausible or at least possible?
Measurable	Is there a need to measure the result? How can the results be measured? What is the likely strength or status of evidence for the result?
M&E implications	What are the implications for monitoring and evaluation?
Criteria for each assumption	
Well-defined	Is the assumption unambiguous?
Logical coherence	Is the assumption a pre-condition or event for the effect sought?
Justified	What is the justification for the assumption as being necessary or likely necessary?
Realised	Is it plausible that the assumption will be realised? Are there at-risk assumptions that should be addressed?
Sustainable	Is the assumption sustainable?
Measurable	Is there a need to measure he assumption? How can the assumption be measured? What is the likely strength or status of evidence for the assumption?
M&E implications	What are the implications for monitoring and evaluation?
Criteria for each causal link	
Independence	Are the assumptions for the link independent from each other?
A sufficient set	Are the set of causal link assumptions along with the prior causal factor sufficient to bring about the effect? Is the link plausible?
Strength/Status of evidence	What is the strength or current status of evidence for the causal link being realised?

Appendix 2. Overview of COM-B interventions, including examples and identified behaviour change (May 2021)

Intervention	Definition	Example	Behaviour changes
Education *(Capability)*	Increasing knowledge or understanding.	Providing information about required information for referral form.	None observed.
		Increasing understanding of internal processes within child protection.	Engagement of broader range of staff in child protection. Better articulation of required information. Creative ways of soliciting and determining information ('work-arounds').
		Increase awareness of relevant frontline staff regarding project.	None observed.
Persuasion *(Motivation)*	Using communication to induce positive or negative feelings or stimulate action.	Provision of six types of client-related information will trigger referral.	Emphasising importance of this information for successfulness of project. Visible appointment when information is not readily forthcoming. Offering assistance with sourcing of material on CRM system.
		Encourage case managers to record relevant information for assessing eligibility.	Offering assistance with recording of information.
		Encourage carers/guardians to attend meet and greet session to obtain relevant health-related information.	Making contact with individual carers, stressing importance of meeting attendance and provision of health-related information. Providing alternative meeting opportunities to better suit carers.
Incentivisation *(Opportunity/ Motivation)*	Creating expectation of reward.	Timely and early information gathering will mitigate drawn-out evidence gathering, manageable caseloads, and additional support.	Early engagement with CP staff and case managers, regular and repetitive demands for information.

		Obtaining relevant health-related information from carers/guardians will enable streamlined access process.	Offering to organise case plan meetings and making contact with relevant attendees.
Coercion *Opportunity/ Motivation)*	Creating expectation of punishment or cost.	Senior leadership involvement to progress access or for follow-up.	Health Navigator seeking support from Project Coordinator and line management for initiating child protection engagement.
		Minimal engagement of child protection staff with Health Navigator.	Sourcing information from carers/guardian or young person is resource intensive.
Training	Imparting skills.	Community of Practice, or education sessions to strengthen understanding of project goals and objectives.	Health Navigator spending time with child protection staff to walk through client screening tool. Regular meetings between evaluator and Health Navigator to discuss PDSA cycle. Review of PDSA cycles at CAG meeting. Planning session to develop PDSA cycles. Co-facilitating meet and greet sessions with case managers to discuss project and eligibility criteria.
Restriction *(Opportunity)*	Using rules to reduce the opportunity to engage in the target behaviour.	Setting timelines for gathering and reporting of information.	Maximally four weeks for gathering of required information to progress referral to SCHS.
		System access (usability).	Restricted access to departmental software systems due to legislative and privacy reasons. Guidelines and protocols prescribing information requirements for recording and accessing (bits of information) on systems.
Environmental restructuring *(Opportunity)*	Changing the physical or social context.	Relevant project stakeholders spending time together.	Health Navigator to attend care team meetings (in lieu of physically spending time with child protection staff) Planning meetings for stakeholders Governance meetings.
		COVID-19 restrictions.	COVID-19 restrictions preventing or prescribing physical access to team members, carers, CYP and buildings.

			Meetings via video-conferencing.
		Recruitment of additional staff to key project roles.	Introduction of HEAC for gathering relevant information.
		Conduits for circumventing system challenges.	HEAC spending time with child protection staff and Health Navigator to obtain information about young person and update relevant checklists
Modelling *(Motivation/ Capability)*	Providing an example for people. to aspire to or imitate.	Role modelling good practice.	Principal Practitioner taking lead on PDSA cycle, showcasing relevance and importance. Project members encouraging engagement, prioritising meeting attendance and communication requirements (formal and informal).
		Taking lead on relevant project deliverables.	Case managers emphasising importance of project to carers/guardians and peers regarding project.
Enablement *(Capability/ Opportunity)*	Increasing means/reducing barriers to increase capability or opportunity.	Additional resourcing for relevant positions.	HEAC to support Health Navigator Involvement of case managers from external OoHC providers in project to facilitate access to young person.
		Improved referral pathways	Paediatrician at Child and Family hub with interest in initiating OoHC clinics Increased access to Child and Family hub.

Appendix 3. Client-centred screening tool template

SUNRAYSIA COMMUNITY HEALTH SERVICES

Form regarding: **Client Centred Screening Tool**

Client ID

This page is to be completed to summarise the client's story.
Complete after the Risk Factor Screening section on page 7. This summary is to be utilised by discipline clinicians to develop a care plan with the client.
Do not remove this page from the front of the CCST document

SUMMARY OF CURRENT LIFE STORY (SITUATION)

Summarise relevant information so client does not need to repeat story; **ask the client.**

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

KEY QUESTIONS – clinician to ask client the following three questions and note/action reply

1. What is important to you? _____
2. What would you like to work on or change? _____
3. Who is involved in supporting you? _____

Are there any other concerns that the client would like to discuss today? _____

REFERRALS TO INTERNAL SERVICES - *include **priority** and **reason** for referral*

Details: _____

REFERRALS TO EXTERNAL SERVICES

Details: _____

BROCHURES TO EXTERNAL SERVICES

Details: _____

CLINICIAN SIGN-OFF

Name	Signature	Designation	Date

SECTION ONE (to be completed by Program Support)

Date referral received by SCHS: ____________________

Referral source (organisation and name): ____________________

Service requested and reason(s) for referral: ____________________

Date referral acknowledged by SCHS with client: ____________________

Was the referral urgent or routine? ____________________

Date of Client Centered Screening appointment: ____________________

CONSUMER INFORMATION

Title:__________ Given name/s: ---------- Family name: __________

Preferred name: __________ Preferred name recorded on HMS D

Gender: ---------- UR Number: __________

Date of birth: ---------- Birth date estimated? __________

CONTACT DETAILS

(tick preferred contact method)

Home Address: ____________________

☐ Home: __________

D Work: __________

☐ Mobile: __________

Postal Address: ____________________

☐ Email*:

***NB: policy does not currently allow SCHS to send identifiable information by email**

Is the client a carer, care recipient or seeking caring assistance? ____________________

WHO THE AGENCY CAN CONTACT IF NECESSARY

	PRIMARY CONTACT	*SECONDARY CONTACT*
Name:		
Address:		
Postcode:		
Home:		
Work:		
Mobile:		
Relationship to client:		

SCHS

SECTION ONE (to be completed by Program Support)

DEMOGRAPHICS

Country of Birth: _____ Religion: _____

Identify as being of Aboriginal &/or Torres Strait Islander origin? _____

Language spoken at home: _____ Communication method: _____

Interpreter service required? _____ If yes, language: _____

Refugee Status: _____ Asylum Seeker status: _____

Government pension/benefit status: _____

Nature of disability (if on disability pension): _____

Health care card: Card number: _ _ _ _ _ _ _ _ _ _ _ _ Expiry date: _____

Medicare card: Card number: _ _ _ _ _ _ _ _ _ _ _ _ Expiry date: _____

BROKERAGE

Is the client a **Package Service Recipient?** Yes ☐ No ☐

If yes, type of package *(Home care, ND/5 or TCP):* _____

Package provider: _____

Claim number/details, level of package provided: _____

Package provider aware/has approved? _____ Purchase order raised: Yes D No D

Health insurance status: Insurer name: _____

DVA card entitlement: Card type: _____ Card number: _____

D904 form (or client advised to get from GP) _____

Compensable funding source: _____

Does the client have a relevant : *If yes, claim details/number be/aw:*

TAC claim ☐ Yes ☐ No _____

WorkCover claim ☐ Yes ☐ No _____

GENERAL PRACTITIONER (GP)

GP Name: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

PROGRAM SUPPORT SIGN-OFF - *NB: First two pages need to be completed by on HMS and saved to Drafts.*

Name	Signature	Designation	Date

SECTION TWO (to be completed by Clinician)

CLIENT HEALTH CONDITIONS *Refer to & update Community Health Program Master Code Set*

Does client suffer (or has suffered} from any of the following:

	CURRENT/PAST	HEALTHCARE PROVIDERS
Neurological (Stroke, ABI, MS)		
Cardiovascular (HT, CVD, AMI, IHD)		
Respiratory disease (COPD, Asthma, Bronchiectasis)		
Gastrointestinal		
Renal		
Endocrine (Diabetes)		
Psychological (Depression)		
Genital/urological		
Chronic pain		
Musculoskeletal		
Skin problems (Rashes/wounds)		
Malignancy (Cancer)		
Sensory (hearing/vision)		
Surgical		
Other		
If 0-16 years (measles, mumps, chicken pox)		
Pediatrician?		

ALLERGIES/ ALERTS

Yes ☐ No ☐ *If Yes, document below*

	SUBSTANCE/LOCATION	*REACTION/DETAILS*
Drug sensitivities		
Allergies		
Significant infections IHepatitis,M RSA,C-DIFF' HIV)		

Have Allergies/ Alerts been updated on HMS? Yes D No D

IMMUNISATIONS

Are the following immunisation's up to date?

Influenza	**Yes** ☐	**No** ☐	
Whooping cough	**Yes** ☐	**No** ☐	**Unsure** ☐
Measles	**Yes** ☐	**No** ☐	**Unsure** ☐

If client is a **child 0-16 years old,** ask parent/guardian:

"Have you chosen to immunise your child?" Yes ☐ No ☐

If yes, "Are they up to date?" Yes ☐ No ☐

MEDICATIONS- prescription/ over the counter/ vitamins/ supplements etc.

	Name	Strength	Dose	Frequency	Change/comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

If taking 6 or more medications on a daily basis, have you had a home medication review in the last year? Yes ☐ No ☐

FAMILY HISTORY

Significant family medical history: _____

OTHER SERVICES *List services currently involved in core*

Recent hospital admissions ----------

Case manager: _____

Need for an advocate: _____

Need or use of carer: _____

Power of attorney (medical, financial, enduring): _____

Does the client have an Advanced Care Plan in place? Yes ☐ No ☐

FUNCTIONAL HISTORY *Refer to & update Community Health Program Master Code Set*

Are you able to:

	Without help	With a little help	With a lot of help	Completely unable	Not known
Get Dressed?					
Prepare your own meal?					
Eat your meal?					
Go to the toilet?					
Shower or bath yourself?					
Travel in the community?					
Go shopping for groceries?					
Do the housework?					
Manage your money?					
Get out of bed /chair easily?					
Walk easily?					
Manage your own medication?					
Parenting?					
Yard work / Gardening?					

If client is a **child 0-16 years old,** do they have any issues with the following:

Dressing? _____

Eating? _____

Toileting? _____

Sleeping? _____

CLIENT SOCIAL CONDITIONS *Refer to & update Community Health Program Master Code Set*

Family stressors:
(relationships, work, carer, parenting) _____

Housing issues:
(environment, accommodation, alone) _____

Employment status: _____

Gambling status: _____

Literacy/education issues: _____

Legal issues: _____

Financial issues: _____

Drug or alcohol use issues:
(Type, frequency, impact) _____

Other: _____

RISK FACTOR SCREENING - *ask client the following questions and note/action & advice*

Have you had a general health assessment in the past **two** years? (GPMP) / Maternal & Child Health Assessment

Do you have any sexual health concerns - pap smears, mammograms, prostate checks, STI?
Breast Screen {VIC Phone: 132050}

Do you do thirty (30) minutes or more of moderate intensity exercise on most days of the week?

Have you had a fall in the last twelve months?
Physio I OT referral, Group sessions ☐

Weight concerns, special diet, swallowing, unable to buy food in the last twelve months?
Referral to: Dietician I Speech path I Diabetes I Life ☐

Have you had a dental check in the last two years?
Referral to Dental ☐

Do you smoke?
How many daily? For how long? X-smoker?
Are you interested in Quitting? QUIT Brochures ☐

Is DHHS or Child Protection involved with your family?
Referral to VLA ☐

Do you have any unpaid fines?
(Speeding/ Parking) *Referral to VLA* ☐

If you are renting, are you having problems with your landlord? *Referral to VLA* ☐

Do you owe a debt to Centrelink or have you been refused a Centrelink benefits? *Referral to VLA* ☐

Does someone other than you decide how you spend your money? *Referral to VLA* ☐

Does someone other than you decide the health treatment you receive? *Referral to VLA* ☐

Note:*The following question is to be asked to* ***clients aged 16 years and over*** *and in* ***privacy***

Do you have any past or current issues related to domestic violence or sexual assault that you would like to discuss with a Counsellor? Yes ☐ No ☐
(Ma/lee Sexual Assault Service/ Ma/lee Domestic Violence Service - 5025 5400}

If yes: Note the issue: _____

Past or current issue? _____

"Would you like to talk to someone from these services?" _____

SUMMARISE THE CLIENT'S STORY ON THE FIRST PAGE OF THIS DOCUMENT

SCH
SUnraysia Community Health Service

FINANCES

Is the client **exempt** from fees? Yes ☐ No ☐

If yes, reason for exemption: _____

Is the client a **health care card** holder? Yes D *(see pg. 2 for details* No☐

Will client or someone else be paying for this service? Client D Other D *see Brokerage section*

If the client is paying:

Income range (based on DHHS income levels): Low ☐ Medium ☐ High ☐

If client requests a **fee waiver/reduction,** list reasons why? _____

List any additional expenses incurred by the client related to health care */e.g. pharmaceutical, travel for medical appointments).* _____

Explain any conditions of the exemption */number of appointments, amount of time* etc.) _____

Fee waiver request discussed with Manager? Yes D No D

Clinician's signature: _____

Outcome of request Approved D Not Approved D

Manager's signature: _____

OUTCOME OF FEE DETERMINATION AS PER CLIENT FEES SCHEDULE

Has the cost of attending service been explained to, and understood by, the client? Yes ☐ No ☐

Comments/details: _____

FORMS/DATA SET COMPLETED

Consumer Consent to Share ☐

HACC Functional Status (HMS) - *where relevant* ☐

HANDOUTS PROVIDED

	Provided to client
Sunraysia Community Health Service Brochure	☐
Rights & Responsibilities	D
Australian Charter of Health Care Rights	D
Your Information: It's Private, It's About you	☐
Advanced Care Planning	D

CLINICIAN SIGN-OFF

Name	Signature	Designation	Date

Appendix 4. Health Assessment checklist

SUNRAYSIA COMMUNITY HEALTH SERVICES

Form regarding: **Out of Home Care Health Assessment**

***Name:**	Family:
	First:
	Middle:
***DOB:**	
***Gender:**	

Current medical involvement:	GP Name:
	Contact:
	MCHN – maternal child health nurse:
	Contact:
	Other:

***Alerts/Allergies:**	

***Placement type/order:**	
***DHHS CP Practitioner**	Name:
	Phone:
	Email:
***Placement Support Worker:**	Agency:
	Name:
	Phone:
	Email:
***Carer/s**	Name:
	Relationship to child:
	Phone:
Parents:	Names:
	Contact details: (optional)
OOHC Details	Length of time in care
	Length of time with Current Carer
	Reasons for OOHC placement

Any Particular health concerns:

Last health check:

Immunisations up to date: ***Australian Child Immunisation Register – 1800 653 809***

Yes	**No**

Type	**Date**	**Type**	**Date**
H-B-Vax® II Paediatric or **Engerix® B – Paediatric** (Hep B		**MMRII®** or **Priorix®** (MMR)	
Infanrix® hexa (DTPa, Hep B, Polio, Hib)		**Priorix-Tetra®** or **ProQuad®** (MMRV)	
Rotarix® (Rotavirus)		**Infanrix®** or **Tripacel®** (DTPa)	
Nimenrix® (MenACWY)		**Infanrix® IPV** or **Quadracel®** (DTPa, Polio)	
ActHIB® (Hib)		**Gardasil®9** (HPV)	
Boostrix® (dTpa)			

Is a referral required for catch up immunisations?

Referral to GP or Maternal & child health service:

Section A – Physical Health

Significant history: (Medical, birth, Medication issues, social, emotional, trauma – including abuse or neglect)

Medications:

Medication	**Dose**	**Frequency**	**Date Commenced**	**Prescription/over counter**

Sleep: **No Concerns**

Identified Issues	Actions

Consider referral back to Maternal & Child Health/ Sleep Centre / GP

Hearing / Vision (Appearance, glasses, visual concerns)**:** **No Concerns**

Identified Issues	Actions

Consider referral to audiology / optometrist / GP

Speech / communication: **No Concerns**

Identified Issues	Actions

Consider referral to audiology / GP / Speech Pathology

Oral Health (include last dental check)**:** **No Concerns**

Identified Issues	Actions

Consider Referral to dental

Form regarding: **Out of Home Care Health Assessment**

Nutrition (consider what does the child eat for meals, snacks, drinks)**:** **No Concerns**

Identified Issues	Actions

Consider referral to dietician

Elimination: (urinary and faecal) **No Concerns**

Identified Issues	Actions

Consider referral to physio / continence clinic

Skin (Eczema, rashes, bites, scars, bruises, sores)**:** **No Concerns**

Identified Issues	Actions

Consider referral to GP / skin specialist

Sections B - Examination

Height (cm)	
Weight (kg)	
BMI	

General Appearance

CVS (consider any heart conditions)**:** **No Concerns**

Blood Pressure:	
Heart Rate:	
Rhythm:	
Sounds:	

Identified Issues	Actions

Consider referrals to GP / Paediatrician / cardiac specialists

Respiratory (consider SOB, Asthma)**:** **No Concerns**

Resp Rate:	
Sounds:	
Air entry:	
other:	

Identified Issues	Actions

Consider referrals to GP / Paediatrician / Respiratory specialists

INVESTIGATIONS

Test	Date Ordered	Results
Pathology		
HB		
BGL		
Urinalysis		
Pap Smear		
STI		
Audiology		
Optometry		
Radiology / Imaging		

Section C – Emotional & Social Wellbeing

Your Home / Carer Concerns: (can you tell me about your current living arrangements? Whom do you live with? Do you have any concerns? How are your biological children coping with the placement?)

Identified Issues	Actions

HEALTH & WELLBEING

Education / Employment

Name of school/kinder/child care**:** **No Concerns**

Any concerns? (Behaviors, learning, mood, sadness, friendships/bullying, developmental delays, milestones)

Form regarding: **Out of Home Care Health Assessment**

Identified Issues	Actions

Consider referral child psychologist / GP / School support

ADDITIONAL INFORMATION (Sexual health, Substance use)**:**

SUMMARY ACTIONS FOR FOLLOW UP:

Date Commenced:	
Clinicians Name:	
Title:	
Client Name:	
Date Completed:	

Appendix 5. Overview of data outputs and outcomes for final evaluation report

Output data

- Cumulative record of all children in kinship care in Mildura with prescribed medications
- Comprehensive medication histories for all CYP in scope
- Records of reminders to case managers when medication review processes due
- Base line and subsequent measures of workforce attitudes, knowledge and skills re collection and maintenance of timely and accurate child health records
- Annual OOHC population profile of medication use and issues in Mildura cohort
- Quarterly referral/ non-referral records reports
- Quarterly reports on health service waiting times
- Quarterly reports on % of children in scope with up-to-date Medication Management Plans
- Quarterly reports on % of children in scope with cycles of health needs assessment and health plan reviews up-to-date
- Records re children who were not brought to scheduled health appointments
- % of children in scope with nominated doctor responsible for overseeing HMP/MMP
- New tools and templates developed during the project
- Records of input from carers and children about their experiences related to the project
- Measures of carer and child awareness of health service options, benefits, risks, costs etc.
- Measures of carer and child screening re safety with medicines
- Records of support to carers and children to navigate health services within and external to SCHS
- Quarterly data on internal and external health service referrals made and outcomes
- Carer or child complaints register
- Documented Plan-Do-Study-Act (PDSA) cycles will capture system changes during the project lifecycle.
- New area-based Health Pathways developed
- Annual report on health service gaps and barriers for CYP from kinship care

Outcomes data

- Data on % of children in scope with complete, accurate and up-to-date health summaries in their OOHC record
- % of children in scope who are referred to SCHS for health care coordination
- % of health service referrals from OOHC for children in scope which contain agreed minimum data set of health information
- % of children in scope seen by a health practitioner at SCHS within 14 days of referral
- % of carers and/or children requiring an interpreter who receive interpreter services at first SCHS appointment
- % of children in scope whose medication is reviewed by a doctor
- % of children in scope with a Medication Management Plan
- % of children in scope with comprehensive health needs assessment up-to-date
- % of Health Management Plans/Medication Management Plans reviewed within 4 weeks of planned review date
- % of children who experience adverse drug reactions and medication allergies where these are accurately recorded in OOHC child record
- Content and quality of annual population health profile for CYP in OOHC kinship care in Mildura