Inner West Sydney

Healthy Homes and Neighbourhoods

Healthy Homes
and neighbourhoods

2015-2016
Annual Report

An interagency collaboration
for children, young people
and their families

Auspiced by Sydney Local Health District

NSW GOVERNMENT Health
Sydney
Local Health District

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Foreword

I'm delighted to present the first report of the *Healthy Homes and Neighbourhoods* Integrated Care Initiative. The initiative was funded in January 2015 as part of the NSW Government Integrated Care Planning and Innovation Fund, and reflects Government's desire to move toward a more integrated health system. *Healthy Homes and Neighbourhoods* goes beyond the integration of health care and seeks to ensure that the social care needs of families and their children are also addressed.

The proposal for the initiative was developed as a partnership between Sydney Local Health District (SLHD), NSW Department of Family and Community Services, the Inner West Sydney Medicare Local (now the Central and Eastern Sydney PHN), and partners from the Inner West Collaborative Practice Management Group (CPMG). We were able to draw on a significant body of local work, including the: *Families NSW Headline Population Indicators Data Report 2009, SLHD Perinatal Coordination Guidelines, CPMG Working Together Plan, SLHD Vulnerable Families Forum* and Business Case, a FACS-Housing led place-based project in Redfern, *Families NSW Parenting Communication Strategy – Love Sing Talk Read Play*, a General Practice Well Child Training Project, and a shared child and family outcome framework.

Coinciding with implementation of the initiative, the NSW Government identified Sydney District as a launch site for a whole-of-Government Service Delivery Reform - *Healthy Strong Communities*, and Sydney District launched the *Inner West Sydney Child Health and Wellbeing Plan. Healthy Homes and Neighbourhoods* is an integral component of both initiatives as will be reflected in this first annual report. In addition, during 2016, the SLHD Board and the NSW Ministry of Health invested in sustained health home visiting programs in the Canterbury area and Redfern/Waterloo/Darlington, known as *Healthy Families, Healthy Children.* The services provided to families through sustained health home visiting will complement the work of *Healthy Homes and Neighbourhoods.*

Dr Teresa Anderson

Chief Executive
Sydney Local Health District

Healthy Homes and Neighbourhoods aims to ensure that families have their health and social care needs met

Introduction

A focus on families

The children and young people of today are the future of our society tomorrow. Parents and families play an important role in determining the life course that today's children will follow. Yet few of our services focus on the health and social needs of the adult members of families.

Many adult family members are under stress because of their health and social needs. Chronic and complex health and social conditions have a significant impact on all members of a family unit including adults, dependent children and extended family members. Some chronic and complex conditions result in economic disadvantage, social exclusion, intergenerational poverty, mental illness, poor health behaviours, poor parenting, limited formal education and unemployment.

If our children are to thrive, a supportive, nurturing and safe home environment is necessary. *Healthy Homes and Neighbourhoods* aims to ensure that families have their health and social care needs met and that they are connected to their local communities.

Family health care

Family doctors, and their general practice staff, play an important role in supporting the total care needs of families over a life-course. Regular well health care during pregnancy, childbirth and a child's early years ensures the delivery of preventative and health promoting care. General practice plays a critical and enduring role in the management of both acute and chronic health and social concerns, thus avoiding costly and unnecessary hospital presentations.

A cornerstone of the *Healthy Homes and Neighbourhoods* initiative is the establishment of a trusting **'Health Home'** for all families. This is being achieved by supporting both families and general practice to establish and maintain sustainable relationships.

Supportive neighbourhoods

Local neighbourhoods, including schools, play an important role in providing a supportive and safe environment for children and young people. The African Proverb 'it takes a village to raise a child" is never truer than in some of our disadvantaged inner city suburbs. Some of our local neighbourhoods are both socially and physically harmful to our children and their carers. Much can be done to support communities to create local **'neighbourhood nests'** that nurture and protect our most vulnerable children and their families.

Population health

The initiative has strong population foundations and builds on extensive studies of the needs of our families and communities. The family health improvement component promotes family health, wellbeing and safety. Health protection initiatives being developed include: immunisation, tobacco control, and environmental health.

Our service system

Almost all our health, education and social care services are funded by Federal, State or Local Government. However individual teams and business units do not always communicate well, collaborate, or trust each other. The *Healthy Homes and Neighbourhoods* initiative aims to build a robust and innovative collaboration for families across health, social, education and private sectors. To achieve this, the initiative is contributing to the strengthening of a District-wide trusting service network that builds and exchanges evidence-informed knowledge and skills.

Enabler projects have been built into the design to ensure long-term sustainable system change. Some of those initiatives include:

- A practitioner knowledge translation network that builds on the existing schools as communities, local interagency and Inner West Sydney Collaborative Practice Management Group (CPMG) networks.
- Client-centred care coordination phone and web apps that support and enable families to take control of the their own health, education and social care needs.
- Vulnerable child and family care pathways embedded in Sydney HealthPathways.
- Shared Patient Reported Measures for assessment, and monitoring of client experiences and outcomes.

Continuous evaluation

The *Healthy Homes and Neighbourhoods* Integrated Care initiative is a 'complex intervention' and we have therefore drawn on recently published UK Medical Research Council material to design a continuous series of linked mixed method (quantitative and qualitative) studies.

These studies are designed to assess "what is working for whom and why" at family, practitioner, agency and population levels.

Initiative design

Components

The Healthy Homes and Neighbourhoods Integrated Care initiative has nine key components designed to achieve the vision of an integrated service system that supports families.

1. Pathways to care
2. Care coordination
3. Knowledge translation
4. Supporting General Practice
5. Family health improvement
6. Neighbourhood health and wellbeing
7. Collaboration and system reform
8. Child and family centred outcomes
9. Research and evaluation

Governance structures

Three interagency committees provide governance and sponsorship: the Healthy Strong Communities service delivery reform committee; an Inner West Sydney Partnership Committee; and the multi-agency Healthy Homes and Neighbourhoods Steering Committee. A SLHD Healthy Homes and Neighbourhoods Management Committee also provides governance and advice on SLHD relevant matters.

This top-down multi-agency partnership is supported by a bottom-up network of clients and frontline workers that fosters commitment to collaboration at all levels.

GOVERNANCE STRUCTURES AND PROCESSES

District Partnership Committee
Healthy Homes and Neighbouroods Steering Committee

Healthy Homes Care Coordination trial
- Pathways to care
- Identify families
- Link to services
- Sustain and review

General Practice linkage
- Engage
- Support
- Training

Refern/Waterloo trial
- Local hub
- Co-location of services
- Community needs assessment
- Team Around Family

Riverwood trial
- Local hub
- Co-location of services
- Community needs assessment
- Team Around Family

Capability projects
- REDcap and Patient Reported Outcome Measures
- Patchwork
- Care Coordination app
- 'Child at Risk' and 'Adult at Risk HealthPathways

Family health improvement
- Key health messages normative document
- Health needs analysis
- Website
- Social media

STRENGTHENING SECTOR CAPABILITY

Healthy Homes and Neighbourhoods Network

System change
- Professional trust and knowledge
- Identification and risk stratification
- Informed consent policies
- Shared intake and communication systems
- Shared standards of collaboration

Capability building
- Transition research
- Trauma and family partnership skills
- HealthPathways development
- Shared standards of collaboration
- Website for professionals

Inner West Sydney Partnership Committee

The partner organisations which make up the Inner West Sydney Partnership Committee are:

- Sydney Local Health District
- Family and Community Services Sydney District
- Central and Eastern Sydney PHN
- Department of Education Ultimo Operational Directorate
- Inner West Sydney Collaborative Practice Management Group

Healthy Homes and Neighbourhoods Steering Committee

The current steering committee membership includes:

- Sydney Local Health District:
  - Child and Family Health Services (Community Health)
  - Mental Health
  - Drug Health
  - Population Health
  - Aged, Chronic Care and Rehabilitation
- Family and Community Services (Child Protection)
- Department of Education Ultimo Operational Directorate
- Sydney Children's Hospitals Network
- Central and Eastern Sydney PHN
- Sydney District Nursing children's services
- The Infants' Home Ashfield
- Barnardos Australia Family Referral Service
- The Benevolent Society
- Jannawi Family Centre
- Tresillian

Healthy Homes and Neighbourhoods logo

The *Healthy Homes and Neighbourhoods* logo symbolises the collective ownership of the initiative amongst the *Healthy Homes and Neighbourhoods* partners. Though Healthy Homes and Neighbourhoods is led by Sydney Local Health District, representing the initiative with the SLHD logo would not be representative of the contribution and support of other agencies.

In 2015, Tractor Design School Sydney students were provided with a brief to develop a *Healthy Homes and Neighbourhoods* logo. Seven logos were drafted by the students.

Focus testing occurred with three groups of parents attending local playgroups. Feedback from all groups indicated a strong preference for the selected logo.

Healthy Homes
and neighbourhoods

"It represents diversity, harmony, happiness"

"A hand symbolises help"

"The colours of the cultures are represented together"

"It speaks to me culturally, and means embrace, open arms"

"It is a greeting, a way of saying hello"

A population approach to child and family health and wellbeing begins during pregnancy

1. Pathways to care

Sometimes, health and social care systems can be difficult to navigate and occasionally mistakes happen. Previous reviews have found that pathways to care are not clear or well documented. Where there are complex needs it is usually necessary to use several pathways and to have a worker help with the navigation. A big picture view is needed as individual services and clinicians may not appreciate the complexity of the path ahead. The first year of the project has focused on a number of critical pathways and enabling tools.

Pregnancy and childbirth

A population approach to child and family health and wellbeing begins during pregnancy. SLHD has undertaken several studies of pregnancy and childbirth outcomes (2012-2014). One of these studies identified a significant proportion of mothers with high social care needs who fail to engage with services after birth.

Coordination of pregnancy and childbirth services for families with complex needs is not simple. There are often concerns regarding substance use, mental health, domestic violence, prior psychological trauma, and intellectual capacity to parent. The pathways to care need to be robust.

The *Inner West Sydney Child Health and Wellbeing Plan* identified that a high priority was to develop an integrated multi-agency approach to high-need client groups with a common family-centred care plan commencing before birth. There is strong evidence that multi-agency interventions should commence as early in pregnancy as possible. This is also a key focus of the new *Healthy Families Healthy Children* program.

During 2015, *Healthy Homes and Neighbourhoods* established a multi-agency family centred 'wrap-around' approach to the care of antenatal clients referred to the initiative. To facilitate this pathway, staff endeavoured to attend all antenatal care coordination meetings at Royal Prince Alfred and Canterbury hospitals.

The NSW Health Safe Start Policy and SLHD Perinatal Coordination Guidelines were used to inform the development of perinatal pathways to care. An important component of these policies is the requirement to have multi-agency attendance at antenatal meetings. This approach ensures that maximum use is made of the support and care that is available in the service system. Thus pregnant women and their partners, who require additional support, are able to receive services in their own homes or communities prior to the birth of the infant with improved outcomes for mother and infant.

Significant progress was made during 2015 toward establishing multi-agency support for antenatal referred clients. Further work is required, however, to strengthen non-government agency involvement in the antenatal pathways.

A number of the families referred to *Healthy Homes and Neighbourhoods* wrap-around care subsequently had their infants assumed into care due to child protection concerns. As a family-focused initiative, *Healthy Homes and Neighbourhoods* sought to address the ongoing needs of the parents following the assumption of their child into care. The *Healthy Homes and Neighbourhoods* Steering Committee agreed that the parents would continue to be registered clients and the committee has sought to identify suitable therapeutic counselling and health care interventions for the parents irrespective of whether there was a possibility of the infant's restoration to the family.

Schools

The *Healthy Homes and Neighbourhoods* initiative has built on an existing SLHD Community Paediatric Service relationship with several schools in high-need neighbourhoods.

During 2015, consultation was undertaken with 10 schools across two high-need neighbourhoods:

- Glebe Public School
- Alexandria Park Community School
- Darlington Public School
- Our Lady of Mount Carmel Primary School
- Jarjum College
- St Jerome's Catholic Primary School
- Punchbowl Public School
- Lakemba Public School
- Hampden Park Public School
- Riverwood Public School
- Hannan's Road Public School

Work has been done with some of these schools to pilot care coordination in partnership with education staff. The aim of the pilots is to build capacity of educators to navigate the complex health and social sector to more confidently address the needs of families.

Interagency discussions during 2015 highlighted the differentiating behavioural needs of students in the Redfern and Waterloo communities. Consequently, discussions were undertaken with the principals of Green Square School and Alexandria Park Community School. The two principals prepared a vision statement for a 'knowledge translation and service network' that would be based around a shared clinical facility at Green Square School, in partnership with Family Referral Service and Youthblock. Proposals for a new clinic and pathways to care are currently being developed.

Emergency Department

Healthy Homes and Neighbourhoods staff have visited the Emergency Department at Royal Prince Alfred Hospital on a number of occasions. Emergency Department staff were provided with information about referral pathways to *Healthy Homes and Neighbourhoods* care coordination, as well as general information about vulnerable families and their complex needs. Until further work is done to connect these families with General Practice, many will present at hospital emergency departments in the first instance to seek medical support.

Family and Community Services

Both the Community Services and Housing branches of Family and Community Services (FACS) are important pathways to care.

Families often come into contact with FACS Housing staff at the RedLink integrated services hub located in Redfern's McKell Building (an initiative of FACS Housing). At this point of contact, if either the family or Housing staff identify a need for further health or psychosocial support, the family are referred to the *Healthy Homes and Neighbourhoods* clinical nurse consultant or social worker who are co-located in the RedLink office. This pathway to care has meant that many families who otherwise would not have come into contact with health services, have now been supported to have their family health needs met.

To assist *Healthy Homes and Neighbourhoods* staff in understanding processes and decision making at FACS Community Services, all Healthy Homes and Neighbourhoods clinical nurse consultants and social workers attended the Sydney District FACS Community Services offices for a one week 'immersion' experience. The aims of the immersion were to foster relationships between Healthy Homes and Neighbourhoods staff and Community Services staff; enhance Healthy Homes and Neighbourhoods' understanding of the nature of Community Services clients and processes in order to work together and communicate most effectively and appropriately.

Perinatal Family Conferencing

Perinatal Family Conferencing (PFC) is a joint initiative between SLHD and FACS Sydney District. It was envisaged that the *Healthy Homes and Neighbourhoods* care coordinator would support and extend the impact of PFC by ensuring sustained long-term health and social care support for PFC families.

During 2015, efforts were focused on developing relationships with key stakeholders who facilitate PFC at Royal Prince Alfred Hospital. The possibility of using a wrap-around model of care for these families will be explored in the second half of 2016.

General Practice

A cornerstone of the *Healthy Homes and Neighbourhoods* initiative is the establishment of trusted **"Health Homes'** for all families. This will be achieved by supporting both families and general practices to establish and maintain sustainable relationships.

Joint general practice visits are attended by a *Healthy Homes and Neighbourhoods* clinician, CESPHN project officer and a GP researcher, in the suburbs identified as having the most family disadvantage in the District. Practice visits provide opportunities to introduce *Healthy Homes and Neighbourhoods* referral pathways, online care coordination tools and family health improvement resources.

Risk assessment tools

Risk assessment tools have been developed for adult and child family members based on Safe Start indicators. The tools incorporate known social determinants of health and the relationship of health and wellbeing with adverse child events and are used at the point of referral to assist in prioritising cases.

Intake systems

Families must meet the following criteria to be referred to Healthy Homes and Neighbourhoods care coordination.

Inclusion criteria:

- Family must have one or more children unborn or 17 years of age.

AND

- Parent/carer with complex health and/or psychosocial care needs which are impacting on their capacity to provide a safe and nurturing environment and to participate in their community.

Exclusion criteria:

- Family does not reside in Sydney district
- Family does not consent for *Healthy Homes and Neighbourhoods* care coordination

A *Healthy Homes and Neighbourhoods* care coordination referral form has been developed for referrers to complete. This form has been designed to capture important information about including family contact details; professionals already involved in the family's care (including general practice); family strengths and protective factors; concerns about adult and child family members and the consent to refer. Referral forms are emailed to a generic intake email account, and triaged at a weekly intake meeting.

HealthPathways Sydney

HealthPathways Sydney is a web-based information portal supporting primary care clinicians to plan patient care through our primary, community and secondary health care systems. HealthPathways Sydney is a collaboration between Central and Eastern Sydney PHN and Sydney Local Health District.

The HealthPathways Sydney site is designed to be used at the point of care, primarily by general practitioners but is also available to hospital specialists, nurses, allied health and other health professionals in inner west Sydney. The pathways provide information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the timeliest way.

Healthy Homes and Neighbourhoods is currently creating HealthPathways for families with complex health and social care needs which will contribute to the sustainability of the *Healthy Homes and Neighbourhoods* initiative. These pathways will be accessible by general practice (medical, nursing and allied health), private practitioners, AHPRA registered school counsellors and health workers in partner NGOs.

Healthy Homes and Neighbourhoods convened a working group to commence the development of pathways for 'Psychosocial High Risk Adult' and 'Psychosocial High Risk Child'. The group is transferring knowledge gained from care coordination to date onto the sustainable and accessible HealthPathways site. The 'Psychosocial High Risk Adult' pathway has been completed and is on the draft HealthPathways site and development of the child pathway will be drafted by end 2016. These pathways will complement over 100 child-related pathways which already exist on HealthPathways Sydney.

2. Care coordination

A central component of the *Healthy Homes and Neighbourhoods* initiative is long-term care coordination and coordination of enrolled vulnerable families. The experience of clinicians and partner organisations is that clinical care and service interventions for vulnerable families is usually episodic and 'families fall between the cracks'. The clinical care and service system is designed around a requirement for individuals and families to manage their own care, usually with the support of a general practitioner. The objectives are to:

1. Ensure vulnerable families are referred to appropriate services
2. Identify families who slip through gaps and subsequently do not engage with services, and connect them back into services
3. Identify gaps in health service provision for this population, and in collaboration with existing services, develop sustainable strategies to fill these gaps.

The care coordinator is required to:

1. Provide leadership and support in the building of local service networks and referral pathways for vulnerable families
2. Liaise with and support service providers to ensure referral to appropriate services in accordance with the care plan
3. Coordinate and track service provision for identified vulnerable families, including ongoing information coordination for providers
4. Provide information, support and referral services to women identified as vulnerable within the project target group.

During 2015, significant progress was made in developing the care coordination model. Unlike the perinatal model on which it was based, the clinical model requires intense engagement and assessment of families. Combined with a lack of services, this sometimes led to the care coordinator assuming case management tasks. Thus the planned "step-down" process was often delayed, particularly in suburbs outside of the identified disadvantaged suburbs, as these suburbs can have limited local support services and programs.

Intense interagency work to develop the service network aspect of *Healthy Homes and Neighbourhoods* has led to new clinical partnerships being developed. The recruitment of a Staff Specialist as clinical lead has also assisted to initiate and support the "step down" process.

The initiative aims is to break down service silos and provide an integrated service response that appropriately reflects the interconnected nature of complex support needs. It is hoped that by supporting colleagues to take on work that historically would not be within their domain and building on individual and agency strengths, not all families will require a referral to *Healthy Homes and Neighbourhoods* care coordination.

A monitoring system has been developed to plan for throughput of families and to measure the "step down" process.

Wrap-around care

During 2015, a wrap-around model of care was trialled in the Redfern and Waterloo Public Housing Estates. *Healthy Homes and Neighbourhoods*' approach of wrapping the multi-agency team around the family over a sustained period of time endeavours to mediate the impact of individual crises.

Aims of wrap-around care

- To facilitate a phased approach of care coordination focusing on connecting care and bridging gaps for families.
- To offer care coordination by working in partnership with families, other services (including GPs) and community. The level of care coordination needed will increase with greater system fragmentation. The level of need is not fixed in time and is tailored to the individual's needs.
- To provide a 'team around the family' model of intervention to increase a family's capacity to independently manage their complex health and psychosocial needs.
- To encourage early referral to *Healthy Homes and Neighbourhoods*, particularly during pregnancy, to provide sufficient time to coordinate and encourage parental contribution at all stages of assessment and planning.

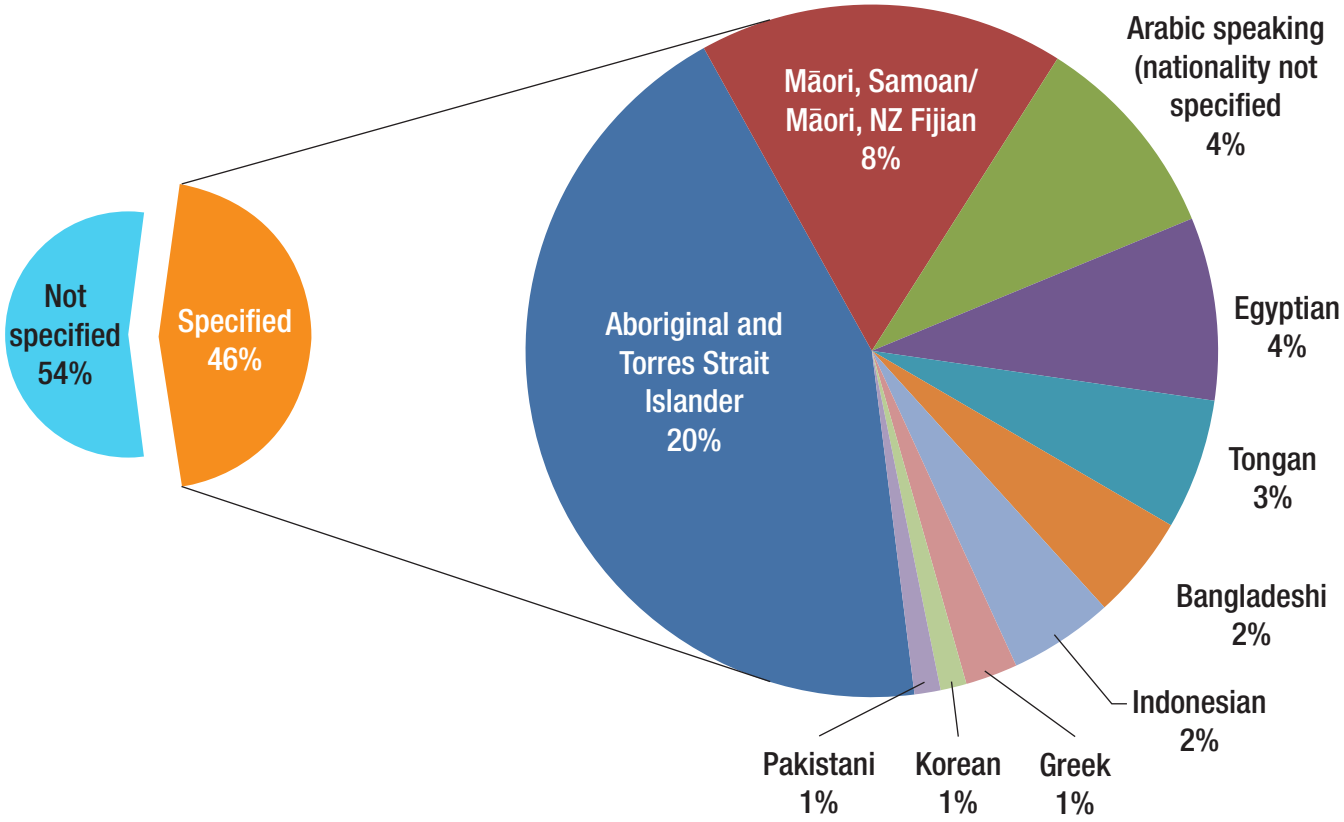
The wrap-around care model

Who is being referred for care coordination?

Healthy Homes and Neighbourhoods began accepting referrals for care coordination in June 2015. By April 2016, 145 individuals from 65 families received care coordination services (including wrap-around care) from *Healthy Homes and Neighbourhoods* clinical nurse consultants and social workers. Of these individuals, 53 per cent are children (including unborn children) and 47 per cent are adults (parents, carers or other adult family members). Three quarters of the adult family members receiving care coordination are female, reflecting the high number of single parent families where a female is the primary carer.

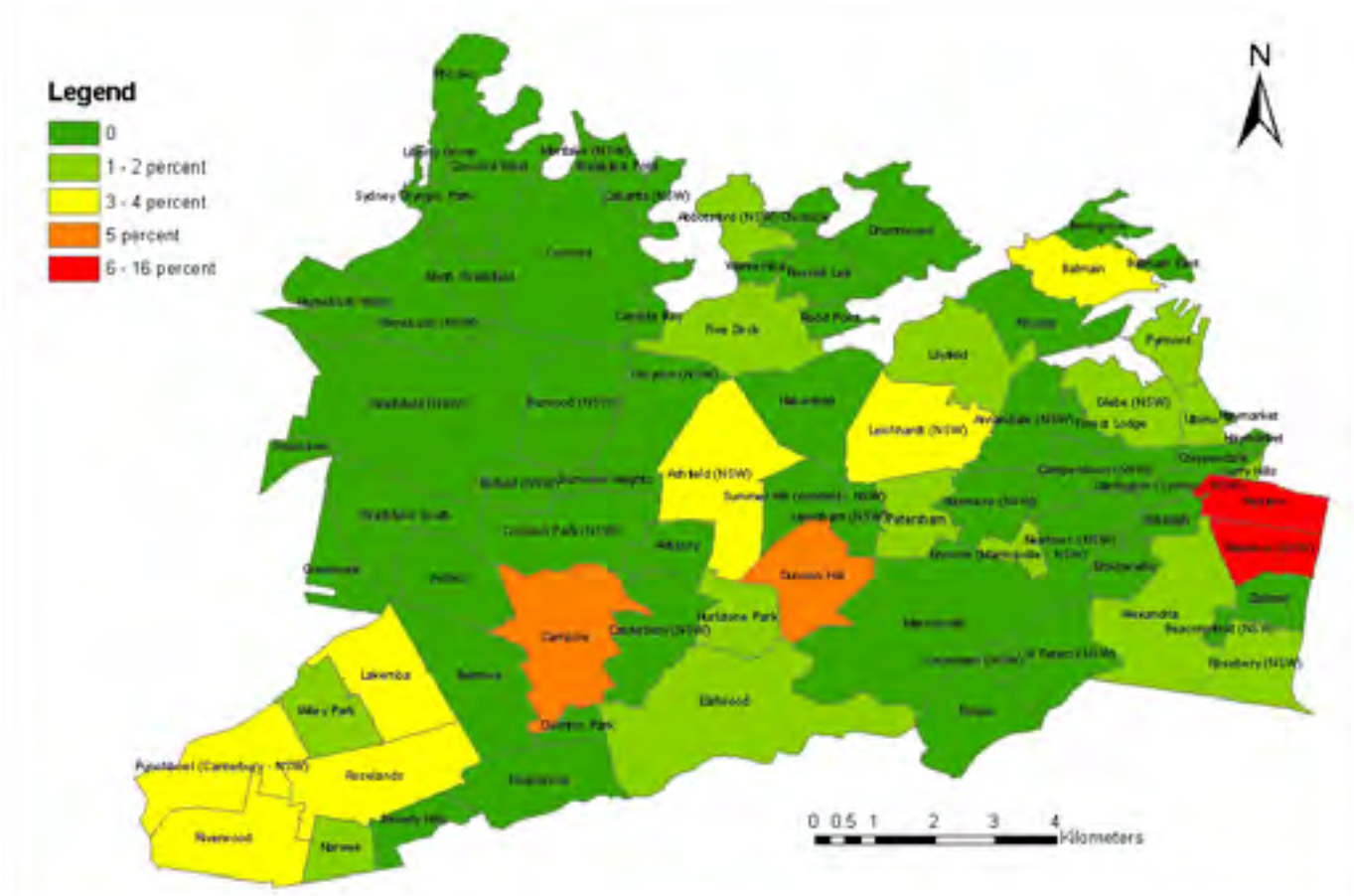
Forty-six per cent of individuals referred specified their cultural background. Out of these individuals, the cultural group most represented is Aboriginal and Torres Strait Islander. Anglo-Celtic individuals are assumed to be under the not specified group.

Cultural background



The majority of referrals are for families residing in the Canterbury LGA and Redfern/Waterloo. The map below shows the distribution of families referred to care coordination. Families with no fixed address (living in a refuge, temporary accommodation or homeless) account for eight per cent of referrals, and two per cent of referrals were for families living outside SLHD.

Geographic distribution of families



3. Knowledge translation

The *Healthy Homes and Neighbourhoods* initiative uses and promotes use of evidence-informed interventions. There is extensive health, education and social services literature on approaches to improve life-course outcomes for vulnerable children and their parents including: sustained health home visiting, child and family health centres, targeted parenting programs, multi-systemic therapy and other multimodel wrap-around approaches. There is also extensive literature on integrated care and place-based initiatives for children and families.

Integrated care evidence review

Dr Rebekah Grace, Children and Families Research Centre of Macquarie University, completed a literature review to support the *Healthy Homes and Neighbourhoods* initiative. The review, titled 'Hard-to-reach or not reaching far enough? Supporting vulnerable families through a coordinated care approach', covered the following:

1. Explored the facilitators and barriers to service engagement for vulnerable families, including what is meant by the term 'hard-to-reach' and the factors that contribute to services being hard-to-access
2. Outlined service responses designed to improve engagement with vulnerable families
3. Described models of coordinated or integrated care that have been employed to address complex family support needs
4. Assessed the strength of the evidence indicating that coordinated care leads to improved outcomes for vulnerable families.

Highlighted interventions

The original proposal gave additional information on wrap-around care and family group conferencing as these were being proposed for use in the place-based trials. Sustained health home visiting, child and family centres, targeted parenting programs and multi-system therapy remained on the integrated care agenda but were not expanded further in the expression of interest.

Wrap-around

Wrap-around services were initially developed in the 1970s, and are most commonly conceived of as an intensive, individualised care planning and management process as opposed to a treatment per se.

There have also been about 10 controlled (experimental and quasi-experimental) studies published in peer-reviewed literature as well as a meta-analysis that has been conducted on seven of these studies. These showed consistent and significant outcomes in favour of the wrap-around group compared to control groups across a wide range of outcome measures including residential placement, mental health outcomes, school success and juvenile justice recidivism.

Wrap-around approaches are usually used for adolescents and young adults. The use with families is innovative and will require subsequent evaluation of efficacy. Our evaluation will focus on acceptability and feasibility.

By April 2016, there were 27 families registered to the Redfern place-based project receiving a wrap-around model of care. Ethics for the process evaluation was approved in 2015. Outcome measures are currently being finalised.

Family Group Conferencing

Family Group Conferencing (also called family group decision making and family decision making) was developed to bring families together, including children and extended family members, with community organisations and agencies to express concerns, problem solve and plan for future action (Huntsman, 2006)[2]. The principles of Family Group Conferencing models are:

1. *Collaboration* between families and community supports
2. *Respect* for the family's community and culture
3. *Children's rights* to a voice in decision making and to safety
4. *Empowerment* of families
5. *Mobilisation* of increased *support* to the family (Berzin, Cohen et al., 2008)[3].

Staff training for Family Group Conferencing will be undertaken in 2016.

[2] Huntsman, L. (2006) 'Family group conferencing in a child welfare context - a review of the literature'. Sydney, NSW Department of Community Services.

[32] Shlonsky A, Tugwell P. (2009) 'Systematic reviews of social interventions'. Evidence-Based Child Health: A Cochrane Review Journal 4(2):387-8.

Healthy Families, Healthy Children

Sydney Local Health District has identified as a priority, the need to further invest in and redesign the broad range of services available to children and families residing within the District. All early years programs and services are incorporated under the banner 'Healthy Families, Healthy Children' (HFHC). SLHD is working to develop a sustainable and equitable service system model that offers assessment and tailored care to all families:

- HFHC supports the best development of children and enables parents to lead healthy and fulfilling lives.
- HFHC is a service, resource program and support network that can be accessed and utilised as required, and includes:
  - Antenatal, maternity and hospital paediatric services
  - GP shared care
  - Resources, information, support and referral post-birth through the Child Health Information Link (telephone and SMS use currently, with website under development which will be complemented by a moderated Facebook page and Facetime consultations)
  - Child and Family Health nurse home visiting
  - Multi-disciplinary child and family health clinical services and programs
  - A structured program of sustained home visiting for families requiring additional support
  - Specialised services such as for children of parents with a mental illness; child protection counselling; inpatient beds for mothers with PND and their babies
  - Multi-agency and specialist team care and service provision

Targeted parenting programs

As noted above there is evidence for targeted parenting programs. The following are under investigation:

1. Parenting under pressure
2. Triple P targeted program
3. Multisystemic therapy

In addition, SLHD Mental Health Services have been funded to implement the 'Got It' conduct disorder prevention project.

Child and family centres

There is considerable evidence for comprehensive place-based child and family centres. Opportunities for this model are being examined as part of the place-based projects in Redfern and Riverwood.

Knowledge Translation Network

Healthy Homes and Neighbourhoods network and website

The *Healthy Homes and Neighbourhoods* initiative provides an opportunity to network enrolled families, general practitioners, allied health providers, schools, and collaborating partners. During 2015 *Healthy Homes and Neighbourhoods* worked to develop a network of clinical teams, services and organisations who share a common vision to provide quality care to families. The network of professionals is growing, and a professionals' website is currently under development to assist them to connect and learn from each other.

Education-health Knowledge Translation Network

Consultation was undertaken regarding strategies to better support children and adolescents with behavioural concerns in Redfern and Waterloo. A vision document was prepared by the principals of Green Square School and Alexandria Community School which included proposals for joint clinics and the development of a collaborative knowledge translation and service network. The Department of Education has installed two classrooms on the Green Square School site and partner agencies are working to establish multi-agency clinical services and knowledge translation hub.

Consultation was undertaken regarding strategies to better support children and adolescents with behavioural concerns

4. Supporting General Practice

General practitioners are family medicine specialists. Together with their practice nurses and staff, family doctors support multiple generations of family members. Beginning prior to conception, regular preventative care promoting health and wellbeing is delivered by GPs to family members throughout their lives. General practice plays a critical and enduring role in the management of both acute and chronic health and social concerns, thus avoiding costly and unnecessary hospital presentations. The trusting relationship formed between a GP and a family is one which must be supported and sustained.

A cornerstone of the *Healthy Homes and Neighbourhoods* initiative is the establishment of trusted **'Health Homes'** for all families. This will be achieved by supporting both families and general practices to establish and maintain sustainable relationships.

General Practice Needs Assessment

A database of 853 general practitioners in the SLHD area (and border suburbs) was completed in 2015. In late 2015 ethics approval was granted for a survey to be administered to all of these general practitioners and general practice nurses, looking at problems frontline clinicians face when working with vulnerable families, and solutions created by their teams. The survey includes a needs analysis of education and support required for practices. Recruitment has commenced and results will be reported on in late 2016.

Strengthening links with local GPs and practice nurses

Healthy Homes and Neighbourhoods builds on strong links with the local primary health network. Joint general practice visits are attended by a *Healthy Homes and Neighbourhoods* clinician, CESPHN project officer and a GP researcher, in the suburbs identified as having the most family disadvantage in the district. Practice visits provide opportunities to introduce *Healthy Homes and Neighbourhoods* referral pathways, online care coordination tools and family health improvement resources. GPs are provided with information on health promotion initiatives and links to practice management support by CESPHN.

During practice visits, GP and practice nurse 'champions' (or leaders) in their communities are identified and invited to participate in further GP related projects in the region. Several GPs have agreed to partner with *Healthy Homes and Neighbourhoods* to provide a **'Health Home'** for families who have not yet linked in with a GP.

Innovative data sharing solutions aim to integrate GP databases with pre-existing central CESPHN GP databases, reducing duplication of information. Semi-structured visit diaries document information, at a glance, about the practice and their staff, and allow GP clinicians to provide feedback about their local problems and individual solutions to keeping family members of their community healthy and engaged.

Providing education and resources

Over 60 GPs attended a *Healthy Homes and Neighbourhoods* presentation delivered at a local paediatrics update in early 2016. During updates and practice visits, clinicians signed on to email distribution lists for *Healthy Homes and Neighbourhoods* updates, child health and parenting resources.

An eLearning child health and developmental surveillance education module for GPs and practice nurses is being developed by a local Developmental Paediatrician, Dr Natalie Ong. It will be piloted in 2016.

Application has commenced for accreditation and training as an education activity provider for the Royal Australian College of General Practitioners. This will ensure online education modules and other events have Continuing Professional Development points allocation for GPs. Educational events will also be endorsed and advertised by RACGP to all GPs across Australia.

The trusting relationship formed between a GP and a family is one which must be supported and sustained

5. Family health improvement

A key feature of the *Healthy Homes and Neighbourhoods* initiative is the early intervention and public health approach to promoting and protecting family health and wellbeing. The initiative works closely with both general practices and enrolled families to support the use of preventative health measures. The extended service sector also plays an important role in promoting preventative health and wellbeing for families.

Sector capacity building

There are several current initiatives to build the capacity of the service sector to promote family health. The Families NSW parenting communication strategy led to the development of *Love Talk Sing Read Play* in 2007 which included widespread sector and community capacity building initiatives. A second component of that strategy was to develop initiatives to promote family health. The Supported Playgroups Plus manual, developed by FACS – South West Sydney in 2011, included key family health messages.

Healthy Homes and Neighbourhoods will be considering sector training needs when analysing data obtained during qualitative research projects.
The Inner West CPMG has agreed to act as a steering committee to assist with decision making about sector capacity building activities.

Immunisation project

Healthy Homes and Neighbourhoods work to encourage families engaged in care coordination to have all their dependent children and adolescents fully immunised. Childhood vaccination is a current key performance indicator for SLHD. *Healthy Homes and Neighbourhoods* have access to the Australian Childhood Immunisation Register and proactively provide catch-up vaccinations through affiliated medical clinics.

Data will be captured mid-2016 and mid-2017 in the initiative to measure progress with vaccination rates of registered families.

Key messages project

A steering committee has been formed for the Healthy Homes and Neighbourhoods' key messages project. Work has commenced on a normative document, based on the World Health Organisation 'Facts for Life'. Key messages are being developed under subheadings which are holistic and acknowledge the social determinants of health:

- healthy living
- healthy bubs and kids
- healthy safe houses
- healthy finances
- healthy safe communities
- healthy minds and relationships.

The principles of the normative document are that:

- The essential messages are distilled in a succinct manner
- The messages are valid (based on evidence or expert opinion)
- The messages carry authority (they should be referenced to agencies such as WHO)
- Messages can be understood by a trained health worker and can be used as a blueprint for media aimed at different target groups (in terms of educational level, culture and language)
- Consistent messages can be disseminated not just by SLHD but also by other partner agencies

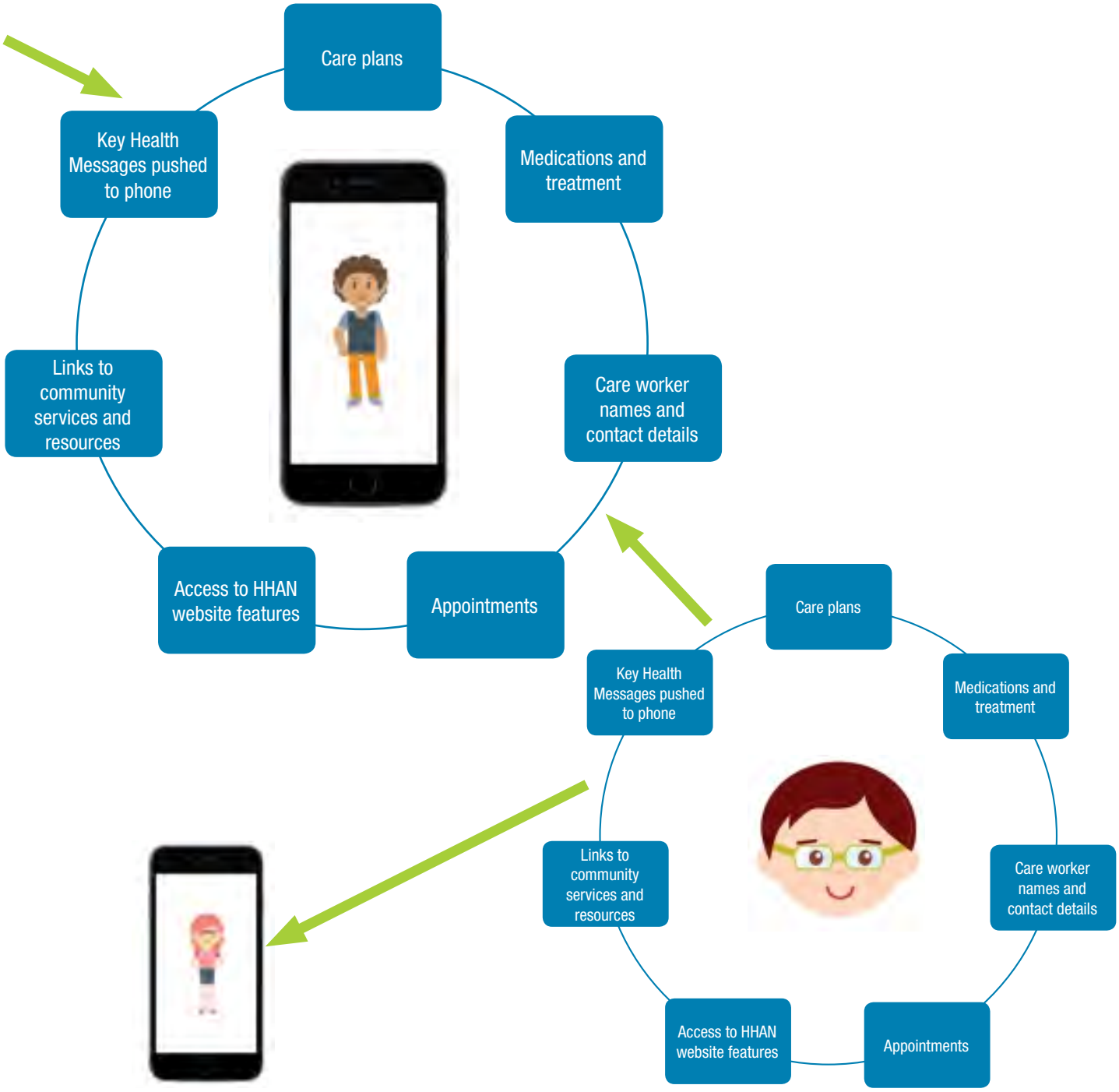
A large multidisciplinary team of partners with diverse skills and experiences are contributing to the content. A broad range of knowledge sharing activities will be produced, using the normative document as a reference. These range from push notifications (via the care coordination mobile application and Facebook) to the *Healthy Homes and Neighbourhoods* website. A research project centred on this project is currently ongoing. Consultation amongst consumers and stakeholders will allow us to ensure that the most appropriate messages are distributed to those in need, via the most appropriate means.

Website developments

Development work has commenced on the *Healthy Homes and Neighbourhoods* website. Initially the normative document of messages will be used to create material for the section of the website aimed at families. The website will serve as the basis for development of a social media strategy incorporating Facebook and the *Healthy Homes and Neighbourhoods* care coordination smartphone application. Multicultural and translational experts have partnered with *Healthy Homes and Neighbourhoods* to assist with translation of key messages to the website. Scoping is currently occurring for a website for professionals. This will enable multi-agency group work and secure shared care planning for vulnerable families.

Integrated care application

Scoping work is taking place on the development of a smartphone application to support care coordination for families. The app will store important information about care providers and their contact details, care plans, medications and treatments, appointment reminders and links to community services and resources. Carers will be able to create profiles for themselves and their children, from a single account. Key health messages will also be pushed to phones via the app, depending on the individual needs of each family.



6. Neighbourhood health and wellbeing

For integration to be successful it needs to be locally driven within a well organised primary and community sector. The approach taken to integration in this initiative is both system-wide 'top-down' change and local 'bottom-up' change. The initiative was designed to have at least two local elements through deliberate recruitment and service partnership development in (the former) City of Canterbury local government area, and City of Sydney - south. This was to enable the development of demonstration site place-based partnerships with local general practice, schools, family support agencies, local government, religious organisations and community members.

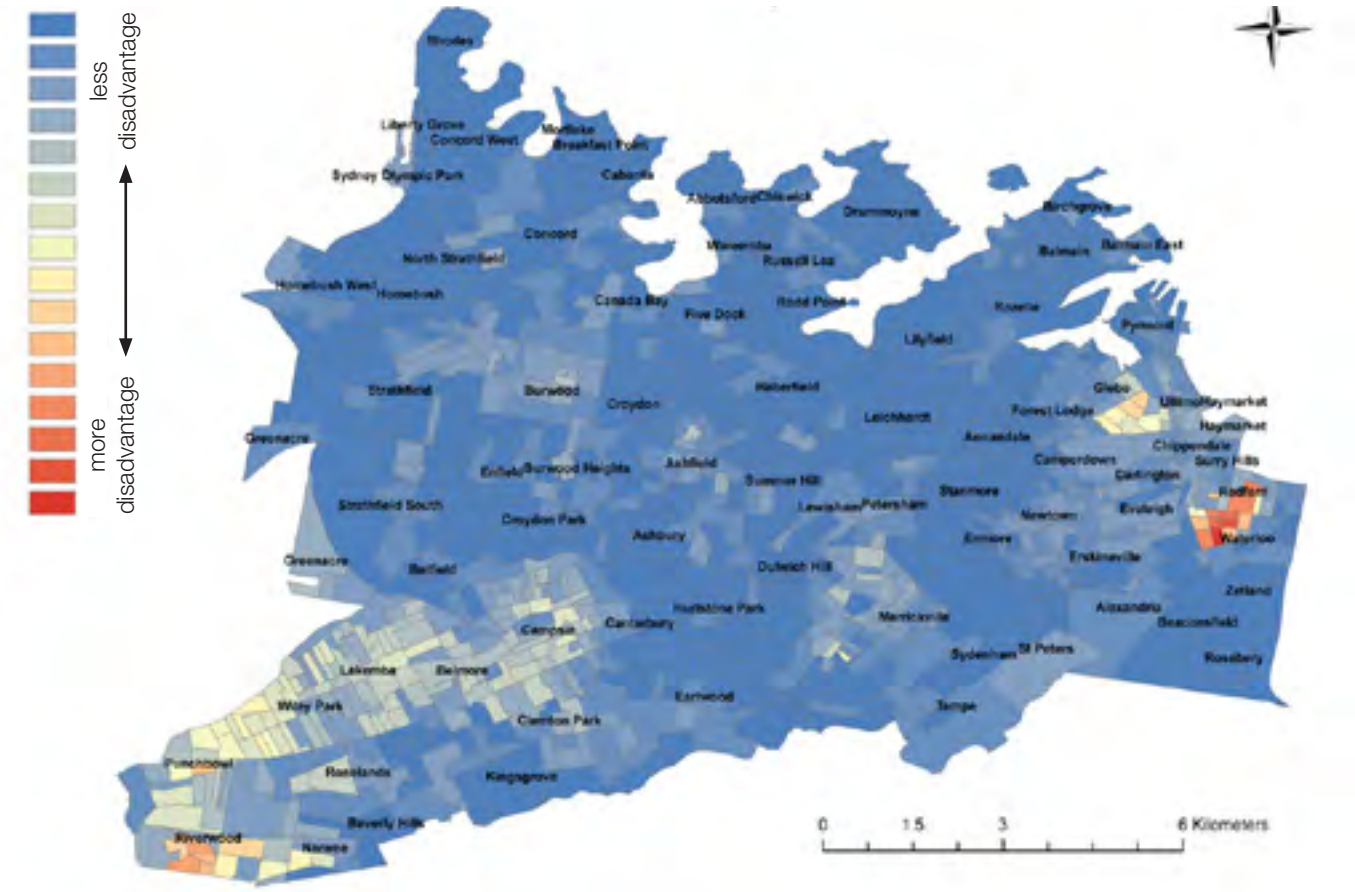
Spatial needs analysis

Healthy Homes and Neighbourhoods has taken a spatial epidemiology approach to identify the geographical distribution of the most vulnerable families with intergenerational cycles of disadvantage and trauma in the District by:

- Identifying indicators of family disadvantage and mapping them within SLHD
- Identifying clusters of disadvantage
- Analysing potential pockets or 'hot spots' of extreme or complex disadvantage.

The above process produced a map which can pinpoint streets or blocks of housing which may require more targeted intervention. This identified priority neighbourhoods for place-based intervention – Riverwood in the Canterbury Bankstown local government area, and Redfern and Waterloo in the City of Sydney.

FAMILY DISADVANTAGE IN SLHD



Riverwood

The Riverwood community is part of both the former Canterbury and Bankstown local government areas, and therefore straddles two local health districts. Riverwood has not been the focus of recent community development work, despite high levels of family disadvantage and poor access to health services. *Healthy Homes and Neighbourhoods* have commenced work in Riverwood by consulting with service providers such as police, education, Riverwood Community Centre, Sydney District Nursing children's services and Family and Community Services. Preliminary analysis of consultation data shows emerging themes across three areas: systemic issues which create barriers to accessing health services; social issues which create barriers to accessing health services; and systemic issues for the service sector.

Healthy Homes and Neighbourhoods have piloted care coordination with Riverwood Public School and Hannans Road Public School. Other activities which will be undertaken include exploration of a community hub/ wellbeing centre; capacity building to facilitate change in understanding, identification and engagement; and community development.

Healthy Homes and Neighbourhoods worked with the Canterbury Child and Family Interagency who hosted the 2016 Riverwood Picnic in the Park. This was the first event in Riverwood in many years which aimed to engage parents and their children in the services available to them.

Redfern/Waterloo

Redfern and Waterloo are suburbs within the City of Sydney local government area, and historically had high rates of social and economic disadvantage, substance abuse, domestic violence and mental illness within its community. However, the demographics of the suburbs are rapidly changing.

The population of the suburb spans a broad spectrum of socioeconomic characteristics. This may be partly due to the geography of the suburb, which is long, narrow, and centrally located. Redfern has become increasingly gentrified, with many medium and high density developments replacing low density and industrial developments. Redfern and Waterloo are very diverse and rapidly changing suburb, and the published literature may not adequately represent this diversity and the pockets of extreme disadvantage that are likely to persist.

Aboriginal community

Redfern is the political and social centre for the urban Aboriginal population of New South Wales. The 2011 Census data is believed to underestimate the extent of Redfern's Aboriginal community, since many people may decline to complete forms or declare Aboriginality, and the proportion of Redfern and Waterloo's Aboriginal population has been estimated by members of the Aboriginal community to be twice that of the national figure of 2.5 per cent.

Life expectancy of Aboriginal people is significantly less than the general population. Many families are faced with serious illness, chronic disease and premature death. Screening rates for cervical and breast cancer are low amongst this population. In addition to chronic disease, the Aboriginal population also have high incidence of co-morbidities including drug and alcohol addiction and mental health issues.

Previous governmental policy that took thousands of children away from their families has caused significant and continuing trauma for the communities. Some people who were removed have not had experiences of good parenting within an Aboriginal family context and consequently struggle to learn how to be parents to their children. Grief, loss and stress are major components of everyday life in many Aboriginal communities. Residents and services often struggle with these disempowering histories and circumstances that result from intergenerational trauma.

Housing

Another reflection of the disparate populations within Redfern is the rate of social housing; 18.3 per cent of people in Redfern live in social housing, compared to 4.3 per cent in Sydney and 3.9 per cent nationally.

Domestic violence

Redfern and neighbouring Waterloo have the highest rates of domestic violence in Sydney Local Health District. The rate of domestic assault incidents in Redfern from January to December 2014 was 776.7 per 100,000; more than double that of the New South Wales rate of 398.2 per 100,000.

Place-based initiative

The *Healthy Homes and Neighbourhoods* place based initiative in Redfern and Waterloo offers a health and social work perspective for families and professionals in the area. The team takes a family-centred approach, employing case-conferencing techniques and actively encouraging families to partake in decision making about their support needs.

Services wrap-around families and work together in an integrated way to support improved outcomes related to: parent health and socio-emotional wellbeing; levels of family dysfunction and violence; and child health, development and education.

The *Healthy Homes and Neighbourhoods* Redfern place-based initiative is located at RedLink. RedLink is an integrated service hub led by FACS Housing NSW based on the ground floor of the McKell Building, in the heart of the Redfern estate. A variety of services are co-located at Redlink with the aim to collaborate, and in partnership with the community, to deliver innovative and integrated services to families and individuals.

Healthy Homes and Neighbourhoods care coordinators as well as professional staff from FACS Housing, Drug Health, Mental Health, Chronic Disease Management, Redfern Legal Centre, Legal Aid, NEAMI and Partners in Recovery are based there to deliver services onsite to the 1,200 people living in the Redfern towers, the most concentrated social housing estate in NSW.

As a result of locating staff at RedLink, *Healthy Homes and Neighbourhoods* have learnt the power of co-location, as they work with social and health service partners to build meaningful working relationships with shared clients.

RedLink helps to engage members of the community who would not otherwise engage with services. Many families are referred to *Healthy Homes and Neighbourhoods* care coordination by FACS housing staff when they present at the RedLink office for assistance with Housing matters. Additionally, RedLink has renovated community spaces and activated them as wellness hubs for community activities such as cooking. These groups serve as soft entry points to health services, and *Healthy Homes and Neighbourhoods* staff attend these groups to engage with the community, build trust and support clients to access services.

A variety of services are co-located in Redfern with the aim to collaborate, and in partnership with the community, to deliver innovative and integrated services to families and individuals

Poet's Corner Preschool

Poet's Corner Preschool is situated in the heart of the Redfern estate and services children from social housing in the area. A high proportion of the children attending the preschool identify as Aboriginal, and a number of families receiving *Healthy Homes and Neighbourhoods* care coordination have children attending this preschool.

The manager of the preschool raised concerns about the health of some of the children attending, including tooth decay, diet, behaviour and developmental delay. *Healthy Homes and Neighbourhoods* offered a weekly drop-in for parents to discuss their concerns with a health professional, build rapport with the *Healthy Homes and Neighbourhoods* team, and demystify and build trust with the health sector.

As a result, five children have been referred for paediatric assessment and care coordination. Six families were offered advice and support to seek services (e.g. legal, immigration, parenting groups, toy libraries) without needing a referral to care coordination.

In the first term of 2016, *Healthy Homes and Neighbourhoods* introduced the SLHD Oral Health team to the setting. Oral health plan to offer a fluoride treatment program to all children and those who need follow up will be supported by *Healthy Homes and Neighbourhoods*.

7. Collaboration and system reform

The *Healthy Homes and Neighbourhoods* integrated care initiative was developed as a partnership between Sydney Local Health District, NSW Department of Family and Community Services, Central and Eastern Sydney PHN, and partners from the Inner West Collaborative Practice Management Group.

The initiative proposed to "build and evaluate a robust and innovative collaboration for vulnerable families across health, social, education and private sectors, with shared planning, commissioning and evaluation of initiatives".

Child Health and Wellbeing Plan

During 2015 the partnership committee finalised and launched the Inner West Sydney Child Health and Wellbeing Plan which focuses on:

- Supporting healthy children, families and communities
- Providing collaborative and integrated care models.

The strategic themes of the plan are:

- Improving system capacity
- Health and wellbeing promotion
- Early intervention
- Supporting place-based approaches.

Healthy Homes and Neighbourhoods has been highlighted as a demonstration initiative of the plan and the cross-agency collaboration.

School workshops

Two workshops were held in 2015, with staff attending from 10 schools in the Redfern/Waterloo area and Canterbury local government area. Also attending the workshops were representatives from partner organisations identified by the schools as organisations they work with when assisting vulnerable families.

These workshops were facilitated by the Director Jannawi Family Centre, with content including: trauma informed care; collaboration and highly complex cases (barriers and enablers) and collaboration in practice. Following the workshop, each school was asked to identify one family to pilot care coordination in partnership with *Healthy Homes and Neighbourhoods*. The intention of the consultations and pilot cases was to establish ongoing clinical pathways with the two groups of schools.

Feedback following the workshops indicated that schools would like more information on: trauma informed care; strategies for engaging families and carers; Patchwork; ethnic specific services; refugee/ settlement services; and high schools. Schools also requested assistance with allocation of time or funding to develop relationships with other agencies, opportunities to network with other professionals, sustaining links with other services, and supporting families over the longer term.

Patchwork

Patchwork was developed in the United Kingdom to save time and resources for busy care providers, helping them to identify all relevant agencies who may be providing care to a young person or their family. It was designed to identify both the visible and hidden networks of care.

In Australia, FACS has purchased the licence for Patchwork and is trialling it as a tool to support better coordination and information sharing across agencies. Patchwork is an online service directory, built around the patient or client. The tool allows a practitioner to:

- Add and maintain contact details for clients and practitioners
- See at a glance what agencies are working with clients and how to connect them
- Invite others into a team working with the client
- Raise attention regarding a client
- Update a client's name, address or date of birth.

No clinical information is stored on Patchwork.

SLHD approved to a trial of Patchwork with clients receiving care coordination services and clients attending community paediatrics branches clinic. The *Healthy Homes and Neighbourhoods* program manager has been appointed Patchwork trial project lead.

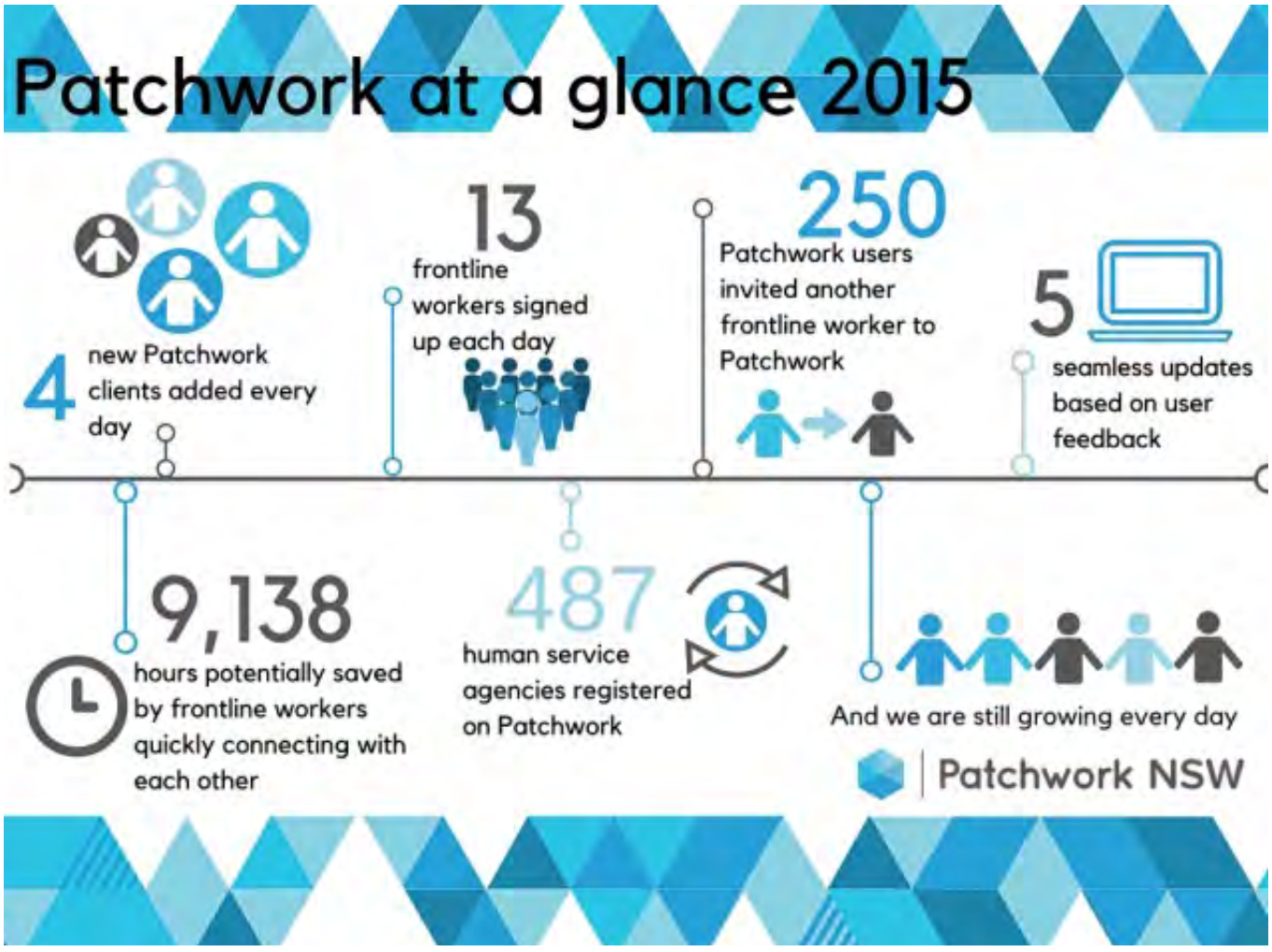
The following SLHD services have been listed as agencies on Patchwork:

- Child and Family Health Services
- Sydney District Nursing
- Drug Health
- Mental Health
- Oral Health
- Youthblock
- Aged, Chronic Care and Rehabilitation
- Balmain Hospital
- Canterbury Hospital
- Royal Prince Alfred Hospital
- Concord Repatriation General Hospital
- Sydney Local Health District – medical and other health care services (a general agency account for staff wishing to not specify their profession).

A guideline for SLHD staff using Patchwork has been developed as well as a privacy and consent education package to refresh staff on their privacy obligations in the context of Patchwork. Teams from these services are being approached to undertake Patchwork training with FACS, which will incorporate the SLHD privacy and consent refresher.

The Patchwork trial project lead will monitor the uptake of Patchwork amongst SLHD staff, collecting data such as the number of:

- active SLHD staff accounts
- client teams that SLHD staff are attached to
- new clients SLHD staff register onto Patchwork.



8. Child and family centred outcomes

Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) are scientifically and linguistically validated instruments that enable definition of patient outcomes and shared decision making as part of care planning. PROMs capture the client's perspectives about how their illness or care impacts on their health and wellbeing. Patient reported measures are an enabler of the NSW Integrated Care Strategy.

Healthy Homes and Neighbourhoods have selected a number of tools to capture PROMs for adult family members, child family members and parents. These tools support a client centred approach to care coordination, allow the client to assess their mental, physical and psychosocial health status and needs, and quality of life. The *Healthy Homes and Neighbourhoods* PROMS improve communication between the client and care coordinators, and facilitate client formed goals.

The *Healthy Homes and Neighbourhoods* PROMs tools include:

- Kessler 6: a global measure of distress about anxiety and depression in the past four weeks
- Growth and empowerment measure: a measure of quality of life, empowerment and wellbeing
- Depression and anxiety stress scale (DASS21)
- Assessment of quality of life (AQOL 6D): measure of health related quality of life
- Strengths and difficulties questionnaire (SDQ)
- Daily life stressor scale: screening for severity of daily stress and avoidance behaviour.

Screening tools are also administered at the time of completion of PROMs. The tools selected screen drug and alcohol use, postnatal depression, domestic violence and developmental or social-emotional delay.

Healthy Homes and Neighbourhoods have commenced work on an online tool for collection of PROMs, using the REDCap database, with assistance from NSW Agency for Clinical Innovation. This will allow families to complete their PROMs assessments using a smart device which will score and report on the measures, saving clinician time and facilitating ease of completion.

Following the PROMs trial period, *Healthy Homes and Neighbourhoods* will evaluate the use of these tools and widen the scope of the project to include the initiative partners who will then be able to utilise and contribute to the REDCap database of shared assessment tools.

INTEGRATED CARE PROGRAM – LOGIC MODEL

INPUTS
What we invest in

- INNOVATIVE WAYS OF WORKING
- PRIMARY AND COMMUNITY CARE AS A HUB
- FAMILY IDENTIFICATION
- INFORMATION SHARING
- FAMILY EMPOWERMENT

OUTPUTS
Activities: what we do → Participation: who we reach

- Develop and test care co-ordination and engagement program (including supporting ethics proposals)
- Develop a proposal for monitoring child health and development outcomes

- Establish protocols for collection of general practice information
- Plan GP capacity building project
- Identify and commence processes for stakeholder engagement
- Identify options for local "hubs"
- Plan family service sector capacity building project

- Identify potential pool of families
- Confirm or establish referral sources (link to perinatal, drug health, mental health, school health projects)
- Identify provisional inclusion and exclusion criteria
- Develop or modify referral forms
- Investigate EMR/flag system
- identify or Develop a provisional risk assessment tool
- Develop a vulnerable families Sydney Health Pathway/Healthy Homes Pathway and associated redesign
- Develop initiative to ensure all enrolled children are immunised

- Develop, with consumer input, a client information package including informed consent package
- Implement the Patchwork tool for information sharing
- Negotiate with stakeholders priority access to services for most participating families by developing formal referral pathways
- Develop a HHAN Network Outline Plan and potential social media application
- Formally link the community paediatric and Public Health Unit immunisation project to Healthy Homes and clarify referral processes

- Develop a Redfern Project Plan including research and evaluation
- Identify the Canterbury geographical distribution of the "most vulnerable" families with intergenerational cycles of disadvantage and trauma
- Undertake Canterbury local consultation and planning

PATIENTS
- Poorly connected and struggling families with complex health and social needs
- Parents, children and young people with chronic health conditions that are unmanaged or undermanaged

SOURCES OF REFERRALS
- Safe Start
- Early childhood sector
- Schools
- Child and family sector
- Youth sector
- Primary care
- Emergency Department and hospital inpatient/outpatient services
- Mental health
- Drug health
- Community Health
- Family and Community Services

PROVIDERS
- Multiple services managing discrete needs and crises without sufficient co-ordination

AGENCIES INVOLVED:
- SLHD
- Family and Community Services IW Sydney Medicare Local
- Dept. of Education and Communities
- Barnardos Family Referral Service
- The Benevolent Society
- Tresillian
- The Infants Home
- Brighter Futures
- Jannawi Family Centre
- Riverwood Community Centre
- Others (Centrelink, Legal Aid, Police, Justice Health, NGOs, local government, employment agencies, neighbourhood centres)

Initial focus areas:
- City of Canterbury
- City of Sydney – South

STAKEHOLDERS
- Families and communities
- Local and state government health, family and legal services
- NGOs
- General Practice
- Providers of early childhood services
- Primary and secondary schools
- Private sector specialist providers

SYSTEM CHANGE TEAM
- SLHD-FACS-IWSML Senior Partnership and Planning committee
- Healthy Homes and Neighbourhoods Steering Committee
- Healthy Homes and Neighbourhoods Program Partnership Group

OUTCOMES
Short (1-2 years) → Medium (3-5 years) → Long Term (10 years +)

CLIENT OUTCOMES
To have identified and arranged appropriate management of:
- Unvaccinated family members
- Diabetes and other chronic disease
- Poor oral health
- Interpersonal violence
- Drug and alcohol related concerns
- Mental health concerns
- Poor parenting practices
- Concerns for the safety of clients and others

PROVIDER OUTCOMES
To have:
- Established a Healthy Homes Pathway with affiliated agencies
- Established Healthy Homes Protocols
- Affiliated agencies interacting with family through use of Healthy Homes pathway and using the Patchwork tool
- Trialled family case-conferencing
- Trialled and report on wrap-around model of care
- Developed training modules for GPs and sector capacity building
- Delivered capacity-building training to partners in the Healthy Homes and Neighbourhoods Network
- Developed and implemented shared family risk assessment tool to guide referrals to the Healthy Homes Pathway

PROGRAM OUTCOMES
To have:
- Processes for identification and enrolment of vulnerable families
- Project plan for Redfern
- Agencies are signed up as Healthy Home and Neighbourhood partners
- Intra- and inter-agency referral pathways
- HealthTracker tool in place to monitor family member outcomes
- Care co-ordination team with both project and partner funded components
- Baseline data collection completed
- HHAN Network project and social media application project underway
- An evaluation design completed

CLIENT OUTCOMES
To have:
- Families have partnered with the HH&N teams to assess the health and wellbeing of family members
- Families are engaged with the healthy home team and affiliated services to address needs
- Families are equal partners in the design of Service packages
- Whole of family plans with specific goals and actions
- Families fy and provide feedback to their Healthy Home GP
- Families having visited their Healthy Homes GP
- Chronic health conditions recognised and stabilised
- Family confidence and knowledge improved
- Families recommend the service

PROVIDER OUTCOMES
To have
- Developed "demonstration site" place-based partnerships with local GPs, schools, family support agencies, local govt, religious organisations and community members
- Refinement and endorsement of the provisional family risk assessment tool and protocols
- Collaborative learning and information sharing between partners
- Completed an EMR data linkage project
- Progressed towards building an innovative social media application that connects enrolled family members to collaborating partners
- Trialled and reported on a model that encourages efficiency via utilisation of Medicare funding

PROGRAM OUTCOMES
To have
- Barriers and enablers to sustained engagement analysis embedded into clinical practice and program design
- Reduction in avoidable ED presentations and admissions for primary care sensitive conditions for enrolled families
- reductions in avoidable involvement with statutory child protection
- reductions in homelessness and housing insecurity
- Support for joint coordinated care and shared service strategies
- Strengthened relationships with local government sector

Client Outcomes
To have:
- Family stabilisation achieved
- Complex health and social needs met
- Supported development of parenting skills
- Improved health, independence, and quality of life
- Increased engagement in learning, earning, and community participation
- Reduced need for intensive, crisis-oriented support and greater use of universal services
- Reduced impact of adult complex health conditions on the safety, health, development and wellbeing of children
- Client voice influences HHAN

Provider outcomes
To have:
- Sustainable models of care
- Networking and secondment opportunities
- Promoting, streamlining or unifying inter-agency groups
- Skilled and well-supported general practice "health homes"
- Empowerment of front-line clinicians and clinical teams to take leadership decisions in partnership with clients with regards to co-ordinating care, assessing program needs and implementing change

Program Outcomes
To have:
- Children and young people attending school and learning; adults and young people are engaged in meaningful activities
- Reduced intergenerational effects of persistent disadvantage, poor health and psychological trauma
- Better returns on health investments via co-ordination of interventions
- Collaboration across health, social, education and private sectors with shared planning, commissioning and evaluation of initiatives
- Children and families recognised as experts in their lives and engaged in planning, implementing and delivering services
- Service providers can identify client-led aspects of HHAN

9. Evaluation and research

The *Healthy Homes and Neighbourhoods* integrated care initiative is a complex intervention, which has drawn on recently published UK Medical Research Council guidance to design a continuous series of linked critical realist mixed method (quantitative and qualitative) studies.

These studies are designed to assess what is working, for whom, and why, at family, practitioner, agency and population levels. The general approach to evaluation has been to build evaluation into each key component or trial initiative. The evaluations have been undertaken within existing resources.

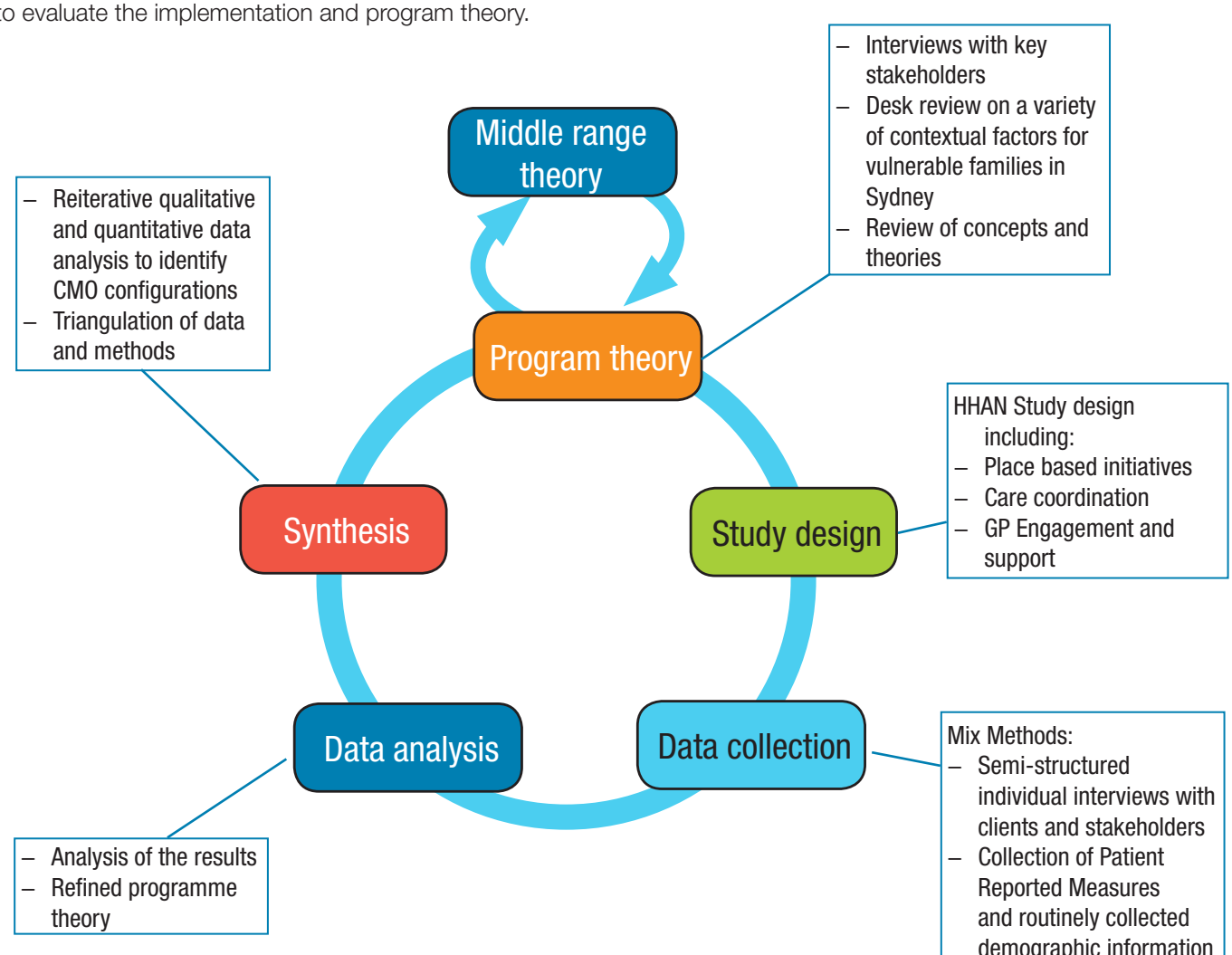
Evaluation design

An evaluation design document was prepared in November 2015. The evaluation design drew on the NSW Health Integrated Care Strategy: Monitoring and Evaluation Framework (NSW Ministry of Health 2015) and the evaluation approach proposed in the *Healthy Homes and Neighbourhoods* integrated care initiative expression of interest. The integrated approach seeks to evaluate the implementation and program theory.

Implementation evaluation

The implementation evaluation approach is aligned with the NSW Health Integrated Care Strategy: Monitoring and Evaluation Framework, including:

- Program logic development
- Indicator development
- Road map development and reporting
- Defining functional component
- Quarterly reporting
- Use of routine data sources
- Continuous improvement approach.



Program theory evaluation

The program theory evaluation approach uses critical realist evaluation and seeks to assess what is working, for whom, and why at family, practitioner, agency and population levels. The reasons behind the successes and/or failures of community based interventions are often complex, but it is extremely valuable to understand them. A critical realist approach has been demonstrated as a useful tool to achieve this knowledge in previous studies and will be used to evaluate *Healthy Homes and Neighbourhoods*. The first phase is to identify the program theory using literature reviews, prior theory development, local studies and the first cycle of qualitative studies.

To achieve this, a series of qualitative studies are currently being undertaken with a focus on:

- Maternal and family context
- Practitioner context
- Place-based settings
- Interagency contexts
- Population-level context.

The general approach to evaluating *Healthy Homes and Neighbourhoods* is to build evaluation into each key component or trial initiative to see what is successful, and determine why. The studies include:

Client level:

- Qualitative interviews with clients and their *Healthy Homes and Neighbourhoods* care coordination practitioners to understand their experience. The context (underlying circumstances), mechanisms (what actually happened physically and socially) and outcomes of the care coordination support will be examined.
- Pre and post intervention PROMs will provide quantitative data about adult, child and caregiver mental health, quality of life, stressors, drug and alcohol screening, empowerment and self-efficacy and child development.

Stakeholder level:

- Interviews with stakeholders and partners, to qualitatively describe the impact of the initiative across multiple agencies. The same approach will be used to assess the context, mechanisms and outcomes pertaining to the place-based component of *Healthy Homes and Neighbourhoods* in Redfern/Waterloo, with interview data from clients, community members and professionals from local organisations.
- A Delphi study has commenced to identify key themes that service providers (including managers and frontline staff) feel contribute to the challenges encountered in providing integrated care services, as well as personal and professional strengths.
- Social network analysis methodology will be used to analyse governance and interagency partnerships.

Population level:

- A spatial atlas of child and family health indicators was developed at the commencement of *Healthy Homes and Neighbourhoods* using population datasets from a range of sources. This will be repeated towards the end of the *Healthy Homes and Neighbourhoods* to measure change at a population level.

Enabler projects

Several of the enabler projects are also being separately evaluated, including:

- eLearning project
- Patchwork
- GP engagement
- Care coordination phone app
- Website.

Research

In addition to the program theory studies, SLHD is undertaking a number of related research projects.

Health information needs assessment of the community

SLHD will undertake a detailed health information needs assessment, titled ‘An analysis of the health information needs of disadvantaged communities in Inner Sydney’. This will involve a full assessment of the normative, expressed, felt and comparative needs of clients (vulnerable families and individuals in SLHD) and the professionals caring for them. A mixture of quantitative and qualitative methods will be used to determine priorities. This study will also examine in detail the types of media which are likely to be most effective as vehicles for delivering these messages. With ethics approval, this study will proceed and results written up for publication.

Geospatial mapping of disadvantage in Sydney Local Health District

This study takes a spatial epidemiology approach to identifying the geographical distribution of the most vulnerable families with intergenerational cycles of disadvantage and trauma in SLHD by:

- Identifying individual indicators of disadvantage and mapping them within SLHD
- Identifying clusters of disadvantage
- Analysing potential pockets or ‘hot spots’ of extreme or complex disadvantage via layered analysis of individual indicators of disadvantage.

See page 19 for more details.

Vulnerability indicators in women not engaging in postnatal child and family health nursing services

The study is being undertaken as part of a large SLHD maternal and child health data linkage study using routinely collected maternal and infant clinical data. Infant birth data for babies born during 2013-14 are linked to maternal antenatal and obstetrics data. Comparative analysis of vulnerability indicators will be completed for the mothers not engaging with available child and family health nursing services.

Perinatal depression research

The aim of this research is to improve outcomes for pregnant women, new mothers, their partners, and children within SLHD who are experiencing perinatal depression or at risk of postnatal depression. The project includes: literature review, quantitative research of routinely collected data in SLHD from 2013-14 of perinatal depression scores including demographics and risk/protective factors, and a qualitative study of the experiences of women experiencing antenatal and postnatal depressive symptoms in SLHD.

Contact us

For further information about the *Healthy Homes and Neighbourhoods* Integrated Care initiative, please contact:

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Healthy Homes
and neighbourhoods

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