HEALTHY HOMES AND NEIGHBOURHOODS INTEGRATED CARE INITIATIVE

INTEGRATED CARE - PLANNING AND INNOVATION FUND (PIF)

Organisation and Partners

Organisation (Lead LHD): Sydney Local Health District

Partner organisations:

Inner West Sydney Medicare Local
Family and Community Services, Sydney District
Barnardos: Family Referral Service
The Benevolent Society
The Infants Home, Child and Family Services, Ashfield
SDN Children's Services, Broadway, Sydney
Jannawi Family Centre, Wiley Park, Canterbury
Riverwood Community Centre, Canterbury
Children's & Families Research Centre, Macquarie University
Menzies Centre for health Policy, Sydney University
Faculty of Education and Social Work, Sydney University
Centre for Primary Health Care and Equity, UNSW

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Position: Chief Executive

*Organisation: **Inner West Sydney Medicare Local***

Nature of collaboration: The IWSMCL is a lead partner in the Governance, and will contribute staff, accommodation and services "in-kind".

Title: Dr

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Position: Director Community Services

*Organisation: **FACS – Sydney District***

Nature of collaboration: Governance, accommodation, contribute PatchWork collaboration software, child protection capacity building.

Title: Ms
Name: Rebecca Coote
Position: Program Manager, Family Referral Service
Organisation: ***Barnardos Australia***
Nature of collaboration: Governance, services and accommodation

Title: Ms
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Organisation: ***The Benevolent Society***
Nature of collaboration: Governance, accommodation, expert advice, staff, clinical services

Title: Ms
Name: Anita Kumar
Position: Chief Executive
Organisation: ***The Infants Home***
Nature of collaboration: Governance, staff, clinical services and accommodation

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Name: Ginie Udy
Position: Chief Executive Officer
Organisation: ***SDN Children's Services***
Nature of collaboration: Governance, services, technical expertise, accommodation

Title: Ms
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Position: Centre Director
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Nature of collaboration: Governance, community services and accommodation

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Name: Pauline Gallagher OAM
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Nature of collaboration: Community consultation, training, accommodation

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Nature of collaboration: Research and evaluation support

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Nature of collaboration: Research and evaluation support

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Nature of collaboration: Research and evaluation support

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Nature of collaboration: Research and evaluation support

Other Support

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Nature of collaboration: In principal support

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Position: Chief Executive Officer
Organisation: ***The Sydney Children's Hospitals Network***
Nature of collaboration: In principal support

Support Letters are attached.

Table of Contents

Title

What is the title of the initiative

A Healthy Homes and Neighbourhoods Integrated Care Initiative

Summary

Provide a brief description of the project – maximum of 100 words

A cross-agency care coordination network will be implemented to ensure vulnerable families: have their complex health and social needs met; keep themselves and their children safe; and are connected to society. The aim is moving families from exclusion to inclusion, from dependency to independence. Vulnerable families will be identified when adults or children come in contact with health, education or community service providers. Care coordinators will work with partners, over multiple years, to ensure the family's health, parenting and education needs are met; they are connected to their local community; and services and supports are in place for the future.

Description of the initiative

Provide a detailed description of the initiative – please ensure that there is sufficient detail here to give an overall picture of your proposal.

The initiative is long-term care coordination for vulnerable families with complex health and social care needs, who are disconnected from key services, require multi-agency support to have their complex health and social needs met; and to keep themselves and their children safe; and connected to society. Initial numbers will be 20 families, increasing as part of a step down process, to sustained support for a planning estimate of 200 families. The initiative will include a sustainable solution as part of an exit strategy.

The initiative has the following key features:

1. Multiple core and non-core agencies working together over a sustained period of time (i.e. 5 years) with families with complex health and social needs

2. All the needs of families are in scope for the intervention, including housing, employment, income support and legal advice

3. An early intervention and public health approach to breaking cycles of family disadvantage, poor health and psychological trauma

4. A focus on efficiency through the maximum use of, and leverage from, existing family, societal and government resources, including Medicare funded services

5. Use of evidence informed integrated care methods by service partners, including family case conferencing, and “wrap around” care delivery

6. Encouraging families to have a “health home” for all their health needs and supporting them to move from dependency to independence

7. Supporting general practice providers to care for families that are often seen to be “too difficult”

8. Development and implementation of shared assessment tools and referral criteria

9. Implementation of family assessment and engagement tools that can be used over the long-term to monitor the health and wellbeing of family members

The initiative is intended for vulnerable families with complex health and social care needs who have one or more dependent children (unborn through to 17 years) where their complex health needs are impacting on their capacity to parent effectively and participate in their community. This initiative will benefit adult members of the family to participate in the social and economic life of the community through better management of their complex health and social conditions. This initiative will benefit child members of the family through lessening the impact of adult complex health conditions on their safety, health, development and wellbeing. Thus the intervention aims to break intergenerational cycles of disadvantage, psychological trauma, poor parenting and poor health outcomes.

The success of the initiative will require working with multiple agencies to make maximum use of available government and societal resources. The core partners are: Sydney Local Health District (SLHD), Sydney District of Family and Community Services, the Inner West Sydney Medicare Local (and then appropriate Primary Health Network), Department of

Education and Communities, Barnados Family Referral Service, Brighter Futures – Sydney Day Nursery, Jannawi Family Centre and The Benevolent Society. Other key agencies will include: Centrelink, NSW Legal Aid, Police, Justice Health, religious organisations, neighbourhood centres, employment agencies and local government.

The intervention will be family focused, addressing the health and social needs of the adult members of the family unit, the health and education needs of child members of the family unit, and the overall functioning of the family as a safe and nurturing family environment for child members of the family. Examples of the adult health conditions include: physical or intellectual disability, mental illness, substance misuse, disruptive behaviours, history of psychological trauma, diabetes, cardiovascular and respiratory disease, obesity and arthritis.

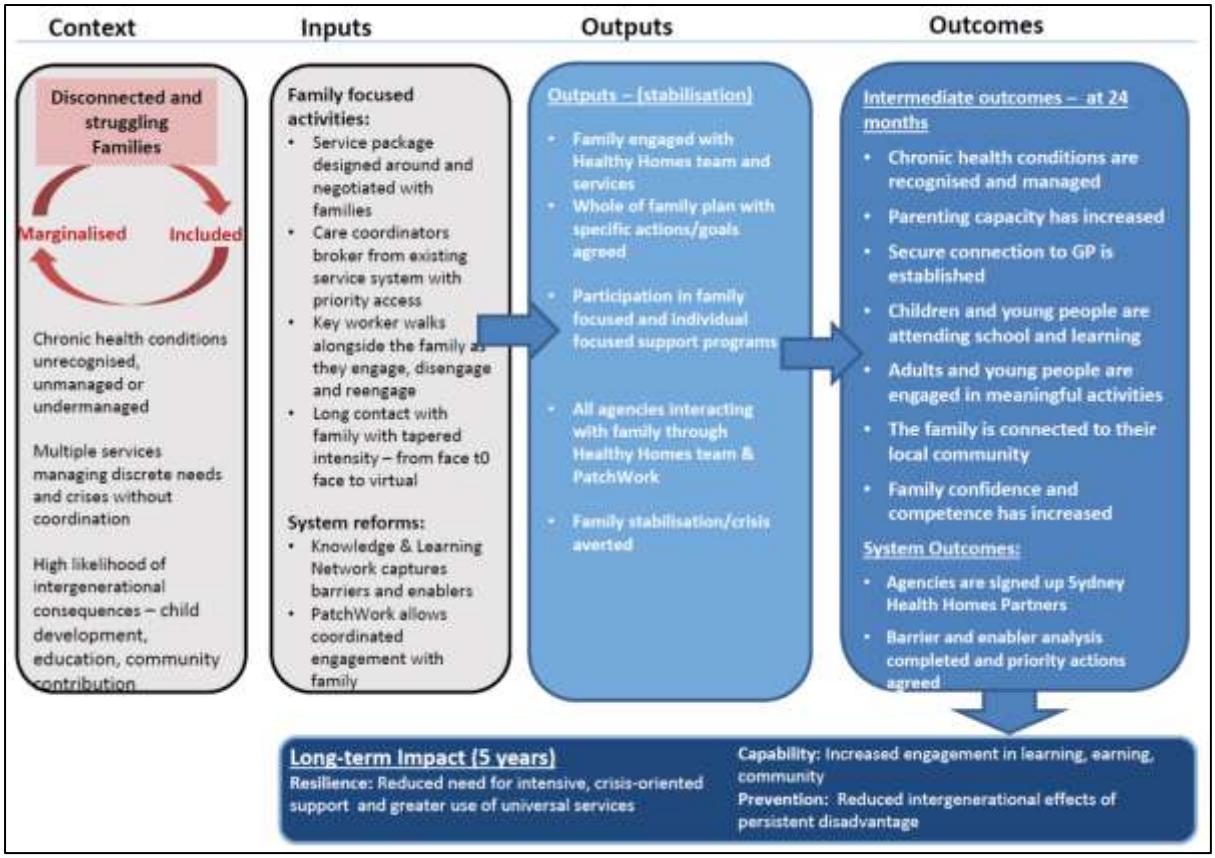
Coordinated family care will be provided using: a family medical home (general practice), family case conferencing, wrap-around multi-agency support, information sharing and long-term health and wellbeing monitoring of family members.

A population-based approach to identifying the most vulnerable families who are disconnected from key services will be developed using current *Safe Start* perinatal systems, developing cross-agency assessment and referral pathways, and improved hospital recognition of the needs of families using an e-health solution.

The central element of the initiative will be targeted or long-term sustained *Cross Agency Care Coordination* for an initial 20 supported families, increasing as part of a step down process to sustained support for a planning estimate of 200 families. This will involve significant system redesign and commitment from partners. The initial model requires a care coordination team with both project funded and partner funded components. The initial model is expected to be modified as sustainable solutions are developed and tested. An outcome will be that these estimated 200 families have enduring connections with the key services, connections which are supported, but largely self-enduring.

The initiative will also have a local element through deliberate recruitment of families and service partnership development in 1) the City of Canterbury, and 2) the City of Sydney - South. This will enable the development of “demonstration site” place-based partnerships with local general practice, schools, family support agencies, local government, religious organisations and community members.

Program Theory of Change



Program Key Components

The initiative has 9 key components:

1. Identification of vulnerable families
2. Healthy Homes care coordination
3. Evidence-informed intervention(s)
4. General Practice engagement and support
5. Family health improvement
6. Healthy Neighbourhood supported initiative
7. Interagency system change and planning
8. Monitoring of individual and family outcomes
9. Evaluation

1. Identification of Vulnerable Families

1.1 Definition

The initiative is for vulnerable families with complex health and social care needs, who are disconnected from key services, require multi-agency support to have their complex health and social needs met; and need assistance to keep themselves and their children safe; and connected to society.

Clinicians report that there are families with adult, or child, members whose mental health or chronic disease is significantly impacting on the wellbeing of all family members. It is known that these families are often are dependent on welfare, are socially excluded, and have difficulties providing a nurturing environment for their children. Health and social service systems do not keep statistics on these families and they are thus **invisible** to planners and policy makers.

This initiative is innovative in attempting to identify and integrate services for these families. The vulnerabilities of a family, especially when occurring in combination, that impact on outcomes for their children and adolescents include:

- chronic illness and disability
- mental illness and disruptive behaviour issues
- substance misuse
- interpersonal conflict
- economic disadvantage
- social isolation
- homelessness
- parental unemployment
- intergenerational psychological trauma.

Aboriginal and Torres Strait Islander people are more likely to experience these vulnerabilities because of historical alienation of their land and culture and the experience of intergenerational economic disadvantage and psychological trauma.

1.2 Identification

A population-based approach to identifying the most vulnerable families will be developed using current *Safe Start* perinatal systems, developing cross-agency assessment and referral pathways, and improved hospital recognition of the needs of families using an e-health solution. This will include:

1. The current pregnancy and childbirth and child and family nursing *Safe Start* psychosocial screening systems at The Royal Prince Alfred and Canterbury Hospitals, and Community Health together with external referrals from other Local Health Districts which are currently made to the Child and Family Intake System

2. Referrals from General Practice and other primary health care providers using *SydneyHealthPathways* and referrals to vulnerable family staff specialist clinics

3. Presentations to Emergency Departments at The Royal Prince Alfred, Concord, Balmain, and Canterbury Hospitals and to hospital inpatient and outpatient services

4. Mental Health and Drug Health Services utilising current systems for identifying Children of Parents with a Mental illness or dual diagnosis

5. Families seen by Child and Family Clinical Services, including paediatric, nursing and counselling run "child at risk" and vulnerable family clinics, sustained health home visiting services, and school referral clinics

6. Referrals to the core partner agencies including: Family Referral Service - Barnados, Brighter Futures Intensive Intervention - Sydney Day Nursery and funded by FACS

7. Reports to FACS, Community Services at Lakemba, Burwood and Central Sydney Community Service Centres

8. Referrals to the FACS/SLHD Perinatal Conferencing Pilot Project.

Action	Input	Estimated Completion
Develop a standard family risk assessment tool for use by General Practice, Hospital and Community providers to guide referral to Vulnerable Family Pathways	Project Funded Clinical Nurse Consultant	June 2015

1.3 eHealth Solution

SLHD currently has an eMR flag for alerting clinicians of children at risk of abuse and neglect. We are also aware of an eMR-based algorithm to identify patients who meet criteria for the Connecting Care initiative. We propose to commence preliminary work to examine and report on options for a Vulnerable Family eMR algorithm and/or flag system. This activity has not been costed into the proposal.

Action	Input	Estimated Completion
Examine and report on options for an eMR algorithm and/or flag system. (Implementation not costed)	Project Funded HSM	June 2015

1.4 Vulnerable Families Intake

The Vulnerable Families Intake will be modelled on: 1) the current Community Paediatric led *Branches* intake for children in out-of-home care, or "at risk of abuse" 2) the antenatal multi-agency *Safe Start* meetings that occur in most NSW Birthing Units and 3) FACS intake for children and young people at risk of significant harm. In summary the process will involve:

1. Phone, facsimile, eMR messaging and email referrals to a central administration office that is supported by a roster of "on-call" clinicians

2. Proactive assembling of clinical and demographic information prior to a multi-disciplinary team meeting

3. Assessment of the referral at a team meeting and the preparation of a preliminary plan for the care co-coordinators.

Actions	Input	Estimated Completion
Establish a Healthy Homes Intake System modelled on the current Branches Intake for children in out-of-home Care	Project Funded HSM	June 2015

1.5 Referral Pathway(s)

Work will be undertaken to develop a vulnerable family *HealthPathway* as part of the joint SLHD/IWSML *SydneyHealthpathway* project. Preliminary work has identified that current pathways direct clinicians and agencies to a number of separate service intake systems. It is proposed that the Vulnerable Family initiative would redesign and support a central intake system for all vulnerable family and child at risk referrals.

Actions	Input	Estimated Completion
Complete a Vulnerable Families *HealthPathway*	SLHD Community Paediatric Input	June 2015

2. Healthy Homes Care Coordination

A central component of the Healthy Homes and Neighbourhoods initiative is long-term care coordination of the most 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 manage their own care, usually with the support of a general practitioner.

2.1 Perinatal Coordination Project (2005-2008)

A Department of Community Services and SSWAHS jointly funded Perinatal Coordination integrated care model was implemented, from 2005-2008, at Bankstown and Campbelltown by Community Paediatrics on the former SSWAHS. The intent was to use all locally available government, non-government and private resources to support vulnerable mothers during pregnancy and until the infant was 12 months. The model was successful and contributed to the design of the *Safe Start* component of *Keep Them Safe.*

The objectives of the Perinatal Coordination Project were to:

1. Ensure vulnerable women were referred to appropriate services
2. Identify women who slip through and subsequently do not engage with services and appropriately re-link 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

This was achieved by:

1. Systematic identification using an agreed assessment tool
2. Interagency referral meetings with government and non-government partners
3. Care coordination contact with women to ensure sustained engagement until 12 months

The project was supported by legal advice from then Department of Health, subsequent policy development, and the development of standards, protocols and guidelines. The model was taken to scale state-wide. In most sites perinatal coordination is now sustained without a perinatal coordinator.

2.2 Proposed Care Coordination

It is proposed that nurse-led vulnerable family care coordination be trialed, evaluated and reported on using adaptations of the above perinatal coordination project. The initiative will differ by supporting care coordination of vulnerable families over a longer period with the intention of bridging the episodic nature of family support. A significant difference will be a deliberate linking of this initiative to general practice engagement and capacity building. The Perinatal Coordinator will be required to:

1. Provide leadership and support in the building of local service networks and referral pathways for vulnerable families

2. Liaison with, and support to, service providers to ensure referral to appropriate services in accordance with the care plan

3. To coordinate and track service provision for identified vulnerable families, including on-going information coordination for providers

4. Provide information, support and referral services to women identified as vulnerable within the project target group

5. Initiate and participate in evaluation of the vulnerable family's coordination initiative

The number of families that can be serviced by the model will be tested during the trial. The intention is to make maximum use of all available District government and non-government resources. The flow of work will vary for different families and can be illustrated by the following two examples.

1. Primary school referral of a vulnerable family, full assessment by partner service undertaken, history of non-engagement with agencies, significant health problems multiple members of family, referral to Family Referral Agency, Dental Hospital, general practice (negotiate GP to participate in project), asthma clinic, Healthy Homes Care Coordination eMR register, phone follow-up, plan long-term contact, coordinate general practice support for care-plans

2. Perinatal Case Conference family referral to Healthy Homes Intake, care plan agreed, Healthy Homes Care Coordination eMR register, tasked with finding a general practice for the family, plan to follow-up every six months

Note: Currently follow-up either does not happen or is being achieved through six – 12 monthly outpatient reviews by Community Paediatric clinical services.

Actions	Input	Estimated Completion
Trial and report on a nurse-led care coordination service for vulnerable families	Project Funded Clinical Nurse Consultant	June 2017

2.3 Patchwork Tool for Coordination

Patchwork is a simple to use web application developed in the UK by FutureGov that allows people across government and non-government sectors to understand who is working with their clients at any given time, thereby giving them the contact details they need to share information as appropriate. This enables professionals to better provide services to clients when they understand and can communicate with the whole team of people around a client or family. The aim of the tool is to build connections between different organisations and agencies, enabling real partnership working, earlier intervention (helping to ensure that no client falls through the gaps) and ultimately better outcomes for children and families. FACS Sydney has received in principle support for licenses, training and support to use Patchwork in Healthy Homes.

Actions	Input	Estimated Completion
Trial the Patchwork tool with the aim of increasing access and engagement with community and local services for vulnerable families	Project funded HSM and Patchwork funded by FACS	June 2017

2.4 Healthy Homes Coordination and Perinatal Family Case Conferencing Clients

Perinatal Family Case Conferencing is a joint initiative between SLHD and FACS-Sydney District, described below. It is envisaged that the Healthy Homes care coordinator will support and extend the impact of family group conferencing (FGC) through ensuring sustained long-term health and social care support. The possibility of using a wrap-around model of care for these families will also be explored.

2.5 Healthy Homes Coordination and Wrap-around Model of Care

The Healthy Homes initiative will trial and report on a wrap-around model of care for vulnerable families using a collaborative use of existing partner funded services (see below). It is proposed that the Healthy Homes care coordinator will invite vulnerable families to participate in the wrap-around trial and maintain support to ensure sustained long-term health and social care support.

3. Evidence-Informed Intervention(s)

The Healthy Homes initiative will use, or promote use of, evidence-informed care-coordination and therapeutic family focused interventions. There is an 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 centres, targeted parenting programs, multi-systemic therapy and other multimodal "wrap-around" approaches. Some of those interventions (i.e. home visiting) have not been shown to work for the "most" vulnerable families, but targeted parenting programs and multimodal "wrap-around" approaches show promise.

3.1 Wrap-around

A central tenant of this proposal is the breaking of trans-generational cycles of disadvantage, psychological trauma, and poor health and social outcomes. One unifying clinical condition (not the only one) in many of these families is intergenerational trauma and conduct disorder with associated poor health behaviours and mental illness. The recent UK National Institute of Clinical Excellence (NICE) systematic review and guidelines for Conduct Disorder and Disruptive Behaviours recommends targeted parenting initiatives and wrap-around approaches. Wrap-around approaches are usually used for adolescents and young adults. The use here, with families, is innovative and will require evaluation of efficacy.

Wrap-around is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth and their families) so that they can live in their homes and communities and realise their hopes and dreams. 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 around 8 – 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. This 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 (Suter et al 2009)[1].

The focus of wrap-around services is to broker community resources in a culturally competent and population-specific fashion. By collaborating with the client, family and family friends, wrap-around seeks to provide long-term relationships for high-needs clients and their families. The goal is to create a safe and supportive environment for high-needs families to thrive in the community.

Wrap-around aims to achieve positive outcomes by providing a structured, creative and individualised team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.

Wrap-around plans are also more holistic than traditional care plans as they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wrap-around also aims to develop the problem-solving skills, coping skills, and the self-efficacy of the family members.

[1] Suter JC, Bruns EJ. Effectiveness of the Wraparound process for children with emotional and behavioural disorders: a meta-analysis. Clinical Child and Family Psychology Review 2009;12:336-51.

Finally, there is an emphasis on integrating needs of the family into the community and building strong social support networks.

Actions	Input	Estimated Completion
Trial and report on a wrap-around model of care for vulnerable families using a collaborative use of existing partner funded services	Project Funded Social Worker	June 2017

3.2 Family Case 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 Conference 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].

The overall aim of FGC is to shift the power to make decisions about the family back to the family, with the primary concern for the child protection system to hold responsibility of ensuring the safety of the children (Huntsman, 2006).[2] Shlonsky et al. (2009) conducted a large systematic review of Family Group Decision Making (FGDM) and concluded that, on its own, FGDM does not appear to reduce child maltreatment or stays in out-of-home care but it seems to be a valuable family engagement tool.[3] Harris (2008)[4] conducted a review of FGC in Australia and found positive outcomes, namely: 'greater feelings of empowerment for families', improved child safety, production of an acceptable plan, and increased 'informal and formal support' for families. The literature review by Huntsman (2006) reported:

1. positives – high participant satisfaction, more placement with family, improved communication within families, more respect among families for child protection professionals.
2. negatives – problems ensuring confidentiality, lack of clarity of procedures including deciding who is to be involved, lack of effective follow-up to implement plans, and a high staff turnover.

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

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

[4] Harris, N. (2008) 'Family group conferencing in Australia 15 years on'. National Child Protection Clearinghouse, AIFS, Child Abuse Prevention Issue No. 27.

Perinatal Family Conferencing is a collaborative project between FACS-Sydney District and SLHD using family conferencing to promote early engagement and interagency planning with pregnant women and families at risk of their newborns entering out-of-home care at birth. At the time of writing a project worker is jointly funded and a mixed method evaluation being supported by Community Paediatric staff. It is envisaged that the Healthy Homes initiative will support and extend the impact of FGC through ensuring sustained long-term health and social care support.

Actions	Input	Estimated Completion
Trial a Family Case Conferencing for Healthy Homes clients, leveraging from existing expertise and models	Model and consultation from SLHD & FACS	June 2017

3.3 Capacity Building Support to the Network

The Healthy Homes initiative is supported by strong academic affiliations. Core partners are currently undertaking translational research in relation to: breaking cycles of trauma; place-based child and family approaches; sustained nurse home visiting; and perinatal family case conferencing.

The purpose of the Healthy Homes Partnerships Group is to provide a mechanism for current evidence-informed therapeutic and service developments to be shared with participating partner organisations including non-core partners. The initiative will promote the use of evidence-informed practice throughout the service network and will seek out partners who are using evidence-informed practice.

Actions	Input	Estimated Completion
Deliver evidence-informed capacity building training to the Healthy Homes collaboration partners and wider network	Project funded CNC & Com. Paed. Public Health Medicine Specialist	June 2017 and ongoing

4. General Practice Engagement and Support

The vulnerable families enrolled into the program will be disconnected from key services including a family medicine orientated general practice that will care and coordinate the health services for family members over the long-term. For some general practices, caring for the most vulnerable families is often seen as "too difficult". Support from specialist agencies can be required to give general practices the confidence to commit to complex clients over the long term.

4.1 General Practice Engagement as a Key Performance Indicator

The Healthy Homes initiative will work, as a priority, to encourage families to have a general practice "health home" for all their health needs. The engagement of families with a general practice, and supporting those general practices, has been identified as an area for Key Performance Indicator development.

At the time of enrolment information will be sought on current and previous use of general practice. Sensitive discussion with family members will be orientated toward encouraging the identification of a general practice that the family is comfortable and happy to use. This process will require the use of qualitative research to ensure an appropriate approach is developed. The setting of a KPI for this activity carries some risk to the development of a sensitive approach to general practice engagement. This risk will be managed by the Steering Committee (see action below).

4.2 Avoidable Hospital Presentations

One objective of encouraging and supporting general practice engagement is to reduce Emergency Department presentations and hospital admissions for ambulatory and primary care sensitive conditions. There is evidence from analysis undertaken by the NSW Department of Family and Community Services that vulnerable families are more likely to make use of Emergency Departments for low triage category conditions. Other studies have demonstrated that general practice can play a key role in preventing, for example, children's admissions with asthma and gastroenteritis. The project staff will work closely with general practices and enrolled families to support the use of preventative health measures (see action below).

4.3 Use of Medicare for Chronic and Complex Health Conditions

It is the experience of IWSML and SLHD services that vulnerable families often do not make use of the available Medicare funding for chronic and complex health conditions. The lack of a general practice "health home" is often one contributing reason. For some general practices it is "too difficult" to engage families for the preparation of health care plans and there may also be poor attendance at the prescribed allied health services. As above the project staff will work to engage families with general practice and will support general practitioners with the preparation of appropriate health care plans. Where appropriate it may also be possible to assist families to attend the prescribed services. The strategy will always be to build independence, but where necessary, and other agencies are not yet engaged, it may be necessary for project staff to assist with transport.

Actions	Input	Estimated Completion
Trial and report on a clinical service model that encourages vulnerable family engagement with general practice and that provides support to those general practices make full use of available Medicare and other sources of funding	Project funded CNC & Com. Paed. Public Health Medicine Specialist	June 2017

5. *Family Health Improvement*

As discussed above the project will work closely with both general practices and enrolled families to support the use of preventative health measures. The current funding of primary care makes the provision of preventative health care for families difficult. Those who supervise general practice trainees report that some practices will endeavour to provide high quality care and preventative advice despite the current lack of funding. The extended service sector can also play an important role in promoting preventative health for families.

5.1 General Practice Capacity Building

The Department of Community Paediatrics has been leading a primary care capacity building project with NSW Kids and Families, GP Synergy, Karitane, Medicare Locals, and the Australian Primary Health Care Nurses Association (APNA). That project is currently focused on training and resourcing GPs and Practice Nurses to undertake preventative health care for children. It is proposed that the current project be expanded to include other Family Health Improvement activities. Resources for this will be provided as a "contribution in kind" by Community Paediatrics. Note: From Community Paediatric current health promotion service output.

Actions	Input	Estimated Completion
Identify training needs and develop four preventative health training modules for general practice and sector capacity building	Project funded CNC and Contribution from Com. Paed. Public Health Medicine Advanced Trainee	June 2017

5.2 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* 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 included key family health messages. Leadership and technical support to these initiatives has been provided by the Department of Community Paediatrics and will continue to be provided as a "contribution in kind". Note: From Community Paediatric current health promotion service output.

5.3 Immunisation as a Key Performance Indicator

The Healthy Homes initiative will work, as a priority, to encourage families to have all their dependent children and adolescents fully immunised. Childhood vaccination is a current KPI for SLHD. Vaccination rates in SLHD are low, especially among vulnerable populations. An initiative will be developed and implemented to ensure that all vaccination is offered at Community Paediatric clinics for vulnerable families. Note: From Community Paediatric current service output.

Actions	Input	Estimated Completion
Develop and implement an initiative to ensure that all enrolled children are immunised	Project funded CNC & Com. Paed. Public Health Medicine Specialist	June 2015

5.4 Other Family Health Improvement Priorities

Other family health improvement priorities will be identified for each family group as part of the assessment and intake process. It is envisaged that the agreed family plans will included health improvement goals such as tobacco cessation, exercise, nutrition, "screen time", and various health related screening. The project staff will, where possible, work with families and the partner agencies to promote these family health improvement activities over the long term. These activities will be project funded initially and will be built into the Sustainability Plan and Project Exit Strategy.

6. Healthy Neighbourhoods Supported Initiative

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 will have a local element through deliberate recruitment and service partnership development in 1) the City of Canterbury, and 2) City of Sydney - South. This will enable the development of "demonstration site" place-based partnerships with local general practice, schools, family support agencies, local government, religious organisations and community members.

6.1 City of Canterbury

The City of Canterbury has the highest concentration of vulnerable families in SLHD. The SEIFA score of 922 for the City of Canterbury is in the bottom 14% of NSW. Suburbs with significant locational disadvantage include Riverwood, Lakemba, Campsie, Punchbowl and Wiley Park. Forty six percent of the residents in Riverwood live in social housing.

Current local efforts to address social exclusion provide an opportunity to develop a neighbourhood approach to supporting vulnerable families. Leadership for a local initiative is being driven by local interagency group that includes Canterbury City, SLHD, IWSML, Department of Education and Communities (DEC), Family and Community Services (FACS) Jannawi Family Centre, Riverwood Community Centre, Koorana Child and Family Services, and Barnardos Family Referral Services.

The Healthy Homes initiative will link closely with the Canterbury Interagency Group 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.

Canterbury-based core partners in this proposal are Jannawi Family Centre (Wiley Park) who work closely with vulnerable families, SDN Children's Services (Riverwood) and the FACS Lakemba Office. It is anticipated that part of the Healthy Homes team will be initially out posted at FACS Lakemba during the implementation phase of the City of Canterbury pilot. FACS has strong experience of out posting, having successfully out posted Child Protection Caseworkers in Child Wellbeing Units run by Health, Education and Police. Out posting embeds core team members in the culture of partner agencies and builds enduring and trusting relationships.

Also under consideration at the time of proposal preparation are "Team around the Family" initiatives at:

1. Jannawi Family Centre (Wiley Park)

2. Riverwood social housing estate in partnership with SDN Children's Services and Riverwood Community Centre

3. Schools and Communities Centres (i.e. Punchbowl, Wiley Park and Lakemba).

6.2 City of Sydney - South

There is significant locational disadvantage in the South Sydney suburbs of Redfern, Waterloo, Alexandria and Glebe. Much of this is associated with the social and community housing estates in those suburbs. The vulnerable families living on those estates have perhaps the highest complex health and social needs of any population group in SLHD.

At the time of writing this proposal there are several initiatives to develop place-based interventions for vulnerable families. Core partner agencies including: SLHD (Community Health, Drug Health and Mental Health), FACS (Housing and Community Services), Sydney Day Nursery, Education and Communities (Glebe and Alexandria Park Public Schools) and The Benevolent Society are actively working on new initiatives. The SLHD Partnership with the Redfern Aboriginal Medical Service has recently resulted in stronger collaboration with the development of shared service delivery models.

There is a strong justification for working with families in South Sydney but the local context is complex and implementation will have challenges. Opportunities to progress local partnerships have emerged through:

1. Partnership discussions with the Redfern Aboriginal Medical Service regarding child and family health services

2. Recent referrals from Jarjum College (Redfern) for Aboriginal children with special needs

3. Outreach paediatric clinics with Our Lady of Mt Carmel Catholic Primary School, and Glebe and Alexandria Park public schools

4. Shared clinics for vulnerable families with The Benevolent Society (Rosebery)

5. A joint City of Sydney and Housing planning initiative for the Redfern Social Housing Estate

Actions	Input	Estimated Completion
Undertake community and consumer consultation in Canterbury and Sydney – South to develop a collaborative local approach to meeting the needs of vulnerable families	SLHD Funded Social Worker	December 2015
Trial and report on a wrap-around model of care for vulnerable families as part of Canterbury and South Sydney Healthy Neighbourhood Support Initiatives using a collaborative use of existing partner funded services	SLHD Funded Social Worker	June 2017

7. Interagency System Change and Planning

A Sydney District Partnership for Children and their Families

The Healthy Homes PIF proposal has been developed in the context of a strong cross agency collaborative partnership. Sydney District formed a collaborative partnership and planning committee in 2013, initially with FACS, IWSML and the Department of Education and Communities. The purpose of the partnership is to:

1. Provide a forum to progress collaborative strategic planning and data sharing, including the development of a Child Health and Youth Health Plan

2. Oversee the implementation of any plans developed or other relevant (interagency) plans

3. Support coordinated care and services/programs for shared clients and communities

4. Advise on improvements to referral pathways and processes, service linkages and integration

5. Promote innovation in addressing the needs of vulnerable groups within the District.

The partnership is currently developing and consulting on a Child Health and Wellbeing Plan for Inner West Sydney. The preliminary framework has been used in preparing this PIF proposal.

Vision

"Our vision is for the children of Inner West Sydney to be healthy, safe, and happy living in the embrace of loving families and nurtured in strong inclusive communities. Children will be well-supported by a cohesive inter-sectoral network of agencies collaboratively delivering appropriate universal, targeted and specialised services with a focus on families with vulnerabilities and risk factors so that no child is left behind in reaching their full potential."

Source: Draft Sydney District Child Health and Wellbeing Framework

The outcomes that the partnership seeks to achieve are listed below under 'program impacts and benefits'. These are draft outcomes and will be subject to a consultation process in October and November. One of the key enablers identified in the Framework is to '**enrich interagency and inter-professional collaboration'** through, for example:

1. Informal networking opportunities between services to engage more effectively

2. Support 'work swaps', secondments across agencies

3. Promoting and unifying Interagency groups

The Healthy Homes initiative will seek to ensure that the multiple service units and external agencies involved in a long-term care and support of vulnerable families are providing services in a timely and integrated manner and that the system is learning and developing.

This will be achieved through:

1. The SLHD-FACS-IWSML Partnership and Planning Committee

2. A Healthy Homes Steering Committee
3. A Healthy Homes Reference Group (for technical advice and sector consultation)
4. Feedback from the Healthy Home Team

Actions	Input	Estimated Completion
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	Contributions from all collaborating partners	Annual reporting against partnership evaluation tool

A Healthy Homes and Neighbourhoods Network

The Healthy Homes initiative provides an opportunity to network enrolled families, general practitioners, allied health providers, schools, and collaborating partners. The initiative will seek to identify innovative strategies that will enable:

1. Sustained client centred support for families
2. Information sharing
3. Collaborative learning

Policies, tools and practices that might support this include:

1. Informed consent to share information with the partners
2. Branding and promotion of the initiative
3. Robust and trusted privacy by contributing partners
4. Skilled and well supported general practice “health homes”
5. A social media strategy for enrolled families.

Social Media Strategy: A literature review and community survey has been conducted by Community Paediatrics that confirms the value of social media to our local vulnerable families. We propose the development of an integrated and comprehensive social media strategy that supports the: Healthy Homes Care Coordination; General Practice Engagement and Support; Family Health Improvement; Healthy Neighbourhoods; and Network components of the initiative. The *social media strategy* will combine evidence based child development, parenting and health promotion information with personal stories, current/ topical issues and will provide an opportunity for families enrolled in the program to interact with health providers and each other in a safe and participatory environment to explore issues and receive information.

Actions	Input	Estimated Completion
Build an innovative Healthy Home system that connects enrolled family members to collaborating partners	Project funding for web-based social media application	Ongoing with annual reports of KPIs

8. Monitoring of Individual and Family Outcomes

Unlike acute health, changes in chronic health and wellbeing change slowly over time. The long-term measurement of individual and family outcomes has proved difficult except in longitudinal research projects. It is proposed that a system be developed to measure outcomes that are patient and family-centred and able to be shared with those working with the individual and family.

HealthTracker is an online health monitoring platform developed by clinicians in the UK that contains developmentally appropriate patient centered outcome measures for children and adolescents with chronic disorders. *HealthTracker* is used to track treatment response in chronic disorders (both rare and common) and can also help with screening, triage and patient pathways. It has been used by clinical paediatric, child and adolescent psychiatry services and in international research projects. It has been shown to be cost-efficient, clinically relevant and well received by children and families.

HealthTracker uses computer animation and narration specifically designed for children and adolescents to measure change across a wide range of symptoms, side-effects, moods, feelings and quality of life through the use of questions, games and interactive cartoons. Currently *HealthTracker* contains over 100 child and adolescent clinical questionnaires. Results are fed back to clinicians and families in real-time if requested, and *HealthTracker* can generate reports on trends in symptoms and response to interventions over time. The ability to rapidly feedback results from *HealthTracker* to clinicians enables increased use of non-face to face clinic follow-up, with the potential to save face to face assessments for when things are deteriorating.

Actions	Input	Estimated Completion
Trial the adaptation, implementation and evaluation of the *HealthTracker* tool for monitoring family member outcomes	Project funding of set-up and trial & clinical and evaluation input from Com Paed. Public Health Medicine and Paediatric Specialists	June 2016

9. Evaluation

The initiative is a "complex intervention" and the evaluation will draw on recent MRC (UK) guidance for the evaluation of complex public health interventions.[56] These realist mixed method approaches examine the quantity and quality (or process) of what was actually implemented in practice, the context, the mechanisms and seek to answer the question why.[78] MRC guidance argues that only through close scrutiny of causal mechanisms is it possible for evaluation to contribute to developing more effective interventions, and provide insights into how findings might be transferred across settings and populations.

The general approach to evaluation, in this proposal, will be to build evaluation into each key component or trial initiative. The evaluations will be undertaken within funded and seconded program resources (including public health staff). In several cases these projects will build on existing research projects as noted below.

1. A mixed method evaluation of the identification and care-coordination system (extending a Masters level access and equity study undertaken in 2013)
2. Qualitative and survey evaluation of the general practice engagement and capacity building (extending a current PhD general practice research project, and evaluations of a GP developmental surveillance capacity building project)
3. A qualitative evaluation of the Patchwork tool for coordination (new project)
4. As noted below a partnership evaluation will be undertaken using a tool development by VicHealth

Individual Outcomes

Exploration of child and family outcomes for families who participate in this initiative, including in relation to the following variables:

a. Problem solving / empowerment
b. Coping skills
c. Self-efficacy
d. Community engagement and connectedness
e. Social support networks
f. Social and emotional wellbeing
g. Child safety within the home (i.e. decreased risk of abuse)
h. Service engagement (including preschool attendance for young children, etc.)

As outlined below (see 'data') the individual enrolled family members will be invited to have the impact on their health and wellbeing monitored. The *HealthTracker* tool will be trialled and adapted to test its utility for monitoring patient outcomes over time. Use of health services will also be monitored and reported on. Funding is requested to support the trialling of *HealthTracker.*

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[5] Moore, G., et al. "Process evaluation in complex public health health intervention studies: the need for guidance." *Journal of Epidemiology & Community Health* 68.2 (2014): 101-102.
[6] Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2013). Developing and evaluating complex interventions: new guidance. 2008. See www. mrc. ac. uk/complexinterventionsguidance.
[7] Pawson R, Tilley N. *Realistic evaluation.* London: Sage, 1997.
[8] Bonell C. et al. Realist randomised control trials: a new approach to evaluating complex public health interventions. *Soc Sci Med*. 2012; 75:2299-306.

A “Research” Evaluation will be developed with academic partners. Taking a mixed-methods approach we would explore outcomes from the perspectives of both parents and children. Qualitative interviews would also include discussion of their experiences with this initiative and their satisfaction with it. Separate funding will be sought for this.

Electronic Medical Record Linkage

The linkage of data for family members is problematic because this functionality is not currently built into the Cerner eMR. We have completed a maternal and child data-linkage and have 10 year ethics. Data is extracted by SLHD and the analysis has been undertaken by the Ingham Institute, UNSW. Funding will be requested to support the analytical capability and to explore its applicability to the families enrolled in this initiative.

Population Level Data

As noted below we have developed capability to monitor a wide range of family related population indicators. This was reported in 2013 and will be undertaken again in 2016.

Neighbourhood Place-Based Evaluation

The neighbourhood integration initiatives will develop based on local community consultation. Research and evaluation options will evolve as part of that process. Dr Rebekah Grace has a Macquarie University research fellowship to undertake place-based child and family research and has indicated (see letter) interest in working in one of the communities identified in this initiative.

One option being explored at the time of writing is a “Community Place Based Strengths and Challenges Study. This would be a large place-based, mixed-methods study to understand the strengths, challenges and service needs of the local community (particularly in relation to families and children) from the perspectives of community members, children and local service providers. This study provide community-level information on which to development the local initiatives, and contribute to understanding if and how the initiative is contributing to community level change.

Funding

Research funding is not requested in this proposal. The funding requested for *HealthTracker* and *EMR linkage* is to trial clinical and operational tools that can be used to monitor client outcomes, and better identify vulnerable families respectively. Evaluation will be undertaken within resources.

Research Evaluation funding will be requested in partnership with academic partners from Macquarie, UNSW and Sydney Universities.

Program Justification

What is the need for the program?

A Need for System Wide Changes

Chronic and complex health and social conditions have a significant impact on all members of a family unit including adult partners, dependent children and extended family members. Some chronic and complex conditions result in economic disadvantage, social exclusion and intergenerational transmission of poverty, mental illness, poor health behaviours, poor parenting, education and employment failure.

There are four features of the current system that this integrated care coordination initiative seeks to address. They are:

1. Families who need this initiative have problems which are too complex for any one agency to adequately address. For example, while general practice has a key role in coordinating care for these families, the problems and solutions exceed the capabilities of most family practices

2. Current service and system interventions are usually of short duration (6 weeks to 3 years) with limited follow-up, when for some families, a level of input will be required over a long period if the impact on children and other family members is to be mitigated. This initiative will help the system identify those families where long-term integrated and sustained effort is needed to prevent problems re-emerging or emerging in subsequent generations

3. This initiative is designed to address the known barriers to efforts to “wrap” multiple key agencies around vulnerable families: lack of coordination, poor information exchange, and limited partner commitment to the process

4. Families with chronic and complex conditions are often frequent users of health and community services, but service providers are often not aware of these other episodes, or do not coordinate their interventions. Investment is considerable, and does not produce commensurate outcomes

It is clear from the above that there is a need to improve the coordination of care for individuals with chronic and complex conditions and their family members, and to improve the whole health and social care system.

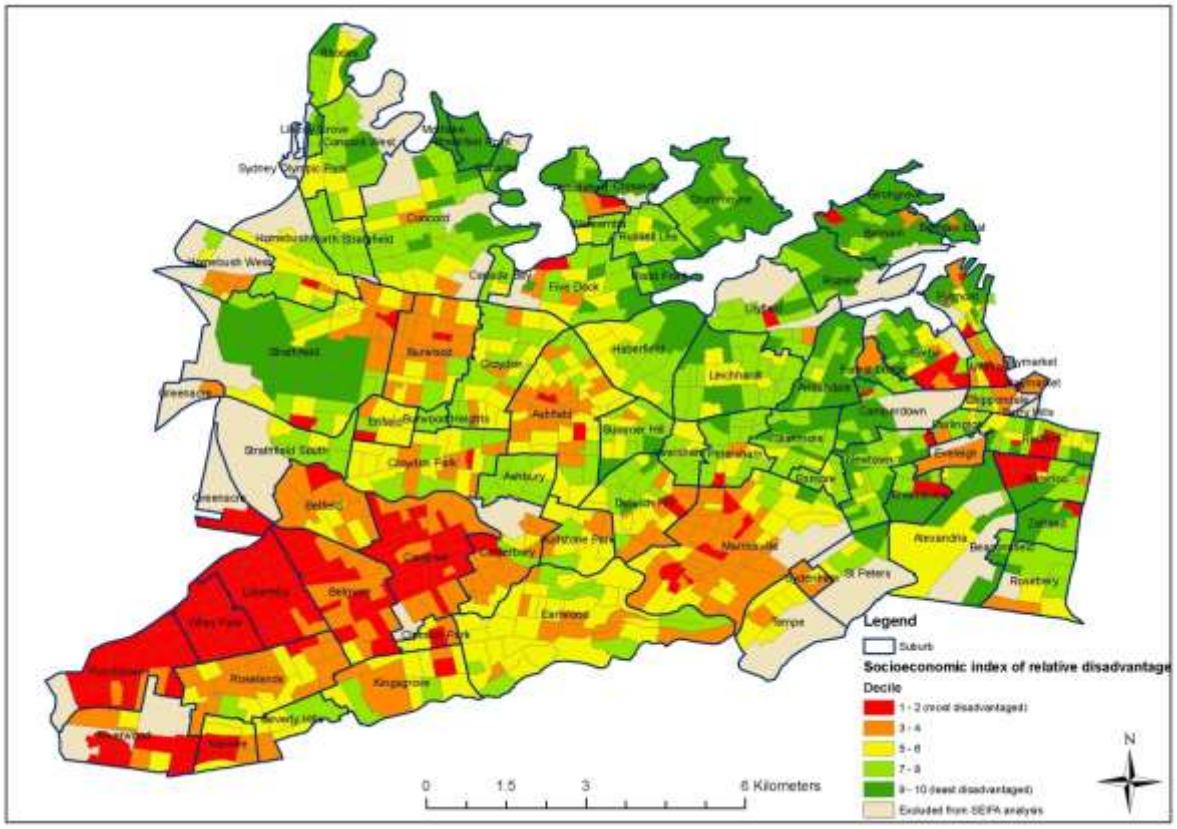
There are fundamental changes that are required to the service system to ensure that intra- and inter-agency changes are systemic and sustainable, thus ensuring that all needs of families with complex conditions are addressed in a comprehensive and long-term manner.

Vulnerable Neighbourhoods

The communities of Canterbury and City of Sydney – South have been selected as a result of collaborative analysis and planning for the Sydney District Child Health and Wellbeing Plan. The **most** vulnerable families can be expected to live in streets, neighbourhoods and suburbs experiencing socio-economic disadvantage.

Figure 1 shows that in SLHD the most socioeconomically disadvantaged areas occur in a small area of South Sydney (Glebe, Redfern and Waterloo) and large areas of western Canterbury (Campsie, Belmore, Lakemba, Wiley Park, Punchbowl, Narwee and Riverwood).

Figure 1: Socioeconomic index of relative disadvantage by statistical area level 1 and suburb, 2011

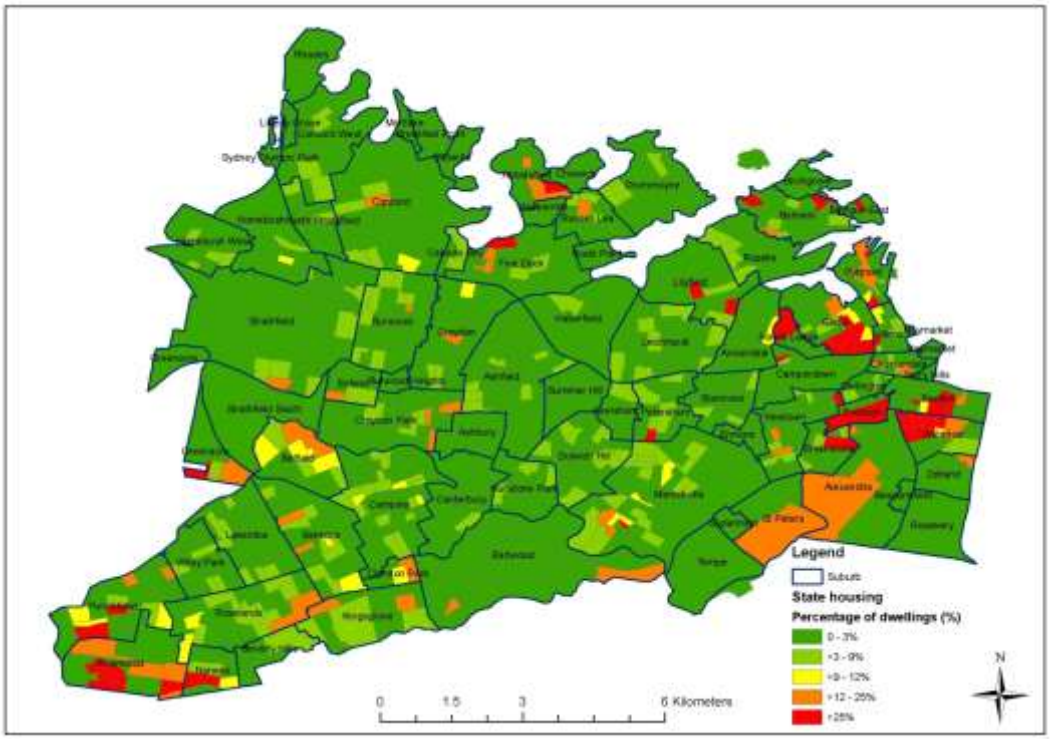


Source: Australian Bureau of Statistics Census of Population and Housing, 2011.

Vulnerable families are also more likely to be living in social housing which are concentrated in Glebe, Redfern, Waterloo, Narwee and Riverwood (Figure 2).

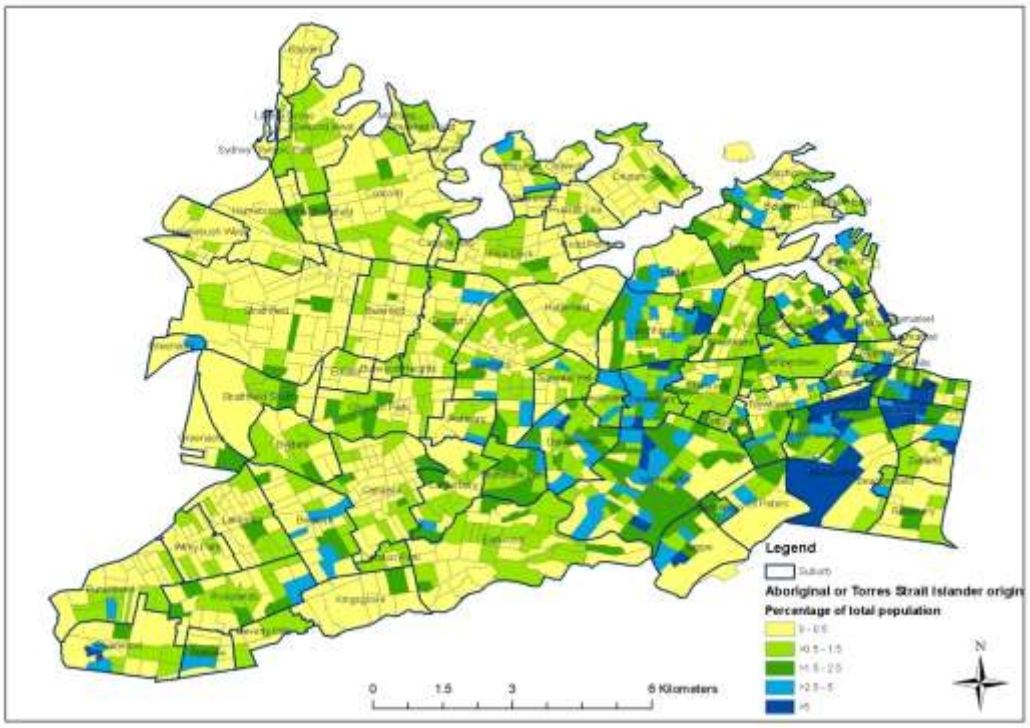
In the Sydney District the highest concentration of Aboriginal and Torres Strait Islander people are in South Sydney and Marrickville (Figure 3).

Figure 2: Proportion of dwellings that are social housing by statistical area level 1 and suburb, 2011



Source: Australian Bureau of Statistics Census of Population and Housing, 2011.

Figure 3: Aboriginal and Torres Strait Islander population by statistical area level 1 and suburb, 2011

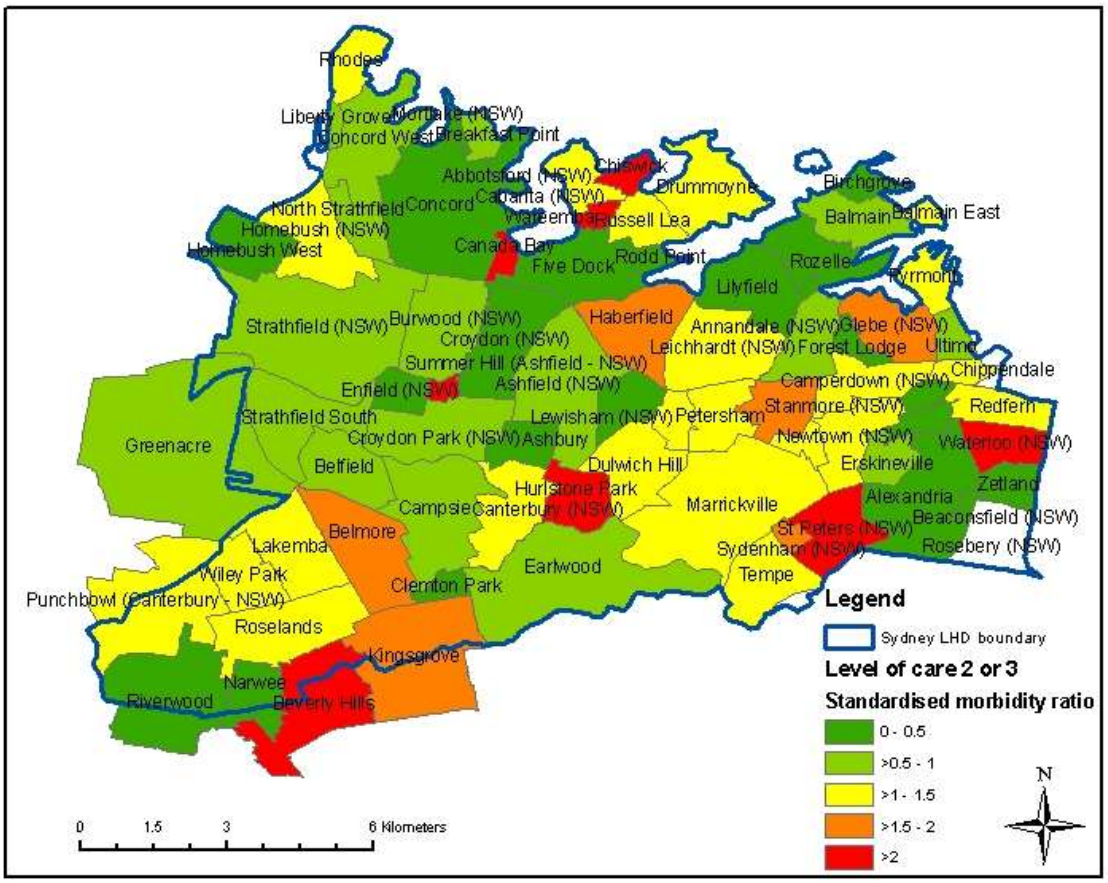


Source: Australian Bureau of Statistics Census of Population and Housing, 2011.

Family Vulnerability: Maternal and Child eMR Data Linkage

Maternal psychosocial screening gives one view into who vulnerable families are and where they live. Maternal psychosocial screening occurs at pregnancy booking and at the postnatal nurse home visit. The Early Years Research Group, Maternal and Child Health Data Linkage project has analysed Maternity and Child and Family Nursing (Cerner) Electronic Medical Records (eMR) for 2012. Postnatal findings for level of care (LOC) in 2012 are shown below (Figure 4).

Figure 4: Vulnerability level of care 2 or 3 at time of first universal home visit - Standardised Morbidity Ratio (SMR) by suburb, 2012



Source: Early Years Research Group Maternal & Child Health Data Linkage Project, Ingham Institute of Applied Medical Research, SLHD & SWSLHD, 2012

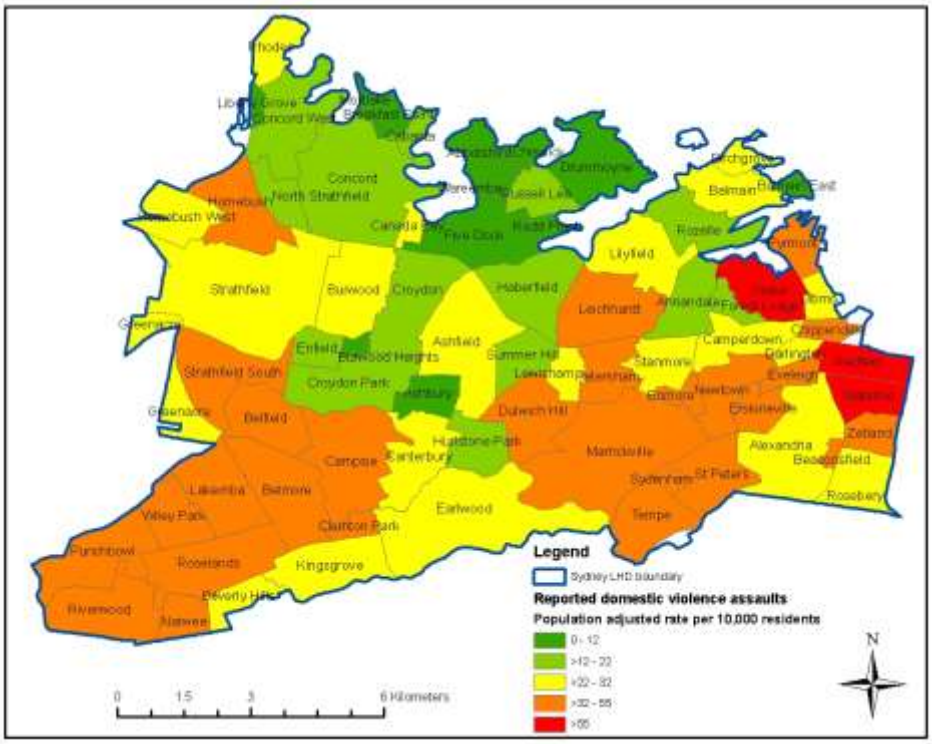
The LOC levels in Riverwood and Narwee are lower than expected and are currently being reviewed using the 2013 analysis. Ethics for this project includes ongoing collection of data from the eMR for all encounters with the health system.

Note: At the first universal home visit families are assessed for their level of vulnerability and are given a level of care (LOC) code: 1 = Families with universal needs; 2 = Vulnerable families requiring intervention; 3 = Vulnerable families requiring specialist response. The number of families being assessed as LOC -2 or LOC-3 was used to calculate the standardised morbidity ratio (SMR) of high level of care assessment in each suburb. An SMR greater than one indicates the number of families requiring a high level of care in that suburb was greater than the expected number. High risk suburbs have an SMR greater than 1.

Family Violence

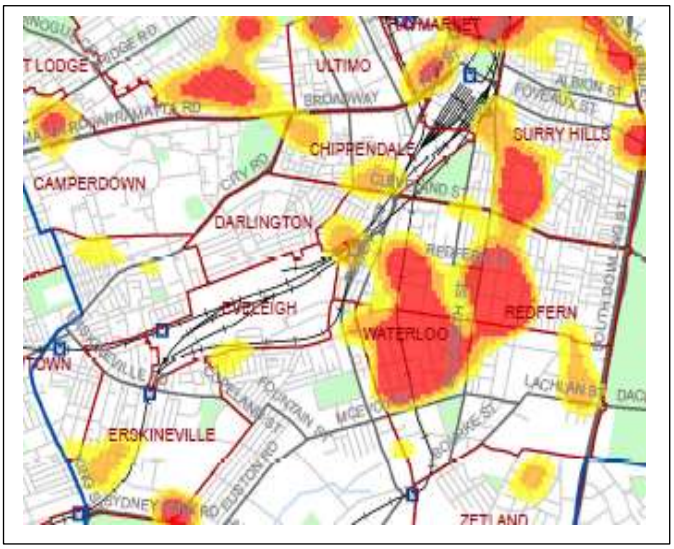
Family violence is one indicator of family function and correlates with the mental health and self-reported health of family members. In 2012, Sydney LGA had the highest population adjusted rate of reported domestic violence incidents at 52.2 incidents per 10,000 residents followed by Marrickville (40.3 incidents per 10,000 residents) and Canterbury (35.4 incidents per 10,000 residents) LGAs. Figure 5 shows at the suburb level, the highest population adjusted rates occurred in Waterloo (100.4 incidents per 10,000 residents), Redfern (79.8 incidents per 10,000 residents) and Glebe (55.7 incidents per 10,000 residents).

Figure 5: Family violence assaults reported to NSW Police by suburb, 2012



Source: NSW Bureau of Crime Statistics and Research 2012.

Figure 6: Family violence hotspots 2012: Sydney LGA - South



Source: NSW Bureau of Crime Statistics and Research 2012

System Changes

What system changes are you hoping to implement?

At the proposal stage the following required system changes have been identified:

1. Registration of vulnerable families with SLHD and partner agencies to ensure that no vulnerable child or adolescent is lost to follow-up
2. Cultural change toward person-centred and long-term shared “duty of care” for vulnerable families
3. Engaging sub-speciality hospital and private clinicians to participate, actively contribute to the supporting vulnerable families, and develop a shared culture with primary care and community service providers
4. An emphasis on providing clients and their families with self-management skills and health and wellbeing literacy that enable individuals and families to take responsibility for achieving their life goals
5. Moving the integrated care as close to the vulnerable families as possible to maximise family access to, and engagement with, the shared services
6. Developing “Health Homes” for the most vulnerable families with complex and chronic conditions
7. Developing locally led neighbourhood initiatives, using system and population approaches, that seek to create supportive social and physical environments for vulnerable families
8. Increasing the emphasis on early sustained intervention with support plans that go well beyond current crises or episodes of care
9. Giving skills to individuals, families and their support “agents” to plan, coordinate and navigate the health, education and social care systems
10. Empowerment of front-line clinicians and clinical teams to take leadership decisions with respect to coordinating care and giving priority of access to the most vulnerable families and their members

Stakeholders and Partners

Who are the current stakeholders?

The core partners of the initiative are:

1. The Inner West Sydney Medicare Local (and future Primary Health Network)
2. The Department of Family and Community Services – Sydney District (including: Housing, Community Services, Sector Development, & Ageing, Disability and Home Care)
3. The Benevolent Society

4. Barnados – Family Referral Service
5. The Infants Home (Ashfield)
6. Jannawi Family Centre (Wiley Park, Canterbury)
7. Sydney Day Nursery – Brighter Futures

The other stakeholders of the initiative are:

1. Providers of early childhood services
2. Primary and secondary schools
3. Private sector specialist providers

Population Impact

Which population/s will be impacted by the initiative?

The initiative is for an initial 20 vulnerable families with complex health and social care needs, who are disconnected from key services, who require multi-agency support to have their complex health and social needs met; and to keep themselves and their children safe; and connected to society.

The initiative is intended for vulnerable families who have one or more dependent children (unborn through to 17 years). This initiative will benefit adult members of the family to participate in the social and economic life of the community through better management of their complex health and social conditions. This initiative will benefit child members of the family through lessening the impact of adult complex health conditions on their safety, health, development and wellbeing. Thus the intervention aims to break intergenerational cycles of disadvantage, psychological trauma, poor parenting and poor health outcomes.

A population-based approach to identifying the most vulnerable families who are disconnected from key services will be developed using current *Safe Start* perinatal systems, developing cross-agency assessment and referral pathways, and improved hospital recognition of the needs of families using an e-health solution.

The initiative will also have a local element through deliberate recruitment and service partnership development in 1) the City of Canterbury, and 2) City of Sydney – South.

What is the estimated size of this population (both actual and relative e.g. percentile of LHD population).

The number of families that might require the initiative is currently unknown. It is known that every year approximately 30 infants are born to parents who are assessed, as part of *Safe Start,* as having “high” needs.

For planning purposes the initiative will start with an initial 20 vulnerable families with complex health and social care needs, who are disconnected from key services who require multi-agency support to have their complex health and social needs met; and to keep themselves and their children safe; and connected to society.

Implementation

What steps are proposed to implement the project?

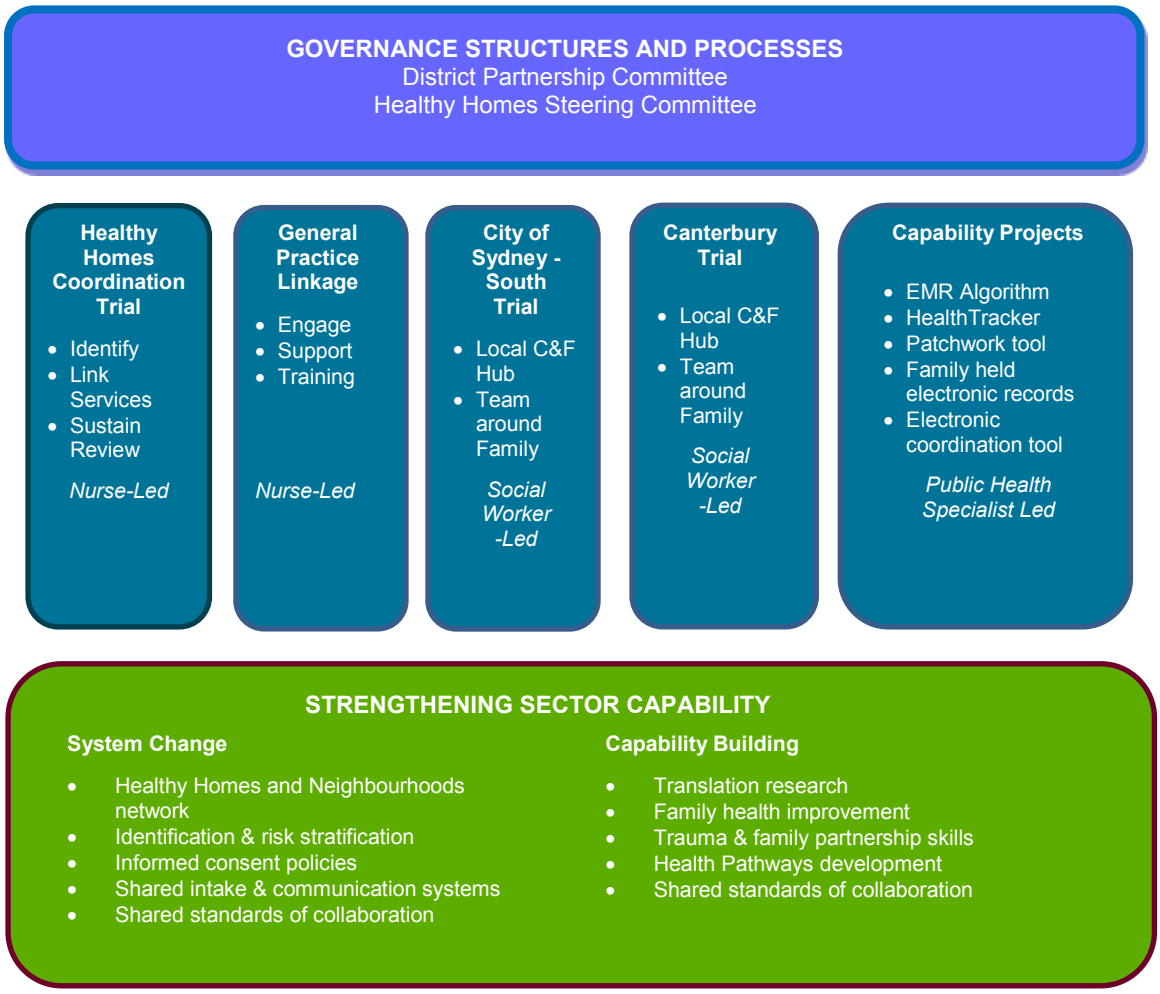
General Approach

The general approach to implementation will be to initially focus funded project resources on District-wide system change while partner agencies progress local place-based initiatives. The progress of local initiatives will be determined by the local context, and in particular by the direction set by local partners, general practice, and the community.

The implementation and design has three broad dimensions:

1. Establishment of District-wide governance
2. Demonstration and trial initiatives
3. Strengthening sector capability within existing resources

This is illustrated below:



Implementation Steps

1. Program Governance

1.1 Interagency Partnership Committee (existing)

1.2 Vulnerable Families Committee – as reference group (existing)

1.3 Healthy Homes and Neighbourhoods Steering Committee

2. Infrastructure and Sector Capability

2.1 General practice capacity building projects (existing and enhanced)

2.2 Research and evaluation capacity (existing and enhanced)

2.3 Establishment of a Healthy Homes and Neighbourhoods Network

3. Establishment Phase Activities

3.1 Human resource activities in preparation for recruitment

3.2 Recruitment of staff to positions

3.3 Establishment of a temporary intake system

3.4 Development of the risk stratification assessment tool

3.5 Development of a vulnerable families *SydneyHealthPathway*

4. Implement Trial Initiatives

4.1 *HealthTracker* tool for client evaluation of outcomes

4.2 Healthy Homes nurse-led coordination and general practice linkage initiatives

4.3 Local team around the family models in Canterbury and City of Sydney - South

4.4 Local vulnerable families collaborative “Hub” in Canterbury and City of Sydney – South with lead partners

5. Exit and Sustainability

5.1 Trial project reports

5.2 Sustainability and exit plan

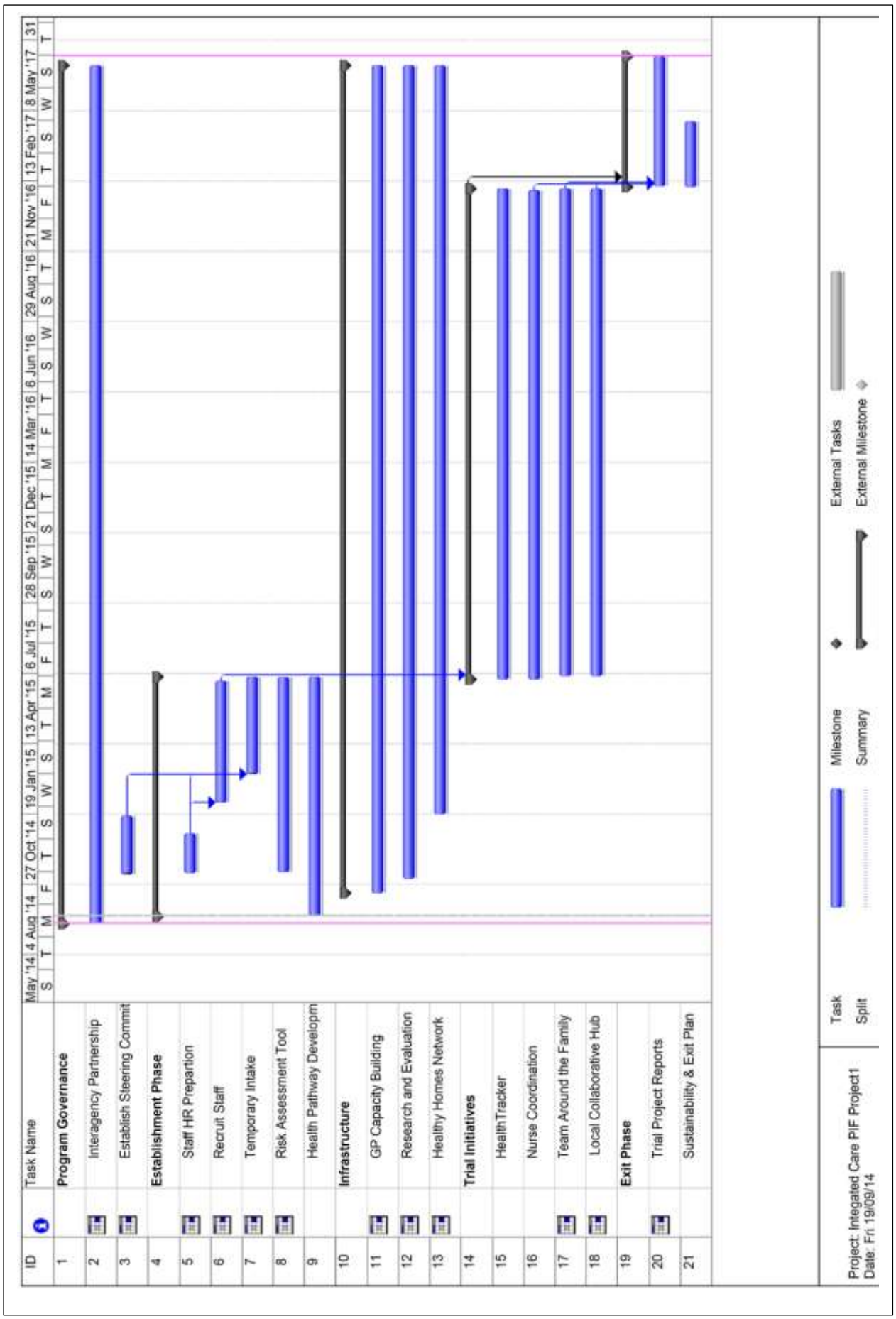
What are the timings and key milestones?

General Approach

As above, the general approach to implementation will be to initially focus funded project resources on District-Wide system change while partner agencies progress local place-based initiatives. The progress of local initiatives will be determined by the local context, and in particular by the direction set by local partners, general practice, and the community.

Phases

	Start	Finish
1. Program Governance		
1.1 Interagency Partnership Committee (existing)	Ongoing	Ongoing
1.2 Vulnerable Families Committee – as reference group (existing)	Ongoing	Ongoing
1.3 Healthy Homes and Neighbourhoods Steering Committee	November 2014	Ongoing
2. Infrastructure and Sector Capability		
2.1 General practice capacity building projects (existing and enhanced)	January 2015	Ongoing
2.2 Research and evaluation capacity (existing and enhanced)	January 2015	Ongoing
2.3 Establishment of a Healthy Homes and Neighbourhoods Network	January 2015	Ongoing
3. Establishment Phase Activities		
3.1 Human resource activities in preparation for recruitment	November 2014	January 2015
3.2 Recruitment of staff to positions	January 2015	June 2015
3.3 Establishment of a temporary intake system	January 2015	June 2015
3.4 Development of the risk stratification assessment tool	October 2014	June 2015
3.5 Development of a vulnerable families *SydneyHealthPathway*	Commenced	June 2015
4. Implement Trial Initiatives		
4.1 *HealthTracker* tool for client evaluation of outcomes	July 2015	Ongoing
4.2 Healthy Homes nurse-led coordination and general practice linkage initiatives	July 2015	December 2016
4.3 Local team around the family models in Canterbury and City of Sydney - South	July 2015	December 2016
4.4 Local vulnerable families collaborative “Hub” in Canterbury and City of Sydney - South with lead partners	July 2015	December 2016
5. Exit and sustainability		
5.1 Trial Project Reports	January 2017	June 2017
5.2 Sustainability and exit plan	January 2017	June 2017


ID
Task Name
1 Program Governance
2 Interagency Partnership
3 Establish Steering Commit
4 Establishment Phase
5 Staff HR Prepartion
6 Recruit Staff
7 Temporary Intake
8 Risk Assessment Tool
9 Health Pathway Developm
10 Infrastructure
11 GP Capacity Building
12 Research and Evaluation
13 Healthy Homes Network
14 Trial Initiatives
15 HealthTracker
16 Nurse Coordination
17 Team Around the Family
18 Local Collaborative Hub
19 Exit Phase
20 Trial Project Reports
21 Sustainability & Exit Plan
May '14 4 Aug '14 27 Oct '14 19 Jan '15 13 Apr '15 6 Jul '15 28 Sep '15 21 Dec '15 14 Mar '16 6 Jun '16 29 Aug '16 21 Nov '16 13 Feb '17 8 May '17
Project: Integated Care PIF Project1
Date: Fri 19/09/14
Task
Split
Milestone
Summary
External Tasks
External Milestone

Change Management

What change management processes are needed?

Healthy Homes will use co-design principles to overcome barriers to coordinated care and leverage from enablers.

At the proposal stage Healthy Homes has developed a Theory of Change for both families, and the services system.

Family change is based on true partnership, choice, control and sustained engagement.

System change is based on shared vision, goals and outcomes that are developed, and owned, at both the front-line and senior interagency level and interagency training and learning opportunities that support the alignment of cultures and enable movement from multi-disciplinary toward trans-disciplinary practice

Both family and system change are supported by a range of technology platforms to:

a. Share family and client information where this has been agreed (i.e. Patchwork tool)

b. Make accessible timely health and wellbeing information to families (i.e. Buddi app)

c. Client and family self-assessment and monitoring of health outcomes (i.e. *HealthTracker*)

d. Shared agency data that provides “real-time” surveillance and monitoring of population needs, thus enabling reconfiguration and tailoring of interventions and system response

Healthy Homes will explore the viability of more significant system changes, e.g.:

1. Changes to current position descriptions and accountability lines to move toward “Task Groups” where senior management give “permission” for staff to give direct, or indirect, operational support to interagency teams as defined in the partnership agreement

2. Changes in the funding and performance agreement environment that ensure that the shared outcomes for vulnerable families are written into contracts thus giving transparent permission for collaborative practice

How does this project differ from previous work on chronic disease management?

The focus is on breaking intergenerational cycles of disadvantage and poor health using early intervention, preventative health, coordinated health and social care management. Better outcomes are anticipated by servicing the client in context – as a member of a family and a community with services tailored to meet individual and familial needs. By adopting a long term approach, a relationship is established and supported, risks and minimised.

This project will focus on early and sustained intervention with a younger population with chronic physical, mental health and social care needs. It will focus on the impact of chronic conditions not only on the person who experiences it, but on their family members. The adults in the family group are likely to be less than 65 years of age and the other members will be dependent children, adolescents and young people with either a chronic condition or affected by the impact of their parents or siblings condition.

How does it align and build on previous work in chronic disease management?

The project aligns with previous and current work in the health, education and social sectors as follows:

1. Linking with and building on Chronic Disease Management Program, including the SLHD Access Care team centralised intake and Self-Management support initiatives
2. Consistent with Keep Them Safe and Supporting NSW Families policies
3. Taking advantage of eHealth initiatives
4. Ensuring that activity-based funding models are incorporated into the clinical aspects of the program
5. Aligning with Safe Home for Life reform in the child protection sector

Criteria 1: Innovation and Policy Alignment

Describe how this initiative is innovative.

The most innovative feature of this initiative is that it will attempt to address the "wicked problem" of trans-generation transmission of disadvantage, poor health behaviours, psychological trauma and chronic and complex health and social needs. For each index child, adult or young person a multi-generational extended family and community-embedded approach will be taken.

The influence of distal and proximal determinants of health will be addressed as they reach into the daily lives of our most vulnerable families. The initiative will not attempt to address those macro and meso social and environmental determinants of health but will focus on mitigating their impact.

The initiative is innovative in that it will use "whole of system" change across: State Health, Commonwealth funded Health including Primary Health Networks, Education (state, Commonwealth and private), Aboriginal Controlled Organisations, Community Services, Housing, State and Commonwealth contracted family and community NGOs, universities, and local government.

The initiative builds on and extends existing innovative partnership work. For example, Sydney LHD's Child Health and Wellbeing Plan is being developed in partnership with FACS, Education, Medicare Local and four local sector wide Interagency Groups that collectively represent approximately 70 non-government and local government organisations. The Healthy Homes initiative will complement and inform the Child Health and Wellbeing Plan with a Youth Plan to follow.

The "Top Down" component involves regular meetings of the Chief Executive and Regional Directors of SLHD, FACS, Medicare Local, Education and Communities together with close collaboration between officials on key components of this proposal.

The "Bottom Up" component has commenced with community focused, interagency "Platforms" workshops facilitated by consultants from the Centre for Community Child Health, Royal Children's Hospital, Melbourne; disability "inclusion" workshops and community consultation; focused community consultation in Canterbury City; leadership from the City of Sydney to develop a safe neighbourhood in the Redfern Social Housing Estate; close collaboration with school partners in South Sydney, Marrickville and Lakemba; and the pushing out of "Vulnerable Family Joint Clinics" into South Sydney, Marrickville and Canterbury communities.

The Vulnerable Family Integration initiatives in this proposal have been developed through collaboration and consultation with Sector Partners, community organisations and "core" clinical and health promotion services that will be required to ensure integrated physical and mental health, and social and preventative care of the most complex and vulnerable families in SLHD.

Key to the change management will be changes in values and attitudes of all partners in the system. New ways of working have been proposed but it is anticipated that as change occurs further innovations will emerge.

Provide details on how you will ensure that the program has patient input and maintains a patient focus.

Family and Community Input

The initiative is designed around meeting the needs that families and communities identify for themselves. Family ownership and focus will be achieved through: family case conferencing, team around the family, family partnership training of sector staff, shared care plans, family informed consent for sharing access to *Patchwork* and *HealthTracker,* and use of social media. Our early work has focused on seeking "informed consent" from program clients to their information being shared with supporting and helping agencies and workers. That approach will be extended here across all access points such as schools, AMS, NGOs, health clinics and maternity services.

The initiative is informed by community consultation undertaken in Canterbury as part of the joint IWSML/SLHD CanGet health project and the Redfern Neighbourhood Advisory Board. Throughout 2013 and 2014 community engagement forums have been held by members of this partnership in relation to: inclusion of people with disability needs of vulnerable children and their families and the development of a child health and wellbeing plan. The Healthy Neighbourhood component of the program will focus on ensuring local community input to defining the needs, designing the initiatives and evaluating outcomes.

The Healthy Homes and Neighbourhoods partners have been working on innovative ways of sharing information with parents and families through the use of phone apps, web portals and social media. Social media as a health literacy tool is a useful way to target disadvantaged populations, especially vulnerable families. Social media is an effective means of communication to expand reach, foster engagement and increase access to health information. Not making health information available on social media risks leaving major target groups, such as vulnerable families, out of the conversation. Social media use via apps such as the *Bubsi* phone app, *Love Talk Sing Read Play* app, *Deadly Tots* phone app allow parents to share their positive experiences, personal stories, and can send a powerful message to consumers who are determining where to obtain their health information and services.

Children, families and communities are experts in their own lives and need to be engaged in planning, implementing and delivering services to meet their local needs. Providing clients and their families with self-management skills, health and wellbeing literacy through platforms such as social media in turn enables individuals and families to take responsibility for achieving their life goals. The following SLHD and FACS site has been developed and is used by the partners of this proposal: www.resourcingparents.com

Family Focus

The Healthy Homes initiative will be family focused, addressing the health and social needs of the adult members of the family unit, the health and education needs of child members of the family unit, and the overall functioning of the family as a safe and nurturing family environment for child members of the family.

This initiative will improve the journey of families through the system by integrating and coordinating services, improving collaborative methods, providing local services and care that address the needs of identified vulnerable families. It will support efforts to improve self-care and community care, and develop locally focused and responsive services. It will also support the better integration of health services delivered by both government and non-government providers.

The Healthy Homes initiative will empower vulnerable families to perceive (health literacy, health beliefs, trust and expectations), to seek (personal and social values, culture, gender, autonomy) and to engage (empowerment, information, adherence and caregiver support) in their care. Current service and system interventions are usually of short duration with limited follow-up, when for some families, a level of input is required over a longer period if the impact on children and other family members is to be mitigated. This initiative will help the system identify those families where long-term integrated and sustained effort is needed to prevent problems re-emerging or emerging in subsequent generations.

What will be in place to encourage and allow for the participation of patients and carers, clinicians and care provider organisations?

Patients and Carers

This initiative will ensure the ease of access for vulnerable families and referring agencies to both health and support services. Care will be delivered in settings where vulnerable families are located to improve access. Innovative and integrated service models from this initiative will help build capacity and support access to health, wellbeing and support services. Models include service co-location or integration to create more family-centred models and more seamless intra- and interagency referral pathways thereby reducing inappropriate service utilisation and avoidable hospital admissions. Services are wrapped around the child and their family to provide better access, better planning, education and empowerment in seeking services for their personally identified needs.

Patients and their families will be encouraged to actively participate in the initiative in a variety of ways including: the use of social media and phone apps, giving families the opportunity to be involved in courses such as Family Partnership Training, conducting community surveys and client evaluations of the initiative, the presence of Community Physicians who families can phone and talk to, and holding community forums and groups in target communities.

Clinicians

The Healthy Homes initiative will help clinicians to build, develop and maintain comprehensive community communication and engagement strategies and strong networking with stakeholders. Clinicians will have opportunities to develop and maintain their skills in improving the continuity of clinical care, coordination of services, effective clinical management, and transition to community care. They will benefit from interagency training and learning opportunities that support the alignment of cultures, and enable movement from multi-disciplinary to trans-disciplinary practice. Clinicians will be able to maintain links and discuss follow up plans with GPs, patients and family, carers, outpatient services, allied health and community service providers.

Care Provider Organisations

The initiative will build effective working relationships between organisations and professionals with different roles and expertise through improved coordination and information sharing, transitions within and across the different care systems, and delivery of flexible, accessible and responsive services at all levels. Continuing strong relations between care provider organisations resulting in joint service planning and data sharing will expand partnerships and linkages. This will in turn open up opportunities to enhance relationships with the local government sector to jointly solve issues, consider new models of service delivery with supporting infrastructure, and conduct local/regional planning and activities with the aim of fostering a healthy community. Health and welfare providers will come together in the community to improve coordination of, and access to, care for complex individuals who may see multiple providers, to eliminate gaps and duplication in care.

Criteria 2: Sustainability, Scalability and Transferability

Embedding into Practice

Describe how this program will be embedded into practice

SLHD will build on earlier experience with perinatal, multidisciplinary developmental assessment, and out-of-home care integration projects. Those initiatives have been embedded into practice through multidisciplinary and multiagency clinical redesign projects that included:

1. Assembling and disseminating robust background research of current practice and evidence-based practice exemplars

2. Collaborative program planning and consultation with all stakeholders

3. Establishment of tiered multi-agency/unit governance structures including the embedding of weekly collaborative intake meetings into routine work flow

4. Development of operational standards, protocols and guidelines to support the business processes and to ensure accountability

5. Client centred changes including new informed consent procedures, client information and use of social media to engage and support clients

6. Workforce training focused on acquiring new skills and changing attitudes toward having a duty of care beyond the episode of care

7. Service level agreements, Memorandum of Understanding and other instruments that clearly describe the operational responsibilities between agencies including: NGOs, other Government Departments and internal business units

8. Using the current Canterbury *HealthPathways* initiative, including primary care capacity building, to embed vulnerable families pathways into regular use by general practice (medical, nursing and allied health), private practitioners, AHPRA registered school counsellors and health workers in partner NGOs

9. Using new technology such as: eMR messaging, web app messaging and the Patchwork tool to strengthen and embed collaborative client-centred care

Taking to Scale

How might the program be scaled or transferred to other LHDs or regions?

The Clinical Leads in this proposal have previously developed and taken to scale a number of similar initiatives including:

1. Integrated Perinatal Care and Perinatal Coordination as the NSW Safe Start Policy
2. Multidisciplinary clinics for children in out-of-home care that are now extended as NSW State Policy
3. The Parenting Communication Strategy - *Love Talk Sing Read Play* and Aboriginal *Deadly Tots*

The Healthy Homes and Neighbourhoods initiative described here is being developed in partnership with agencies that will support and enable the taking to scale and transferring to other NSW and Australian regions. Those partnerships include:

1. City of Sydney
2. Family and Communities Services
3. The Royal Australasian College of Physicians
4. University partners: Sydney, Macquarie, and UNSW
5. The Benevolent Society
6. Health Pathways Network of Australia and New Zealand

The specific project outputs described will be evaluated and published both as web-based project documents and manuscripts in peer reviewed publications. The training modules that are being developed will be made available through appropriate web-based e-learning portals.

Change Management

What change management processes will be needed? (As above)

Healthy Homes will use co-design principles to overcome barriers to coordinated care and leverage from enablers.

At the proposal stage Healthy Homes has developed a Theory of Change for both families and the services system.

Family change is based on true partnership, choice, control and sustained engagement.

System change is based on shared vision, goals and outcomes that are developed, and owned, at both the front-line and senior interagency level and interagency training and learning opportunities that support the alignment of cultures and enable movement from multi-disciplinary toward trans-disciplinary practice

Both family and system change are supported by a range of technology platforms to:

1. Share family and client information where this has been agreed (i.e. Patchwork Tool)
2. Make accessible timely health and wellbeing information to families (i.e. Buddi app)
3. Client and family self-assessment and monitoring of health outcomes (i.e. *HealthTracker*)
4. Shared agency data that provides "real-time" surveillance and monitoring of population needs, thus enabling reconfiguration and tailoring of interventions and system response

Healthy Homes will explore the viability of more significant system changes, e.g.:

1. Changes to current position descriptions and accountability lines to move toward "Task Groups" where senior management give "permission" for staff to give direct, or indirect, operational support to interagency teams as defined in the partnership agreement
2. Changes in the funding and performance agreement environment that ensure that the shared outcomes for vulnerable families are written into contracts thus giving transparent permission for collaborative practice

Sustainability

Sustainability Assessment Matrix

Guiding questions	Possible Evidence	Yes	No	Comment
Policy Framework				
Is the program/project consistent with, and supportive of, relevant Government sectoral policies?	Relevant policy documents and decisions have been read and are referred to in the proposal document Linkages between policies and program/project are described	Yes Yes		Documentation of the policy context was been prepared for partnership planning
Participation & Ownerships				
Have the local stakeholders actively participated in the identification and design process?	The stakeholder consultation process undertaken during preparation is clearly described - who, when and how long Stakeholders and counterparts have been included in the design team Design work has been appropriately phased, or sufficient time has been allocated, to support genuine stakeholder participation Documented evidence of stakeholder contributions to design are available	Yes Yes Yes		Stakeholders participated in writing, and reviewing proposal content Preparation, Phase 1 & 2 includes stakeholder participation
Are senior representatives of stakeholder groups clearly supportive?	Senior stakeholder representatives attend meetings and actively contribute ideas Representatives are well informed about the scope of 'their' program/project and the expected benefits	Yes Yes		Senior managers of partners participated in preparation of proposal
Have beneficiaries/target groups been clearly defined?	Adequately detailed and disaggregated demographic/population data is included in the design Target groups are defined by: number, location, gender, age, socio-economic status, or other appropriate differences		No	Further defining of target group is a Phase 1 activity and a final project output
Will appropriate information and awareness activities been conducted during preparation?	Stakeholders are adequately informed of the proposed program/project scope and realistic benefits Stakeholder workshops have been conducted Appropriate written materials and electronic media materials have been prepared and disseminated during the preparation phase	Yes		Consultation workshops have been held and further planned. Communication in Phase 1
Are participatory approaches a clear element of the implementation strategy?	Participatory approaches are included in the design, including such activities as: Application of, and training in 'Participatory Learning and Action' methods for counterpart staff and community members Establishment of, and support for, local management groups/committees Use of participatory monitoring and review approaches	Yes		Use of local interagency network Neighbourhood initiatives to use strong participatory methods

Guiding questions	Possible Evidence	Yes	No	Comment
Management & Organisation				
Is sustainability specifically included in the program/project objectives?	The logframe narrative description contains specific reference to sustainability The benefits that are to be sustained are specifically described in the design	Yes		Design is focused on long-term sustainability
Has local institutional and absorptive capacity been assessed?	An institutional analysis of key implementing agencies is included in the feasibility or design study		No	To be undertaken during Phase 1 & 2.
Is the program/project timeframe sufficient to support sustainability objectives?	The implementation strategy is clearly phased to allow for required institutional and behavioural changes There is an inception phase during which basic management and administrative capacities are established Allowance is made for possible successor activities, following appropriate reviews of performance	Yes		The Program is a learning initiative designed to allow for institutional and behavioural change throughout the duration.
Do proposed management and financing arrangements support flexibility in implementation?	Workable financing mechanisms have been described, taking into account the need to integrate with local planning, budgeting and expenditure management systems Financial authority is going to be appropriately devolved to field-level managers	Yes		Exiting financing is maximised. Project financial delegation devolved
Has a sustainability monitoring framework been proposed in the design?	Indicators for monitoring progress towards achieving sustainable benefits have been included in the design The responsibility for, and approach to, monitoring sustainability is described Arrangements for stakeholder participation in the monitoring framework promotes their ownership of the process	Yes	No	A sustainability KPI has not be proposed Program Director & partners involved in monitoring sustainability
Has an exit strategy been included in the design, or at least, how and when will it be more fully developed?	An exit strategy is described in the design. This might include such elements as: • A phased use of funded positions based on an analysis of local operational and absorptive capacity • Changing roles of funded positions over time -from executing to supporting • A clear training/skills development strategy • Consideration of some on-going technical and financial support after the main period of funding has been completed • Establishment of long-term institutional linkages	Yes		An exit phase and exit strategy is proposed. The initiative is designed to phase out use of funded positions, use available technical and financial resources and long-term institutional linkages.

Guiding questions	Possible Evidence	Yes	No	Comment
Financial				
Is it clear how local implementing agencies will access financial resources from 'own' sources both during and after implementation?	A description of the main elements of local planning, budgeting and expenditure management systems is provided in the design The Department of Finance/Planning Office are aware of and support the proposal's financing requirements	Yes	No	Maximum use of existing planning, budget and management systems Planning and finance Department contributed to proposal
Are recurrent financing costs likely to bet met?	Past experience regarding recurrent cost funding is assessed in the design Recurrent cost financing requirements for staffing, operational support, and asset maintenance, etc, are clearly identified in the design, including an analysis of expected financing source Counterpart contributions are clearly identified User pays strategies have been considered in the design, based on an analysis of willingness to pay A phased approach to handing over operation and maintenance costs to local agencies within a realistic time-frame is provided for in the design Additional recurrent costs are kept to a necessary minimum in the design Implementing partners accept the recurrent cost implications as being manageable and can describe how these will be met	Yes Yes Yes		Previous project outcomes assessed as part of design Maximum use of existing resources ABF and Medicare financing will be built into implementation design Recurrent costs are minimised in the design Recurrent costs are acceptable to partners
Do the financial benefits outweigh the costs from the perspective of targeted stakeholder groups (i.e. is it financially viable)?	Enterprise budgets have been prepared which demonstrate that financial benefits are greater than costs (at the market prices faced by stakeholder groups) Financial benefits to different stakeholder groups, including men and women, have been analysed		No No	Anticipated increases in Medicare and ABF revenue for SLHD business units based on previous project experience
Do the economic benefits outweigh the costs (ie is it economically viable)?	An economic cost-benefit analysis has been prepared which shows an acceptable internal rate of return over a defined time period Social and environmental costs and benefits have been identified and assessed in the design	Yes	No	The design is intended to be value for money with built-in economic benefit to whole of Government. No economic analysis undertaken in proposal
Is the proposed intervention the most cost-effective strategy/option?	Alternative approaches have been considered in the design, cost effectiveness analysis carried out, and the most cost effective approach chosen	Yes		It is not a new service but leverages of all existing investment for complex families
Has the involvement of private sector stakeholders been appropriately considered and integrated into the design?	Strategies which involve or support private sector participation are included in the design such as: Private sector groups have been consulted during design preparation and their role in implementation is clearly described; Support to the research and development costs of commercial technology beneficial to target groups; and training and management support services provided to local businesses providers	Yes		Private stakeholders were involved in the development of the proposal. Will be key partners in generating benefits.

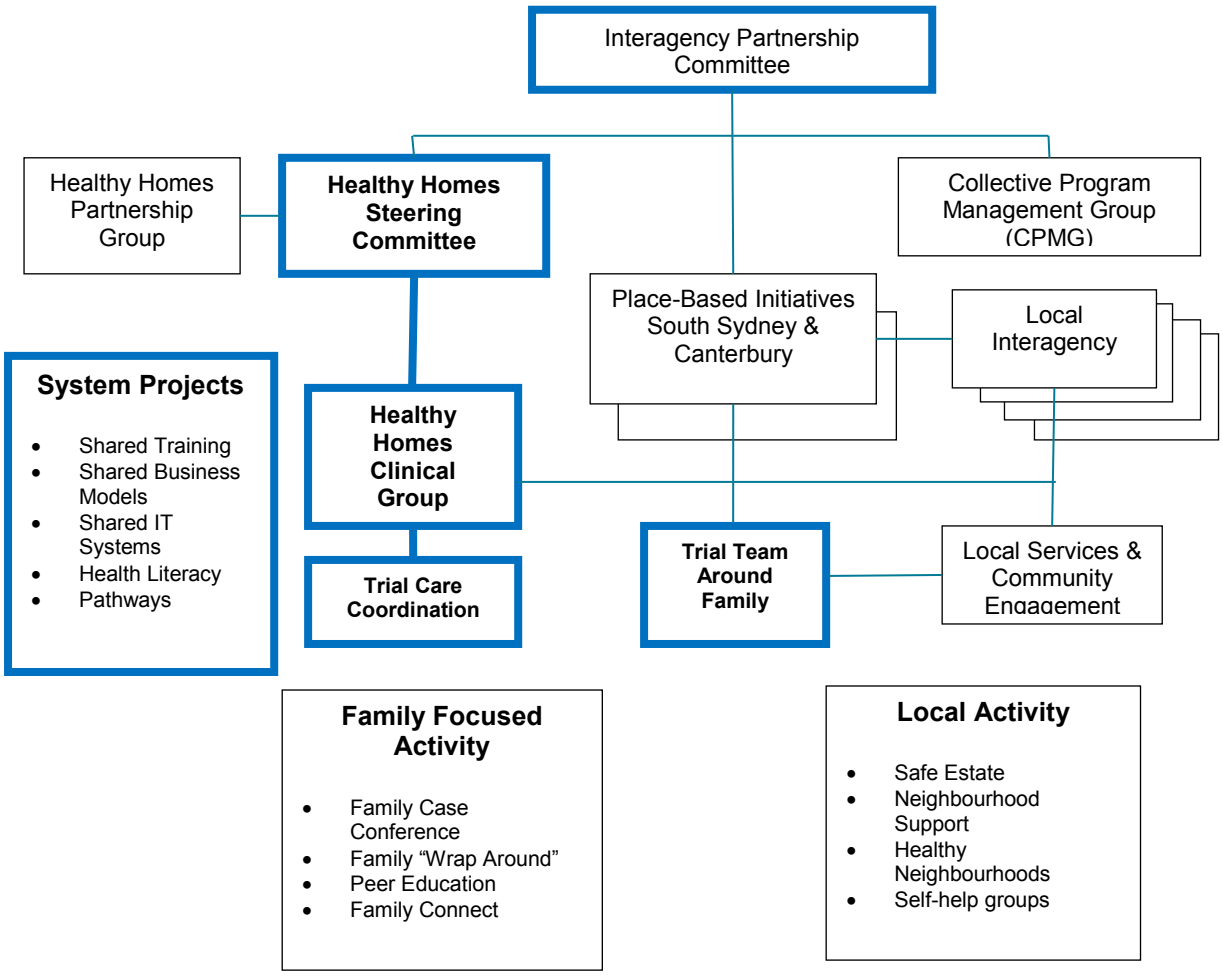
Guiding questions	Possible Evidence	Yes	No	Comment
Awareness and Training				
Have the needs for on-going information dissemination and awareness training been assessed and provided for in the design?	The design includes resources for such activities as: • Translation of key project documents and reports and dissemination of multiple copies • Newsletter production and dissemination • Use of media to raise awareness and inform people • Developing networks within and between key stakeholder agencies.	Yes		Maximum use will be made of electronic and social media and other forms of information dissemination
Has a training strategy been developed and described which addresses sustainability issues?	A training needs analysis been carried out and documented It is clear in the design which, if any, training activities need to be continued on an on-going basis in order to sustain benefits Responsibilities for managing and funding any future or recurrent training activities are described	Yes Yes	No	Training is being conducted by lead agencies and is sustainable within current resources.
Social, gender & culture				
Have social, gender and cultural issues been adequately assessed in the design?	The consultation process with the stakeholders and target groups is clearly described A sociologist has provided input to the design Social/cultural norms and gender considerations which may impact on the acceptability of new technologies or approaches have been described Time and resources are included in the implementation strategy to allow project staff to understand local culture	Yes		Consultation with target groups will occur. Sociological input occurred Gender analysis will be undertaken during implementation
Do management arrangements incorporate feedback mechanisms which allow target groups to effectively voice their views on the type and quality of goods and services provided?	Feedback systems are described, which may include such elements as: • Sample surveys of men and women's views and satisfaction • Regular field trips by program/project managers • Community member participation in program/project management groups • Establishment of complaint or comment procedures	Yes		In the Healthy Neighbourhood trials there will be surveys, community participation and comment procedures
Have gender strategies been proposed which will enhance the participation of both men and women in all the activities?	Disaggregated data (quantitative and qualitative) is presented in the feasibility/design study Constraints to gender equity/opportunity are described Gender strategies are clearly reflected in the logframe and activity schedule Resources to implement gender strategies are included in the input and cost schedules		No	Gender specific strategies have not been included in the design but will be addressed as part of operational guidelines
Has an equity assessment been undertaken?	An appropriate level of equity impact assessment is included in the design Equity issues of concern are identified and mitigating measures proposed	Yes		Equity analysis was included in the design and further is planned.

Criteria 3: Partnerships and Contribution

How will the initiative be managed and governed e.g. will there be a steering committee and who makes the decisions about the initiative?

Interagency Partnership Committee

There is an established Interagency Partnership Committee that includes representation of Chief Executives and senior directors and advisors of SLHD, FACS, IWSML and DEC. The Interagency Partnership Committee will make decisions about the initiative.



Healthy Homes and Neighbourhoods Steering Committee

The Steering Committee of the initiative reports to the Interagency Partnership Committee. The Steering Committee will be composed of those Managers who are line managing project funded staff and those collaborating managers who are contributing resources to the initiative. At the time of writing it is envisaged that the Steering Committee will include managers from: Community Services (FACS), Lakemba Client Services (FACS), Child Protection (SLHD), Drug Health (SLHD), Community Mental Health (SLHD), Community Paediatrics (SLHD), Family Referral Service (Barnados), and IWSML/Primary Health Network.

Program Director

Senior Staff Specialist Community Physician and Paediatrician (SLHD funded)

Healthy Homes and Neighbourhoods Clinical Group

The purpose of the clinical group is to support the identification, intake and coordination of care for enrolled families. The composition and function of the group will be modified as the initiative progresses. The functions, roles, responsibilities and sustainability of the group will be reported on as a project output. At the time of writing it is envisaged that the group will have a small core and a number of supporting clinicians or support officers.

Core Clinical Staff

1. Clinical Lead - Child Youth and Family Medical Officer (SLHD Community Paediatrics)
2. Children of Parents with Mental Illness (COPMI) Coordinator (SLHD Mental Health)
3. Healthy Homes Clinical Care Coordinator **(CNC2-Project Funded)**
4. Healthy Neighbourhoods Wrap-around Coordinators (SLHD funded)
5. Clinical support officer – Administration Officer **(AO3 – Project Funded)**

Supporting Clinical Staff

1. Chronic Care Program Coordinator
2. Paediatric, Addiction Medicine, Psychiatric and Ambulatory Care Staff Specialists
3. Drug Health CNC
4. Sydney Community Nursing
5. Child and Family Nursing CNC
6. Child Protection Counsellors

Healthy Homes and Neighbourhoods Project Group

The purpose of the project group is to support the non-clinical activities. At the time of writing it is envisaged that the group will include.

1. Healthy Homes Project Manager – **(HSM2 – Project Funded)**
2. Perinatal Case Conference Project Officer (Paediatric Advanced Trainee)
3. Capacity Building Project Officer (Public Health Medicine Advanced Trainee)
4. Healthy Homes Clinical Care Coordinator **(CNC2-Project Funded)**
5. Healthy Neighbourhoods Wrap-around Coordinator (SLHD funded)

Healthy Homes and Neighbourhoods Partnership Group

All partners in the initiative will be members of a *Partnerships Group.* It is envisaged that this group will be expanded to include non-core partners.

Major Partners

Who will be the major partners in the initiative e.g. NGOs, primary care organisations, Aboriginal health services, other government agencies?

Major Partners	Supporting Partners
• Sydney Local Health District	• Redfern Aboriginal Medical Service
• Department of Family and Community Services – Sydney Region	• Jannawi Family Centre
• Department of Education and Communities	• SDN Child and Family Services
• The Inner West Sydney Medicare Local	• The Infants Home
• Barnardos Family Referral Service	• The Benevolent Society

Collaboration

What methods for collaboration are being proposed?

This proposal has been developed as a result of a strong collaboration between the SLHD, FACS-Sydney District and the IWSML. A joint Partnership and Planning Committee has been meeting regularly to develop a joint Sydney District Child Health and Wellbeing Plan. As a result there are mutual goals, purpose and benefit to the partners with strong governance, trust, and leadership.

Public Sector Collaboration Models

In developing the collaboration for this initiative we have drawn on the collaboration research report prepared for the NSW Public Service Commission by the Nous Group.[9] The collaboration model adopted is based primarily on coordination of collective interests with future consideration of joint purchasing and outsourcing. Three models of coordination collaboration (i.e. coordination forum, taskforces, joint teams) will be used, or explored, in this initiative.

1. **Coordination forums** have been used, and will continue to be used, to build and sustain a collective impact approach at both District and local community levels. The coordination forums are contributing to the development of the Child Health and Wellbeing Plan
2. A **Taskforce** approach is being used to design and implement this initiative within the overarching governance of the Partnership and Planning Committee. There are separate **Taskforce** groups developing place-based initiatives in Canterbury and South Sydney to which this initiative is linked
3. **Joint teams** are described in the above report as a relatively "new model of collaboration used to address service delivery issues that traverse multiple departments and sectors [and benefiting] from shared accountability structures. The Joint Investigation Response Teams (JIRT) has provided the agencies with a shared

[9] Collaboration between sectors to improve customer outcomes for citizens of NSW. Research report prepared for the NSW Public Service Commission. Nous Group, Sydney, 2013

experience with this using model. It is proposed that this model be used, and evaluated, for the Healthy Homes Operational Group. For the model to work shared accountability structures and processes will be established.

The **Joined Up Entity,** or special purpose organisation, model has been explored as a new way to deliver whole of government services. The model has been explored for this initiative but will not be advanced at this stage. Following the establishment of the Primary Health Networks in 2015 further examination of this approach will be considered.

Other Mechanisms

The proposal includes several other key elements that are intended to establish a strong environment for collaboration. They are:

1. KPIs that are relevant, owned and important to the partner agencies
2. Resources, tools and training that benefit partner Departments/Agencies/Sectors
3. Shared client informed consent, information sharing and case-coordination
4. Collaborative service delivery (i.e. intake meetings, clinics, shared visiting, education etc)

Formal Agreements

What formal/contractual agreements will be in place between partners?

The partners will use the methods that are currently in place as appropriate and guided by legal and contract management advice. They include:

1. Shared Plan with a common set of values, goals, outcomes and activities (example: proposed Child Health and Wellbeing Plan)
2. Exchange of letters and invoicing for services
3. Memorandum of Understanding in relation to joint services (example: current joint Benevolent Society and Community Paediatric clinic)

Evidence of Collaboration

Provide evidence of successful collaboration in the past.

SLHD & Inner West Sydney Medicare Local

There are a number of features that contribute to the strength of the partnership between Sydney Local Health District (SLHD) and the Inner West Sydney Medicare Local (IWSML). Many of these features are also core features of integrated care. They include:

1. shared geographic boundaries
2. strong engagement at an Executive level
3. reciprocal representation on planning and management committees
4. pooled resources
5. co-located staff
6. formalised agreements
7. significant range of collaborative project initiatives

Reciprocal Representation on Planning and Management Committees

Both organisations have worked hard to ensure reciprocal representation on a range of planning and management committees at various levels across the organisations (listed below). High level executive participation is notable.

IWSML Board*	IWSML/UNSW/SLHD Can-Get-Health Advisory Committee
HealthPathways Sydney Advisory Committee*	SLHD Clinical Council*
SLHD Clinical Quality Council*	SLHD/IWSML GP Liaison Committee*
SLHD/FACS/IWSML Partnership and Planning Group	SLHD Chronic Disease Management District Steering Committee*
SLHD/IWSML/UNSW Integrated Primary Health Care Planning Working Group*	SLHD Aboriginal Early Years & Young People Working Group
SLHD Aged and Chronic Care Advisory Committee*	SLHD Chronic Care Redesign Working Group
SLHD Domestic Violence Committee	SLHD Sexual Health Advisory Committee
SLHD Vulnerable Families Committee	Sydney Research Advisory Committee*

**Denotes Chief Executive representation*

Pooled Resources

A number of existing collaborations have included the 'pooling' of resources with additional funds provided by the Medicare Local and SLHD providing staff resources. Current examples include:

- IWSML funded Nurse Practitioner, Residential Aged Care Facilities
- IWSML funded New Graduate Speech Pathologist, Child & Family Health Services
- IWSML funded Speech Pathologist for Speech Pathology Voucher Project
- IWSML funding contribution towards chronic disease prevention education for culturally diverse communities.

Formalised Agreements

Formal Memoranda of Understanding have been developed to support the following collaborative activities:

- Community Child & Family Health Speech Pathology Voucher Project
- Community Child & Family Health Speech Pathology New Graduate Program
- *HealthPathways* Sydney
- (Canterbury) Can-Get-Health Project.

Range of Collaborative Initiatives

SLHD and the IWSML collaboratively developed nine LGA health profiles that describe the health status and demography of each of these the local communities. This quantitative data was complemented by community and stakeholder consultation forums with over 120 participants. The IWSML, in consultation with the SLHD then established six key primary care priorities.

Both agencies have worked together to develop their population health plans and all SLHD departments were invited to provide comment.

The Medicare Local has participated in a range of planning forums for new initiatives. Recent examples include planning regarding models of integrated primary health care, allied health services, child and family health and wellbeing and reducing presentations to the Canterbury Hospital Emergency Department.

Referral Pathways

HealthPathways Sydney is an online local health information portal to support local GPs and local clinicians while they are seeing their patients. It provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the most timely way. Twenty pathways are now active on the live site with a further 88 under development.

Improving Service Access for Vulnerable Communities

The Child and Family Speech Pathology Voucher Project targets families (with children aged 3 to 5 years) in low SES areas seeking Speech Pathology intervention. The Medicare Local

provides funding for SLHD to employ a part-time Speech Pathologist to complete client assessments and provide families with a voucher and prescription for intervention by a private Speech Pathologist. This initiative commenced in January 2013 and has reduced waiting lists for priority children accessing the SLHD Community Children's Speech Pathology service.

In addition, the Medicare Local has funded a temporary SLHD Children's Speech Pathology New Graduate position based at Canterbury Community Health Centre to increase the capacity of the SLHD to provide services to vulnerable families.

The IWSML/SLHD/UNSW 'Can-Get-Health' Project addresses health issues in the Canterbury LGA. It is anticipated that collaborative initiatives targeting vulnerable families will flow from this partnership.

GP Clinics in Community Health Centres

The District and the Medicare Local have collaborated to introduce a co-located GP clinic at Marrickville Mental Health Services to provide medical care to mental health patients. This initiative has been recognised as a notable achievement towards excellence, innovation and best practice in primary care.

Professional Education

With the support of the Medicare Local, SLHD provide an annual calendar of accredited Active Learning Modules for GPs and Practice Nurses, most recently in the areas of sexual health, women's health, hepatitis and domestic violence screening.

Community Education

Sydney District Nursing works with the Medicare Local to promote the 'ComDiab' community education program for people with Type 2 diabetes and encourage GP referral and patient uptake.

Family and Community Services

The strong collaborative partnership between FACS and SLHD is illustrated throughout this initiative which is underpinned by a joint partnership planning and governance group that is working toward a Sydney District Child Health and Wellbeing Plan. Highlighted in this proposal is the current Perinatal Family Case Conference initiative.

Perinatal Family Case Conference

Perinatal Family Conferencing is an innovative program developed by Sydney Local Health District and Family and Community Services and uses family conferencing with an independent facilitator to promote early engagement and interagency planning with pregnant women and families at risk of their newborns entering out-of-home care at birth. Early engagement aims to reduce risks and the number of infants assumed into care and/or the identification of an appropriate carer prior to birth. The program utilises a strengths based model which promotes a participatory and transparent process for parents and families. Referrals commenced in April 2012, the number referred to end June 2014 is 40.

The pilot program was endorsed by SLHD and Family and Community Services via exchange of letters and the implementation of an interagency protocol to proceed. A Program Steering Committee consisting of senior SLHD and Community Services staff

supports and directs the program. Facilitators are provided by Community Services and SLHD within existing resources. The SLHD Child Protection Strategy Unit within existing resources initially provided the coordination of the program, support to facilitators and interagency liaison. Due to the success of the pilot SLHD and Family and Community Services agreed to jointly fund a Coordinator for 12 months with the key duties of: primary facilitator; coordinator of the program with strong emphasis on interagency relationships and the ongoing recruitment and support of other facilitators. The Coordinator was appointed in June 2014 and has program accountability to both SLHD (Director Child Protection Strategy Unit) and to Family and Community Services (Sydney District Director Community Services) The position is hosted and line managed by Family and Community Services.

Other Collaborations

There are a number of other collaborations within include:

1. Family and Community Services have an MoU with SDN Child and Family Services for the Brighter Futures program

2. Family and Community Services facilitate the Integrated Complex Case Coordination Panel, which is attended by Health, DEC, Juvenile Justice, Police, Housing, ADHC and all NGOs in the area

3. Family and Community Services facilitate the Adolescent Interagency Meetings, which is a referral point for youth at risk of serious harm and is attended by Police, NGOs and Health

4. Family and Community Services work collaboratively with providers of Intensive Family Support to conduct joint risk assessments and coordination

5. Community Paediatrics, SLHD provides a joint monthly clinic with The Benevolent Society for vulnerable children and children in out-of-home care

Criteria 4: Program Benefits and Outcomes

What are the benefits of the initiative? For example:

Sydney District is in the process of developing a child health and wellbeing plan in partnership with Family and Community Services, Department of Education and Communities, the Inner West Sydney Medical Local, a collaborative program management group representing four local interagency groups and a broad range of agencies working with families and children (approximately 70), and local government. The strategic focus is on vulnerable families and communities. The partnership has developed a draft outcome framework which is currently undergoing sector consultation. The draft outcome framework is used here, where relevant, to inform the outcomes below.

Patient Outcomes (both short and long term)

We have defined the patients in this proposal as being vulnerable families with adult, child and youth family members with complex physical and mental comorbidity, and significant social care and preventative health needs.

Focus area	Outcomes (Targeted Families)
Caring for vulnerable families	Early identification and intervention approach is implemented for families with **vulnerable risk factors not yet in crisis** • Families enrolled through peri-pregnancy referral • Families enrolled through preschool & school referral
Caring for the parents	The importance of **good parental health** is promoted • Gestational Diabetes • Parental Type 2 Diabetes • Parental tobacco smoking • (Parental muscular skeletal conditions) • (Parental cardio-respiratory conditions)
	Parental social and emotional wellbeing is promoted, with early detection and intervention for social and emotional distress, mental illness and drug dependence, which are known to impact on parenting capacity • Parental Stress • Parental Anxiety and Depression • Parental Drug and Alcohol Use • Parental Psychosis
Prevention of family conflict and violence	**Prevention of family conflict and violence** by changing attitudes to promote respectful, non-violent relationships and gender equity • Parental conflict reduced • Less harsh parenting • Fewer reports of interpersonal violence

Source: Draft Sydney District Child Health and Wellbeing Framework

Focus area	Outcomes (in Vulnerable Families)
Caring for children	The **health and development of all children** is monitored • All children have schedule of health checks • All children vaccinated on schedule • Health & Development Tracked (*HealthTracker*)
	Breastfeeding rates and nutrition are improved • Breastfeeding at hospital discharge • Introduction of solids is delayed
	Growth in **childhood obesity** is halted or reversed. • BMI of children is not in obese range
	Children **start school with good health and positive behaviour**, with families ready to support educational attainment and school community relationships.
	The burden of predictable and preventable **unintentional childhood injuries** is minimised • Schedule of minimum child safety measures is in place for each child
	Age-appropriate **sexual growth and development** promoted • Delayed sexual activity of children • Safe sexual activity of children
	The **mental health of young children is promoted and protected** • Less depression and anxiety • Less disruptive behaviours
Securing school pathway engagement	Children who have complex social, emotional and health needs and their families feel connected to the school community and **value educational attainment** • School participation and attainment • Parental involvement with schools
Responding to children and their families at risk of and/or subject to violence, abuse and neglect earlier	The **early stages of maltreatment and potential harm is identified and acted upon** in families • Children are kept safe in their families

Source: Draft Sydney District Child Health and Wellbeing Framework

Patient Experience

Focus area	Outcomes
Providing strengths-based parent support and education	**Parental support and development** of parenting skills is tailored to the evidence base around key life stages and transition points, building on the unique strengths of each family. Greater intensity in placement prevention and family and parent support services to enhance parental capacity to provide a safe home environment, including perinatal monitoring and response to risk.
	All parents and children have access to and understanding of all relevant care messages that are evidence-based and shown to be beneficial. **Health promoting messages** include primary prevention strategies, health education, child safety, parenting skill development and support.
Joined-up working between organisations and professionals, wrapping services around children, families and communities	Services are **wrapped around the child and their family** to provide better access, better care planning, education and empowerment in seeking services for their personally identified needs. Health and welfare providers are brought together in the community to improve coordination of, and access to, care for complex individuals who often see multiple providers, to eliminate gaps and duplication in care.
Fostering community engagement	Children, families and communities are recognised as experts in their lives, and **engaged in planning, implementing and delivering services** to meet their local needs.

Source: Draft Sydney District Child Health and Wellbeing Framework

Provider Experience

Focus area	Outcomes
A focus on place-based approaches to health and wellbeing issues	Exploration of potential **place-based and family-centred approaches to areas experiencing significant disadvantage** in the community, addressing factors that shape health and wellbeing at multiple levels in partnership with key stakeholders and the community.
Joined-up working between organisations and professionals, wrapping services around children, families and communities	Services are **wrapped around the child and their family** to provide better access, better care planning, education and empowerment in seeking services for their personally identified needs. Health and welfare providers are brought together in the community to improve coordination of, and access to, care for complex individuals who often see multiple providers, to eliminate gaps and duplication in care.
Cultivating interagency integrated models of care and care pathways	Innovative and integrated service models are explored to build capacity and support access to health, wellbeing and support services. Models may include service colocation or integration to create more family-centred models and **more seamless intra- and interagency referral pathways.** Effective working between organisations and professionals that have different roles and expertise, for improved coordination and information sharing, and improved transitions within and across the different care systems, to deliver flexible, accessible and responsive services at all levels.
Fostering community engagement	Children, families and communities are recognised as experts in their lives, and **engaged in planning, implementing and delivering services** to meet their local needs.
Trauma-informed services and care	Services are more **trauma-aware and trauma-informed**, equipped to address the multiple needs faced by children and their families exhibiting symptoms of childhood or intergenerational trauma when they enter the system. The availability and clear referral pathways to trauma-specific services and treatments characterised by a child-focused, family-centred, gender-specific and culturally sensitive, strengths-based approach to facilitate healing.

Source: Draft Sydney District Child Health and Wellbeing Framework

Provider Relationships and Partnership Building

Focus area	Outcomes
Strengthening relationships with the local government sector	**Enhanced relationships with the local government sector** to jointly solve issues, consider new models of service delivery with supporting infrastructure, and conduct local/regional planning and activities around population health issues and fostering a healthy community.
Preparing for NDIS together	Services in the District **work together to support families** in exercising informed choices in accessing their support needs and the needs of their children through NDIS, while securing connection to the community and universal services.
Building child safe environments in organisations and communities	Inner West Sydney organisations are **committed to the safety of children**, taking a preventative, proactive and participatory stance on child protection, safety and wellbeing issues.
A focus on place-based approaches to health and wellbeing issues	Exploration of potential **place-based and family-centred approaches to areas experiencing significant disadvantage** in the community, addressing factors that shape health and wellbeing at multiple levels in partnership with key stakeholders and the community.
Joined-up working between organisations and professionals, wrapping services around children, families and communities	Services are **wrapped around the child and their family** to provide better access, better care planning, education and empowerment in seeking services for their personally identified needs. Health and welfare providers are brought together in the community to improve coordination of, and access to, care for complex individuals who often see multiple providers, to eliminate gaps and duplication in care.
Cultivating interagency integrated models of care and care pathways	Innovative and integrated service models are explored to build capacity and support access to health, wellbeing and support services. Models may include service colocation or integration to create more family-centred models and **more seamless intra- and interagency referral pathways**. Effective working between organisations and professionals that have different roles and expertise, for improved coordination and information sharing, and improved transitions within and across the different care systems, to deliver flexible, accessible and responsive services at all levels. Partner organisations include other government agencies, non-government organisations (NGOs), philanthropists, key community agencies and the private sector.
Fostering community engagement	Children, families and communities are recognised as experts in their lives, and **engaged in planning, implementing and delivering services** to meet their local needs.

Source: Draft Sydney District Child Health and Wellbeing Framework

Whole of Government Cost and Hospital Usage

The setting of government and hospital usage outcome objectives for vulnerable families is difficult because, as observed earlier, they are invisible to the system. There is very limited collection of data on their cost to government.

One innovative aspect of this initiative is the attempt to define vulnerable families and develop methods to measure their impact on health care usage.

The NSW Government has recently commissioned a study of the impact of FACS clients on government costs. The findings are not yet available.

Focus area	Outcomes
Avoidable Emergency Department presentation	Family members are able to **self-manage minor illness and injuries** using their own resources, community pharmacy or general practice.
Ambulatory sensitive avoidable deaths and hospitalisation	**Decreased deaths, hospitalisation and emergency presentation** for conditions listed by WHO as ambulatory sensitive conditions.
Early onset chronic disease morbidity	**Delayed or prevented onset of life-style related chronic disease** conditions such as diabetes, bronchitis, kidney failure and cardiovascular disease.
Dual diagnosis mental health and drug misuse	The **mental health of family members is promoted** and those with mental illness and/or substance misuse receive treatment in the community and are able to avoid hospital presentation, seek employment and participate in society.
Road traffic crashes and injuries	Safe use of cars and roads is promoted to family members and road traffic related injury is avoided.
Alcohol related conditions	Family members have a **moderate use of alcohol** and avoid alcohol related disease and injury.

Key Performance Indicators (KPIs)

What are the measureable outcomes / Key Performance Indicators for the initiative? Please ensure that these outcomes are SMART (Specific, Measurable, Attainable, Realistic, Timely)

The following Key Performance Indicators are proposed:

KPI	2014/2015	2015/2016	2016/2017	2017/2018
Proportion of families with active general practice engagement	n/a	50%	60%	80%
Proportion of enrolled children fully immunised at age 5 years*	85%	90%	95%	95%
Proportion of children regularly attending school	n/a	80%	85%	90%
Family experience (proportion of family adults who would recommend the service)	Survey measures	Survey Measures	Survey Measures	Survey Measures
Proportion of family members with chronic and complex conditions whose care is in-line with locally developed *SydneyHealthPathways*	n/a	50%	60%	70%
Child safety (proportion of children and young people reported at risk of significant harm where chronic health issues impact on safety referred to project)	n/a	50%	60%	80%

** Excluding children not immunised due to medical reasons or a parent/guardian with a conscientious objection to vaccination*

Data

What data will be used to monitor the expected impact of the initiative?

Individual Level Data

For enrolled individual family members, the following data will be monitored to assess the impact of the initiative:

1. Presentation to Emergency Departments by enrolled family members
2. Ambulatory and outpatient use by enrolled family members
3. Hospital admissions for enrolled family members
4. *HealthTracker* Outcome Data on family stress, mental health and developmental scales described above
5. Immunisation uptake by family members
6. Risk of Significant Harm (ROSH) reports to Community Services

Population Level Data

Child & Family Indicators: We have previously reported on population-level data in 2009 and 2013 using available population level indices of child and family health and wellbeing for SLHD. That analysis will be undertaken again following the 2016 Census. The 2015 Australian Early Development Census (AEDC) data will also be analysed and reported.

Electronic Medical Record Linkage: We have undertaken a data-linkage of Maternity and Child and Family data for SLHD. This data enables auditing of the current perinatal screening and referral process. That analysis will be undertaken annually.

Partnership Evaluation: The Partnerships Analysis tool will be used to monitor the District wide partnership. The Partnerships Analysis tool was developed by VicHealth to support partnerships across different health sectors.

The tool includes the following measures:

1. Determining the need for partnership
2. Choosing partners
3. Making sure partnership works
4. Planning collaborative action
5. Implementing collaborative action
6. Minimising barriers to partnerships
7. Reflecting on and continuing the partnership

When used with qualitative data from key informant interviews, the tool is useful for evaluating partnerships and assists reflection by partnerships on their progress, as well as facilitating discussion about issues and ways to move forward in developing closer partnerships.

Neighbourhood Level Data

Population level indices from sources including the ABS Census and the AEDC (formerly known as the Australian Early Development Index) will be analysed longitudinally to measure the impact on social, economic, health and developmental indicators in selected neighbourhoods such as Redfern, Waterloo, Riverwood and Lakemba.

In addition a community survey of residents will also be conducted in selected neighbourhoods to monitor the impact of the initiative. The survey tool will be modified from our earlier work in Miller and Claymore, SWSLHD.

How will data be sourced, shared and reviewed?

The methodology for the above **population and neighbourhood level** analysis is established with ethics approval, data custodian permission, previous analysis, peer review and sharing previously undertaken. Reports and publications have also been previously prepared and disseminated.

The **individual level** data will be sourced internally within the Health and FACS teams. Data sharing will occur at the clinical level for individual shared clients. As with our previous joint DOCS-SSWAHS Perinatal Coordination Project, informed consent will be obtained from individual clients with respect to data sharing between clinicians and agencies. Legal advice will be sought from FACS and NSW Health with respect to the procedures proposed. All individual level clinical data will be stored securely and protected in accordance with NSW Health and FACS policies.

Criteria 5: Project Design and Feasibility

What capability development is needed to implement this program?

The initiative has been designed to develop sustainable capability within the proposed Healthy Homes and Neighbourhoods network. The following capability development is required to establish and sustain the initiative:

1. Developing informed consent and privacy business processes that will support sharing of clinical information between providers of care

2. Developing a standard family risk assessment tool for use by general practice, hospital and community providers to guide referral to Healthy Homes and Neighbourhoods pathways

3. Developing business models that will ensure the identification and referral of vulnerable families by District hospital and community units including Emergency Departments, wards, outpatients, maternity, mental health and drug health services

4. Establish a Healthy Homes Intake System modelled on the current Branches Intake for children in out-of-home care

5. Adapting the *HealthTracker* software to monitor family outcomes

6. Development of individual-level data monitoring capability through eMR data-linkage, use of *HealthTracker* to monitor child and family outcomes

7. Further developing the capacity to assess needs and measure program impact in local neighbourhoods

8. An electronic networking system that alerts the network when supported family members change their use of services agreed in the family plan (possibly built into Patchwork Tool)

Risk Analysis

What are the risks to the initiative? What are the likelihood, consequences and proposed mitigation of the risks (e.g. financial risk mitigation could involve formal risk sharing across partners)?

See Project Risk Matrix over.

Project Risk Matrix

L= Likelihood	5=Almost Certain	1=Rare
C=Consequence	5=Severe	1=Negligible
R=Risk Level	5-Extreme	1=Low

Source of Risk	Risk Event	Impact on Program	L	C	R	Risk Treatment	Responsibility	Timing
Political								
Concerned communities, professionals or agencies	Complaints to the Ministers or Departments	Project goals and objectives may be jeopardised	1	2	1	Share information and involve local communities in awareness raising and training	Project Manager	Phase 1 and ongoing
Change in the Government or Government interest in the project	Political intervention in resources management decisions and direction of the program	Reorganising of the project priorities and objectives	2	2	1	Communicate to Government and other agencies the benefits to the community and to government of the program	Program Director, GM, and CE	Ongoing
Insufficient or variable levels of support for the project at community level	Poor attendance at community events Complaints from community	Reduction in the extent of local ownership and benefit of the program	3	3	3	Share information and involve local communities in awareness raising and training	Project Manager	Ongoing
Financial Risks								
Contact negotiation delayed	Late acquittal of funding	Delay of recruitment and training	3	2	2	Commence start-up processes when notified of EOI outcome	CE and GM approval Director initiative	Phase 1
Contact negotiation delayed	Underspend of 2014/2015 funds	Funds lost at end of financial year	3	2	4	Move forward expenditures from 15/16 where possible	GM & Director	Phase 1
Proposal does not adequately cost inputs	Budget allocation insufficient for task	Reduced length of activity	2	2	1	Delay activity, use other resource	Program Director	Throughout

Source of Risk	Risk Event	Impact on Program	L	C	R	Risk Treatment	Responsibility	Timing
Organisational								
Lack of consultation and engagement of partners	Misunderstandings occur with respect to expectations, roles, responsibilities and shared outcomes	Breakdown in relationships between agencies and/or clinical consequences for clients and families	3	2	2	Early exchange of "head of agreement" letters prior to negotiation of more formal Service Agreements	Program Director	Phase 1
Lack of pre-planning during the design stage	Delay with recruitment of staff with appropriate skills and competencies	Failure to meet project milestones	2	3	3	a) Prepare Position Descriptions immediately and seek appropriate grading prior to decision on funding b) Identify staff who could act in key positions until recruitment and training completed c) Preparation Phase activities undertaken within existing resources	Program Director, and GM	Design Stage
Lack of pre-planning and consultation with partners during the design stage	Key Service Partners are not ready to engage in the project at the required milestone	Failure to meet project milestones	2	3	3	Undertake detailed project management analysis, including critical path analysis, for at least the first year b)Engage identified Key Service Partners early and prepare critical business processes	Program Director, and GM	Design Stage
Expectations beyond those able to be met by the project	High levels of early referrals	Services restricted and key stakeholders would need to be appraised of the actual outcomes	3	3	2	Design and implement the program in close consultation and communication with all stakeholders	Program Director	Phase 2
Workload and pressures on team members	Concern raised by staff or stakeholders Complaints	Inability to complete all activities in projected timeline						

Source of Risk	Risk Event	Impact on Program	L	C	R	Risk Treatment	Responsibility	Timing
Organisational								
Loss of commitment to the project	Key Service Partners disengage in the project	Slowdown in the project activities and failure in achieving outputs	2	2	2	Facilitate ownership of the project by Core Agencies Benefits of the changes to service provision identified and communications Strong leadership maintained Flexibility and responsiveness to the modified timetable and approach to meet priorities	Program Director and Project manager	Phase 2
Complexity of the organisational change and the need for central lack of support from the other agency involvement	Lack of support from other agencies	System change does not achieve planned outcomes	3	3	2	Continue current level of liaison Identify benefits of the change and hold regular discussion	Program Director and Lead Partners	Phase 2
Linkages with other integrated care initiatives not established	Maximum use of integration reform opportunities not achieved	Opportunities are not realised	2	2	1	Open early discussions with other PIF initiatives	Program Director	Design and Phase 1
Linkages with other FACS initiatives not established	The program does not align with policy and program changes within FACS	The program fails to meet objectives	2	2	1	Continue current level of liaison Identify benefits of the change and hold regular discussion	Program Director	Design, Phase 1 and ongoing
Clinical								
Clinical nurse resigns or is on leave	Clinical coordinator not available	Intake does not occur or families are not followed up or a clinical matter is not addressed in a timely manner	3	3	2	Ensure that there are two clinicians supporting the program at all times Involve social work staff and medical staff in a care coordination roster	Program Director and Project manager	Design, Phase 1 and ongoing
Clinical staff are specialised	Clinical skills do not match the need	Clinical staff do not have the clinical skills to assist the family and general practice to develop care plan	2	2	1	Ensure that the clinicians recruited to the program have skill sets that are complimentary to current staff	Program Director and Project manager	Design, Phase 1 and ongoing
Clinical staff are overworked and fully committed	Urgency is required with a family	The program is not able to respond to a families urgent needs and the program loses respect with partners	2	2	1	Maintain uncommitted clinical capacity to respond to urgent casse	Program Director and Project manager	Design, Phase 1 and ongoing

Collaboration Investment

What is the LHD's / Network's / Partner's own investment (financials should be split into operational and capital expenses - see excel template provided separately)

	Resource	Activity	FTE	Comment
SLHD Child and Family Directorate				
1.	Senior Staff Specialist Paediatrician	Program Director	0.2	Current
2.	Social Worker Grade 3	Neighbourhood Clinical Coordinator	2	
3.	Public Health Physician (CMO Grade 2)	Sector Capacity Development including GP & NGO training and Pathways	0.4	Current
4.	Public Health Advanced Trainee (STP)	Sector Capacity Development including GP & NGO training and Immunisation	0.6	
5.	Paediatric Advanced Trainee	Perinatal Case Conference Evaluation	0.2	Current
6.	Child Youth and Family Medical Officer	Clinical Lead for Healthy Homes Intake meetings	0.2	Current
SLHD Area Child Protection				
1.	Director Child Protection/delegate	Program support i.e. consultation, interagency partnering, training, clinical supervision, capacity building, evaluation	0.2	Current
SLHD Mental Health				
1.	COPMI Coordinator	Identification, referral and support for families with a parent with mental illness	1.0	
IWSML				
1.	Project Officer	Capacity building of general practice	1.0	
	Support activities	Recruit GPs, practice nurses and private allied health to programme		
		Undertake professional development and capacity building		
		Upgrade existing electronic medical records and messaging systems		

	Resource	Activity	FTE	Comment
Barnardo's Family Referral Service				
	Glebe-based Accommodation, intake & Management support	CNC working along-side family referral support workers, integrate District-wide referral process and collaboration with IWMCL & partners		
The Infants Home				
	Clinical, early childhood teaching staff, & integrated services manager	Support children and families with complex needs. Contribute to integration of services, work with doctors on-site		
	Ashfield facilities	Interagency meetings, conferences, training.		
Jannawi				
	Lakemba Support activities	Support with initiative in Canterbury LGA. Details to be explored		
Children and Families Research centre				
	Research Support	Program implementation support & rigorous evaluation of family outcomes and service–level change		
Benevolent Society				
	Rosebery facilities & staff	Full participation, case management, clinical support, technical support, meeting space		
SDN				
	Redfern & Riverwood facilities	Full participation, case management, technical support, meeting and clinical space		

NSW Health Support Requested

What other support is needed from NSW Health? e.g. Legal, planning, analytics

Legal Advice

As with a previous Perinatal Coordination integration project it is likely that legal advice will be required for informed consent and privacy business processes implemented.

eHealth Solutions

There are several areas where IT/eHealth support may be required. They are:

1. Development of an eMR algorithm or flag system
2. Development of methods to link family members in the eMR
3. Hospital and general practice secure messaging systems
4. Shared electronic files between hospital, general practice and other approved providers.

Program Development

There are several areas of the initiative where assistance would be welcome from NSW Health agencies such as ACI, CEC and NSW Kids and Families. They include:

1. General practice capacity building with respect to chronic disease management, mental health and family health improvement
2. Development of a standardised risk assessment tool
3. Development of the policy and program support for Healthy Homes and Neighbourhoods.

Budget Requested

Health Services Manager

Project manages the initiative and leads the following deliverables:

1. Examine and report on options for an eMR algorithm and/or flag system. (Implementation not costed)
2. Establish a Healthy Homes Intake System modelled on the current Branches Intake for children in out-of-home care
3. Trial the Patchwork tool with the aim of increasing access and engagement with community and local services for vulnerable families
4. Trial and report on a wrap-around model of care for vulnerable families using a collaborative use of existing partner funded services
5. 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.

	Year 1	Year 2	Year3
Project Manager (HSM2)	$63,574	$130,962	$134,890

Administration Officer

The primary role and responsibilities of the administration officer will be to assist the Clinical Nurse Consultant (Care Coordination) to:

1. Establish a Healthy Homes Intake System modelled on the current Branches Intake for children in out-of-home care
2. Trial and report on a nurse-led care coordination service for vulnerable families

	Year 1	Year 2	Year3
Admin Officer	$33,726	$69,475	$71,559

Clinical Nurse Consultant (Care Coordination)

The primary role and responsibilities of the Clinical Nurse Consultant (Care Coordination) will be to:

1. Develop a standard family risk assessment tool for use by general practice, hospital and community providers to guide referral to vulnerable family pathways
2. Complete a vulnerable families *HealthPathway*
3. Establish a Healthy Homes Intake System modelled on the current Branches Intake for children in out-of-home care
4. Trial and report on a nurse-led care coordination service for vulnerable families

	Year 1	Year 2	Year3
Clinical Coord (CNC 2)	$65,568	$135,070	$139,122

Clinical Nurse Consultant (Capacity Building)

The primary role and responsibilities of the Clinical Nurse Consultant (Capacity Building) will be to:

1. Deliver evidence-informed capacity building training to the Healthy Homes collaboration partners and wider network
2. Trial and report on a clinical service model that encourages vulnerable family engagement with general practice and that provides support to those general practices make full use of available Medicare and other sources of funding
3. Identify training needs and develop four preventative health training modules for general practice and sector capacity building
4. Trial the adaptation, implementation and evaluation of the *HealthTracker* tool for monitoring family member outcomes

	Year 1	Year 2	Year3
Clinical Coord (CNC 2)	$65,568	$135,070	$139,122

HealthTracker Tool

HealthTracker is an online health monitoring platform developed by clinicians in the UK that contains developmentally appropriate patient centred outcome measures for children and adolescents with chronic disorders. *HealthTracker* is used to track treatment response in chronic disorders (both rare and common) and can also help with screening, triage and patient pathways. It has been used by clinical paediatric, child and adolescent psychiatry services and in international research projects. It has been shown to be cost-efficient, clinically relevant and well received by children and families.

	Year 1	Year 2	Year3
Health Tracker	$30,000	$50,000	$50,000

eMR Data Linkage

The linkage of data for family members is problematic because this functionality is not currently built into the Cerner eMR. We have completed a maternal and child data-linkage and have 10 year ethics. Data is extracted by SLHD and the analysis has been undertaken by the Ingham Institute, UNSW. Funding will be requested to support the analytical capability and to explore its applicability to the families enrolled in this initiative.

	Year 1	Year 2	Year3
EMR Data Linkage	$45,000	$45,000	$45,000

Healthy Homes Social Media Network

A literature review and community survey has been conducted by Community Paediatrics that confirms the value of social media to our local vulnerable families. We propose the development of an integrated and comprehensive social media strategy that supports the: Healthy Homes Care Coordination; General Practice Engagement and Support; Family Health Improvement; Healthy Neighbourhoods; and Network components of the initiative.

The *social media strategy* will combine evidence based child development, parenting and health promotion information with personal stories, current/ topical issues and will provide an opportunity for parents enrolled in the program to interact with health providers and each other in a safe and participatory environment to explore issues and receive information.

A phone app has been developed for Aboriginal families and will be trialled at no cost for this project. Funding is sought to develop a "Healthy Homes" interactive web page that links to a regular blog, Facebook and other social mediums through which project related and family health improvement information will be shared with project participants. Internal project resources will be used to support this initiative. Funding is requested for the building and maintenance of an extension to the *Resourcing Parents* web site, or an alternative site if later found to be necessary.

	Year 1	Year 2	Year3
Web and Social Media	$30,000	$20,000	$10,000

All applicants should provide a detailed budget on the template provided. Costs should be clearly linked to key activities in the proposal and a simple explanation of the budget should be provided above.

Proposals, including letters of support and budgets should be submitted via the NSW eTendering web-site www.tenders.nsw.gov.au/health

Applications must be received before 5pm, Friday, 3 October 2014.

2. Letters of Support

a. Inner West Sydney Medicare Local, Ashfield

b. Family and Community Services, Sydney District

c. NSW Kids and Families

d. The Sydney Children's Hospitals Network

e. Barnardos, Family Referral Service, Broadway

f. The Benevolent Society, Rosebery, Sydney

g. SDN Children's Services, Broadway, Sydney

h. Jannawi Family Centre, Wiley Park, Canterbury

i. Riverwood Community Centre, Riverwood, Canterbury

j. The Infants Home, Child and Family Services, Ashfield

k. Children's & Families Research Centre, Macquarie University

l. Faculty of Education and Social Work, Sydney University.

m. Menzies Centre for Health Policy, Sydney University

n. Centre for Primary Health Care and Equity, UNSW

o. Sydney Local health District Consumer and Community Advisory Council