Australian Government Department of Health and Department of Education

Evaluation of the Connected Beginnings Program

Final Report

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AHA Australian Healthcare Associates
Australia's largest health & human services consulting firm

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Table of contents

List of tables

List of figures

List of abbreviations

Abbreviation	Definition
ABS	Australian Bureau of Statistics
47	Aboriginal Community Controlled Health Organisation
AEDC	Australian Early Development Census
AHA	Australian Healthcare Associates
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
ASQ-TRAK	Ages and Stages Questionnaire
CB	Connected Beginnings
CCCF	Community Child Care Fund
CCRIC	Child Care Reform Implementation Committee
CI	Collective Impact
COAG	Council of Australian Governments
Critical Friends	Critical Friends Advisory Group
Education	Department of Education
ES	Evaluation Strategy
FaFT	Families as First Teachers
FTE	Full Time Equivalent
Health	Department of Health
HIPPY	Home Interaction Program for Parents and Youngsters (HIPPY)
HREC	Human Research Ethics Committee
IDC	Interdepartmental Committee
IAHP	Indigenous Australians' Health Program
KPI	Key Performance Indicator
MCH	Maternal and Child Health
NAPLAN	National Assessment Program – Literacy and Numeracy
nKPI	National Key Performance Indicator
PBI	Place-based initiative
PHN	Primary Health Network
PS	Primary School
the Program	the Connected Beginnings Program

Glossary of terms

Term	Definition
Activities*	Specific actions taken by the Program (tasks and processes) that contribute to the identified outputs,
Assumptions	Statements or hypotheses about how and why a Program will work. This includes assumptions that are unstated or implicit.
Collective Impact	The term describes a model of communities coming together to collaboratively solve a social concern. Collective Impact is based on the premise that existing approaches to creating social impact are ineffective for solving complex social issues and a different approach is needed when addressing complexity (Child Family Community Australia 2017),
Community readiness	The degree to which a community is ready to take action on an issue,
Education	Australian Government Department of Education and Training,
Education-funded organisation	Education-funded organisations lead service integration by bringing stakeholders together, developing and implementing a model of shared governance with partners and the community, developing a common agenda in alignment with Program objectives, developing site-specific plans and building community engagement to connect children and families to available services.
Effectiveness	The extent to which a Program produces desired or intended outcomes (Davidson 2005),
Efficiency	The extent to which [a Program] produces outputs and outcomes without wastage of time, effort, money, space, or other resources (Davidson 2005),
Fund holder	In some jurisdictions, CB funding is held by the state/territory government's Department of Education and Early Childhood Development rather than the Education-funded organisation.
Health	Australian Government Department of Health
Health-funded organisation services/service provision	Health-funded organisations are funded to provide additional services to fill service delivery gaps in their community. These services vary from site to site, but may include immunisations, health checks, case management, care coordination, smoking cessation advice, etc.
Impact	The longer-term effects of a Program, direct or indirect, intended or unintended (OECD 2010)
Inputs*	The financial, human and other resources available to deliver program activities and produce program outputs,
Integrated	Integrated service delivery has been defined as "the process of building connections between services in order to work together as one to deliver services that are more comprehensive and cohesive, as well as services being more accessible and more responsive to the needs of families and their children" (Prichard et al. 2010, p. 4).
Outcomes*	Changes for individuals, groups, communities, organisations, or systems in the short, medium, and longer term,
Outputs*	The products or services delivered by the program that reach people who participate or who are targeted by the Program,

Glossary of terms

Term	Definition
Performance report	The modified Departmental excel spreadsheet to record activity data every six months from each Education-funded organisation, including the narrative reporting required by the Department relating to progress against activity work plan,
Place-based initiative	Place-based initiatives (PBIs) are designed and delivered with the purpose of targeting one or more specific geographical location and population group(s) in order to effect change and respond to "wicked problems" and entrenched disadvantage. Because of the different settings and issues they are addressing, they are different from place to place. There are several models for designing and implementing PBIs, one of which is Collective Impact.
Wicked problems	A wicked problem is a social or cultural problem that is difficult or impossible to solve for as many as four reasons: incomplete or contradictory knowledge, the number of people and opinions involved, the large economic burden, and the interconnected nature of these problems with other problems (Kolko 2012),

* Modified from Markiewicz and Patrick 2016.

List of funded organisations and abbreviations

This table lists the Connected Beginnings-funded organisations and the abbreviations used in this report for each organisation.

Jurisdiction	Site(s)	Education-funded	Health-funded
ACT	**Canberra**	-	Winnunga Nimmityjah Aboriginal Health Service (Winnunga)
NSW	**Doonside**	Ngallu Wal Aboriginal Child and Family Centre (Ngallu Wal)	Greater Western Aboriginal Health Service (GWAHS)
	Mount Druitt	Ngroo Education Inc (Ngroo)	Greater Western Aboriginal Health Service (GWAHS)
	Taree	Taree Public School	Biripi Aboriginal Corporation Medical Centre (Biripi)
NT	**Alice Springs**	Braitling Primary School through NT Department of Education	Central Australian Aboriginal Congress (Congress)
	Angurugu	Angurugu School through NT Department of Education	NT Department of Health Angurugu Primary Health Clinic
	Tennant Creek	Tennant Creek Primary School (Tennant Creek PS) through NT Department of Education	-
	Galiwin'kuS	Shepherdson College through NT Department of Education	Miwatj Health Aboriginal Corporation (Miwatj)
Qld	**Doomadgee**	Dumaji Child and Family Centre (Save the Children)	Gidgee Healing (Gidgee)
SA	**Ceduna**	Ngura Yadurirn Children and Family Centre (NYCFC)	Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation (Koonibba)
	Port Augusta	Port Augusta Children's Centre for Early Childhood Development and Parenting (PA Children's Centre)	Pika Wiya Health Service Aboriginal Corporation (Pika Wiya)
WA	**Kalgoorlie**	Wanslea Family Services (Wanslea)	-
Tas	**Bridgewater, Gagebrook**	tagari lia Child and Family Centre (*tagari lia)*	Tasmania Aboriginal Centre (TAC)
Vic	**Mildura**	Mildura Primary School (Mildura PS)	Mallee District Aboriginal Services (MDAS)

Acknowledgements

Acknowledgement of Country

In the spirit of respect and reconciliation, the authors acknowledge and pay respect to the traditional custodians of this country, the Aboriginal and Torres Strait Islander people of Australia, and their continuing connection to land, waters, sea and community.

Acknowledgement of contributions to the evaluation

Australian Healthcare Associates (AHA) would like to thank the many people who provided their thoughts and views on the Connected Beginnings Program. In particular, the site-based staff around the country who shared their working lives with us and showed us great warmth and hospitality. Their generosity on numerous occasions in providing details of program success and challenges has allowed us to gain an enriched understanding of their perspectives, service needs and operating environments.

Many advisors have given us the benefit of their time and experience to help us hone our skills working in challenging environments. Departmental representatives have also taken time from their busy days to assist with the evaluation.

Listening to and learning from this diverse range of stakeholders helped us to gain an understanding of the challenges ahead in these communities and also hope for the future of these communities as they forge new ways of working. We are hopeful that the early changes AHA have witnessed are consolidated over time and bring about long-term sustainable change needed to improve the lives of some of Australia's most vulnerable citizens.

1 Executive summary

1. Executive summary

This Executive Summary is presented as follows:

1. Introduction
2. Program design
3. Program governance and administration
4. Findings: Program design
5. Findings: Program governance and administration
6. Findings: Site-level achievements and learnings.

1.1 Introduction

Connected Beginnings (CB, the Program) is a grants program co-funded by the Australian Government Department of Education (Education) and the Australian Government Department of Health (Health). The Program aims to:

> *"…support the integration of early childhood, maternal and child health, and family support services with schools in a number of Indigenous communities experiencing disadvantage so that children are healthy and well prepared for school."*[1]
> (Health 2017, p.7)

CB has been progressively rolled out since July 2016 and is currently being implemented in 14 communities across Australia.

In April 2017, Australian Healthcare Associates (AHA) was appointed to evaluate the CB Program. The evaluation aimed to inform any wider rollout of the Program. This report presents the evaluation findings, with a focus on:

- The effectiveness of the CB Program in supporting the integration of services across health, education and family support systems
- Key learnings to inform any wider rollout of the Program
- Characteristics of successful CB sites, including narrative examples of successful approaches and progress, to provide guidance for current and any future CB sites.

A separate attachment provides case studies for each of the 14 CB sites, highlighting their progress and successful approaches.

1.2 Program design

The Program was developed in response to recommendations from the 2014 Forrest Review, *Creating Parity* (Forrest 2014), which sought to address the disparity between Aboriginal and Torres Strait Islander people and other Australians. The review recommended that all governments in Australia prioritise investment in early childhood for Aboriginal and Torres Strait Islander peoples, including through progressive investment in integrated early childhood services.

[1] Education Program guidelines do not include "healthy and" (Education 2016a, p. 5).

1. Executive summary

CB provides a framework and funding to support the integration of early childhood, maternal and child health, and family support services with schools. Integration offers a host of potential benefits, including making services more accessible and culturally safe for the community.

A defining feature of the Program is the presence of both an Education-funded organisation and a Health-funded organisation at each site, with specific roles as follows:

- **Education-funded organisation** (either a state/territory-funded school, child and family centre or early childhood education service) **to provide leadership and strengthen the integration of services**. This role includes bringing stakeholders together to:
  - Build a common agenda in alignment with Program objectives
  - Develop and implement a model of shared governance with partners and the community
  - Lead the integration model and develop plans
  - Build community engagement to connect children and families to available services
- **Health-funded organisation to provide the health services** needed to support improved health outcomes and the achievement of developmental milestones so that Aboriginal and Torres Strait Islander children are ready to start school, learn and thrive. All but one of the current Health-funded organisations are Aboriginal Community Controlled Health Organisations (ACCHOs).

It was initially expected that the Health-funded organisation would be **co-located** at the premises of the Education-funded organisation. However, as the Program evolved and the challenges of integrating services in complex communities became clearer, co-location became less of a priority and this requirement was not enforced. Collaboration and integration of the services – working in partnership and sharing data – became more of a focus for the Program.

Other features of the Program are related to the sustainability of sites and the preferred model of service integration. Findings in relation to the key Program features are provided in *Section 1.4*.

1.3 Program governance and administration

A unique feature of the CB Program is the multi-departmental and multi-jurisdictional governance arrangements for the selection of sites and overall administration of the Program.

CB is co-funded and administered by Education and Health. Site selection involves a rigorous assessment process to target communities of need and determine site readiness to implement a CB initiative. Both Education and Health are involved in site selection.

Site selection is initially tested with an Interdepartmental Committee (IDC) (with representatives from the Departments of Health, Education, Social Services and the Prime Minister and Cabinet) and engagement sought from the relevant state and territory government departments, prior to seeking Ministerial approval.

Once a site is approved, further consultation occurs with the above agencies through pre-meetings, and a community scoping exercise is undertaken to assess community readiness, capability, capacity and willingness, and likely providers.

1. Executive summary

Over the three years to June 2019, 14 CB sites have been progressively selected, and 25 organisations have been contracted to deliver the CB Program at these sites. Education contracted 13 organisations[2] (allocating approximately $30 million) and Health contracted 12 organisations[3] (allocating approximately $12 million) over this time.

Education and Health each have their own Program guidelines in accordance with the legislative framework from which their respective components of the CB Program are funded. For Education, CB is funded under the Community Child Care Fund and for Health, CB is funded under the Indigenous Australians' Health Fund.

The design and development of the Program has been supported by an expert reference group (Critical Friends advisory group) which has provided specialist policy advice on integrated early childhood services.

Overall **policy coordination** is undertaken at a national level through the IDC.

State and territory jurisdictions are each involved in different ways in the Program including:

- Education consults with state and territory education departments (and Health and other stakeholders) about the selection of CB sites
- Education departments in the Northern Territory, South Australia, Tasmania and New South Wales administer CB site funding on behalf of the sites in their jurisdiction
- Where CB services are delivered by state- or territory-funded education organisations, the relevant government is also involved in site-level administration, including CB staff employment.

1.4 Findings: Program design

The evaluation has demonstrated that CB can provide an effective framework to support the integration of services across health, education and family support systems. While the pace of progress at CB sites has varied, progress is evident at all sites.

1.4.1 Program framework

Through trialling CB over the past three years, communities, services and government have obtained substantial learnings and insights into CB Program implementation. It has emerged that the **defining features** of the CB framework are:

1. Community-driven and flexible approach
2. Funded organisations have connections to the wider service system
3. Education-funded organisation and Health-funded organisation at most sites.

Although it is early in the implementation period, these features are likely precursors to supporting services to integrate and provide seamless services for children and families, to ensure that children have a positive transition to school. Findings in relation to each of these features are presented below.

[2] One CB site is a Health-only site, with no Education-funded organisation.
[3] Two CB sites are Education-only sites, with no Health-funded organisation.

1. Community-driven and flexible approach

Program guidelines provide flexibility for sites to develop their own approaches and initiatives. This is intended to enable the community to define what is required and decide how best to deliver the Program in their setting.

Education guidelines support the use of Collective Impact (CI) or place-based initiative (PBI) approaches but provided insufficient guidance to sites on how to apply this approach. Education's guidelines describe the CI approach as guiding its thinking about what could make a successful integration model and note that the success and sustainability of the CI approach is reliant on co-design of goals and strategies within the community. This allows each model to be community owned and developed to suit the unique needs of each location.

The Education guidelines were therefore intended not to be prescriptive or limit the arrangements that communities establish to integrate service delivery. To this end the *Good Practice Framework* in the guidelines (Education 2016, p.9) provided a broad sketch of the elements of good practice in PBIs.

Early evaluation findings indicated that some CB sites were uncertain about how to approach the task of service integration. Staff required more direction and guidance about the foundational work to be undertaken prior to developing and implementing a service integration model. This suggests that sites would benefit from more task/activity-oriented guidance and CI (or other PBI) support.

The need for direction and guidance was confirmed at the December 2017 CB workshop attended by Education, Health and AHA. A subsequent communication from Education and Health in October 2018 advised that '*Collective Impact is the approach underpinning the Connected Beginnings Program*'. CI had previously informed Program design and was now identified as a way to provide appropriate direction and guidance to sites.

Collective Impact approach to service integration

Collective Impact (CI) is a form of a place-based initiative (PBI) that provides a framework for facilitating and achieving large-scale social change in a community.

CI approaches, such as that used in the Logan Together[4] project, focus on extensive community engagement and collaboration between all stakeholders to achieve significant and lasting social change.

CI provides direction to sites in relation to the activities and collaborations required to achieve the aims of the CB Program. CI also supports communities and services to work together to address broader health and education issues.

Several CB sites have now adopted this approach. For some, this post-hoc adoption of a CI approach led to a CB 'reset', prompting them to shift from a focus on service delivery towards engaging the community and service providers, and identifying new ways of working together.

[4] Logan Together is a CI initiative based in Logan, Queensland. It is a 10-year community movement which commenced in 2015 and aims to improve health and educational outcomes for the children of Logan by 2025.

To provide additional guidance, Education approved the use of CB funds for sites to access CI training and engage a consultant for advice and support at site level. This provided an important way forward for Education-funded organisations to plan and deliver their CB initiative and was valued by the sites that accessed this support.

As a result of this support, a number of sites have now formally adopted a CI approach and have undertaken a range of initiatives to obtain community views and perspectives. Progress at sites over the past three years has demonstrated that strategies to integrate services must be tailored to the community's needs, through a CI or place-based approach.

Recommendation

- Strengthen Program guidelines to reflect that CB initiatives should be community driven, and provide further guidance on the role of CI/PBI approaches in the design and delivery of CB initiatives.
- Provide core funding for training, advice and guidance in implementing CI/PBI approaches.

2. Funded organisations have connections to the wider service system

The second defining feature of the CB Program is that funded organisations need to develop connections to the wider service system in order to implement an integrated service system across health, education and family support services. This is consistent with a CI or PBI approach.

Each site has invested considerably in building relationships that are specific to their local context. Key service providers and government organisations have been engaged in the governance arrangements established by the Education-funded organisations. Challenges for sites include developing approaches where there are blocks in relationships between key service providers in the network. Despite these issues, all sites are progressing and developing connections with the wider service network, increasing the likelihood of achieving the system changes required to deliver integrated services. This work is still in early development at some sites, while other sites are well advanced.

Recommendation

- Build regular forums into the CB Program agenda to bring Education- and Health-funded organisations together to share learnings and successful approaches, in particular about building connections into the wider service system.

3. Education-funded organisation and Health-funded organisation at most sites

Investment in both Education- and Health-funded organisations at most sites has proven to be an important feature of the Program. The new funding has helped Education- and Health-funded organisations to work together to begin to drive local integration of early childhood services. This is examined at site level in *Chapter 6* and in *Attachment A – Case Studies*.

Collaboration between Education- and Health-funded organisations has been an important first step in integration of the early childhood services system at CB sites. Where Education- and Health-funded organisations can come together to build a local governance group, support community engagement

and co-design implementation and evaluation, local CB initiatives have the greatest chance of successfully embedding an integrated service model. These collaborations will develop in different timeframes depending on the local context and relationships at each site.

An important observation is that population level health and education outcomes have not been achieved in the timescale of this evaluation. The establishment of the initial conditions for achieving integration has only recently commenced at some sites, commonly in parallel with the delivery of services, and is still to be fully implemented at others. In line with Collective Impact/PBI literature, it is unlikely that population level impacts would be measurable until around five years after commencement. In the first 1-3 years of implementing CB at each site, the focus is on setting the foundations. This involves building community partnership and connection, facilitating partner relationships, working with policy makers, program designers, service providers and funders.

Current evidence indicates that CB should continue to support both an Education- and Health-funded organisation at each site, however it is not yet known whether this will lead to improved health and educational outcomes. Two funded organisations at each site may not be the only model that could be considered for CB PBIs going forward.[5] The critical requirements are that an organisation is funded to drive the CI/PBI process and that funding is available to fill service gaps.

Recommendation

- The funding timeframe for each CB site be extended to support the development and implementation of a self-sustaining service integration model.
- Funding continues to be provided for CB models that include an organisation to drive the CI/PBI process and funding for services to address gaps in availability for children under five years old.

1.4.2 Sustainability

Education-funded organisations are expected to demonstrate sustainability and to source necessary funding from philanthropic or non-government funding sources within three years. This is not expected of Health-funded organisations.

A key finding over the past three years has been recognition that it takes time to achieve service integration in communities experiencing complex social and economic challenges.

CI literature indicates that the time between inception and impact for such initiatives can range from 4 to 24 years depending on the scale of the change being affected. For example, the Logan Together project uses 10-year timeframes for planning their initiatives and measuring change (Logan Together Working Group 2015). Given the complexity of CB, this may be a more realistic timeframe than the three-year timeframe originally envisaged for some sites. Education funding could be limited to this timeframe as, after sufficient time, the integrated service model should become self-sustainable.

[5] There are two Education-only and one Health-only sites in the CB Program. However, these sites are not sufficiently mature to assess these variants from the 'two funded-organisations' CB model.

Recommendation

- Education review the requirement that Education-funded organisations achieve sustainability within three years
- Education consider providing additional support to assist sites to secure philanthropic and/or non-government funding
- Provide greater funding certainty to sites, reflecting the lengthy time required to implement an effective CB initiative.

1.4.3 Model of service integration

Education's model of service integration, as outlined in *The Good Practice Framework,* is useful for funded organisations in articulating the elements of an integration model.

Some organisations have indicated that they would also benefit from task/activity-oriented guidance. Specifically, guidance about the tasks and activities needed to implement integrated services, including a community-driven approach with consideration of local contexts.

Section 1.6 of this Executive Summary summarises site-level progress and learnings about implementing integrated service models. Learnings indicate that additional focus or clarification is required about:

- Using a wide range of innovative strategies and existing services to reach 'hard-to-reach' communities
- Case management.

Reaching 'hard-to-reach' communities

Reaching disengaged or hard-to-reach families, children or communities can make a fundamental difference to improving the school readiness of children in the community as a whole. An aim of Connected Beginnings is to overcome historical barriers to service access, through the delivery of culturally-based services that work together more effectively, in a way that disengaged families can relate to.

Reaching 'hard to reach' communities

Some CB sites have found innovative ways to begin to break down these barriers. For example, at one site, children are explicitly placed at the centre of the initiative in the following ways:

- Fun activities such as a unicorn party are advertised in the town so that children will want to attend and ask their parents/grandparents to take them
- Welcome to Country ceremony - where children who are born in a city away from town and then come home to their community, are welcomed to their local community once per year with a big party attended by a range of Elders, which has proved successful in bringing community members into the service.

For CB initiatives to significantly improve school readiness, reaching hard-to-reach children and families will remain a priority in the future.

Recommendation

- Funded organisations, through their governance structures, work together with key stakeholders in the community to develop strategies and a work plan to identify and engage with community members that services are not reaching.

Case management

Case management provides the ability to wrap services around the needs of children and families and is therefore central to the CB model of integrated service delivery. Both Education and Health recognise the importance of case management. However, responsibility for case management is unclear, and the guidelines are sometimes contradictory.

Clarification of expectations regarding the role of Education-funded organisations in providing or procuring case management and case coordination services is required, because of their important role in service integration.

Recommendation

- Revise Program guidelines to clarify expectations in regard to case management and case coordination responsibilities. In particular, clarify that Health-funded organisations should provide case management and/or case coordination as part of their health service delivery responsibilities.

1.5 Findings: Program governance and administration

The establishment of CB sites in every state and territory has demonstrated that interdepartmental coordination can overcome boundaries between the traditionally siloed Education and Health sectors, and across jurisdictions.

From a site perspective however, the CB Program is mostly seen as operating under separate Education and Health guidelines using separate grant procurement processes. In many instances, this has not led to a consistent and integrated Program on the ground. The complexity of funding streams and associated requirements has affected the ability of many sites to move rapidly in decision making and action.

Recommendation

- Develop a unified set of Education and Health operational guidelines that reflect CB's goal of integration, and provide clarification as to:
  - Program objectives and desired outcomes
  - How to implement a community-driven approach with consideration of local contexts, including expectations regarding the application of CI and the funding available to support these approaches
  - Expectations and the application of Program funding in regard to:
    - Roles and responsibilities of Education- and Health-funded organisations
    - Co-design and community engagement
    - Co-location
    - Case management/case coordination responsibilities
    - Service funding, and the requirement to secure philanthropic funding and sustainability
    - Service provision to the expected target groups
  - How funded organisations, through their governance structures, work together with key stakeholders in the community to develop strategies and a work plan to identify and engage with community members that services are not reaching.
- Clarify the respective role of jurisdictional governments in CB Program delivery, to define state/territory and Australian Government responsibilities in the administration and governance of the Program.

1.5.1 Site selection, grant applications and contracting

Both Education and Health guidelines indicate the expectation that organisations applying for CB funding will have consulted with and secured the support of other service providers before submitting their application.

Review of the Education funding applications indicate that the extent of consultation and/or support from other organisations was not clearly addressed in the applications and there is no requirement to undertake community consultation at the time of application. Also, the applications from Health and Education organisations are not necessarily developed jointly and this appears to have been a key factor contributing to delays in implementing CB initiatives.

Recommendation

- Revise the funding process to include a staged approach to site selection, whereby organisations initially receive seed funding to conduct community and stakeholder consultations and develop a CB integration model for their site.

1.6 Findings: Site-level achievements and learnings

For most sites, CB has yielded progress and a sense of purpose and optimism that improvement can be achieved. This is most evident where Education- and Health-funded organisations have taken advantage of the flexible nature of CB funding and worked together to implement initiatives that respond to their community's unique strengths and challenges.

The CB implementation has evolved to include an explicit focus on extensive community engagement and collaboration between all stakeholders. Consistent with this CI approach and the use of governance structures, progress towards integration requires three themes or streams of site level work:

- Community engagement and co-design
- Health, education and family support service engagement and readiness
- Service integration model development and implementation.

The first two themes are the foundation work for developing an effective integration model. The third comprises the activities needed to successfully deliver integrated services. The successful development and implementation of a service integration model relies on both foundational pieces of work being in place. New sites will have a greater chance of success if they are provided with guidance on how to tackle this work. The following describes the characteristics of sites which have successfully progressed in these three areas.

Community engagement and co-design

The success and sustainability of the CB Program relies on initiatives that respond to and are driven by local needs. Models with goals and strategies that are co-designed with the community are more likely to be accepted by the community.

Implementing a PBI with community leadership and engagement through a locally developed governance structure has a much better chance of successfully driving service integration. This structure enables self-determination and facilitates the community's agreement on a common purpose and engagement in CB.

Gaining grass roots community engagement is a challenge for all CB sites. Sites that were successful in this area:

- Are connecting with, listen to and engage with a wide range of community members
- Include Elders and other community members on governance boards and advisory committees
- Employ local people in the CB team to engage with the community
- Develop a local sense of urgency for addressing the issues
- Provide outreach to connect people with services in a culturally safe environment
- Plan how to connect hard-to-reach individuals and families with services
- Provide a welcoming environment at the Education- and Health-funded organisations.

Health, education and family support service engagement and readiness

The success and sustainability of the Program is reliant upon a service system that 'buys-in' to the initiative and is willing to work differently. Initiatives must engage effectively with health, education and family support services, and ensure they are ready, willing and able to provide integrated services.

This requires a CB team with strong leadership and the ability to work across multiple service sectors in often challenging and complex service environments. This proved challenging for some sites, especially where pre-existing relationships between providers were fractious. At other sites, pre-existing relationships were strong, and less work was required to ensure service engagement and readiness.

Sites that were successful in this area:

- Support sector engagement by convening stakeholders and recruiting new partners
- Have established decision-making and reporting processes
- Have developed or joined a governance structure that is representative of stakeholders
- Have the capacity to liaise with government and providers within complex service systems
- Can build a culture of collaboration (or capitalise on an existing one)
- Can attract and retain local Aboriginal and Torres Strait Islander staff to ensure sustainability
- Have an experienced leader familiar with community development, CI or other PBI models.

Service integration model development and implementation

A key learning is that service integration can take many forms and a tailored approach is needed at each site. Importantly, integration of services is reliant upon community engagement and co-design and health, education and family support service engagement and readiness. At many sites, sustained and meaningful community engagement led to the community feeling more comfortable to access services. Coupled with engaging service providers and driving a willingness for change across the sector, service integration became possible.

Sites that were successful in this area:

- Develop systems to track Program progress from a process and system level perspective
- Collect data to inform decisions and enable evaluation of the Program
- Overcome fractious relationships to collaborate in more positive ways
- Maintain regular contact between the Education- and Health-funded organisations
- Develop innovative ways of optimising finite service resources
- Have a shared data collection and measurement strategy.

Further details about sites' progress and learnings are provided in *Chapter 6* and *Attachment A – Case Studies.*

2 Program design

This chapter is presented as follows:

1. Policy background
2. Objectives and design
3. Program governance
4. Site selection
5. Grant applications and contracting
6. Funding.

2.1 Policy background

This section summarises the policy background that led to the establishment of the CB Program.

2.1.1 The Forrest Review

The Program was developed in response to recommendations from the 2014 Forrest Review, *Creating Parity* (Forrest 2014), which sought to address the disparity between Aboriginal and Torres Strait Islander peoples and other Australians.

The first three of 27 recommendations highlighted the crucial role of early childhood in shaping Aboriginal and Torres Strait Islander peoples' education and employment outcomes.

The Review recommended that all governments in Australia prioritise investment in early childhood for Aboriginal and Torres Strait Islander children, including through progressive investment in integrated early childhood services. The Review recommended that governments:

- Put into effect, within 12 months, a new approach that included progressive investment to implement integrated early childhood services and to dramatically improve attendance
- Start with the schools in the 200 communities that have the highest level of vulnerability and developmental need – as determined by the Australian Early Development Census (AEDC) results[6] – and be implemented along the lines of existing models (such as the Challis Model[7])
- If successful, governments could consider further roll outs of these initiatives (Forrest 2014).

[6] The Forrest Review used Australian Early Development Index, which subsequently became AEDC.

The AEDC is a nationwide data collection of early childhood development at the time children commence their first year of full-time school. It is comprised of five domains – physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. Achievement in the AEDC domains has been shown to predict later health, wellbeing and academic success.
Source: https://www.aedc.gov.au/about-the-aedc, accessed 20/4/2019.

[7] The Challis model aims to prevent early disadvantage from becoming a negative factor on a child's chances in life. The model includes a suite of multi-disciplinary services, including a Child Health Nurse, Allied Health Services and a Family Support Worker, and has initiated a program to address barriers to child development and reinforce the family and community support necessary to raise thriving kids. Challis is delivered on a school site in one of Western Australia's most disadvantaged metropolitan communities.
Source: https://www.challiscommunityprimaryschool.wa.edu.au/uploaded_files/media/a_pathway_from_early_childhood_disadvantage_for_australian_children__challis_case_study_embargoed_30_october_2014_low_res.pdf, accessed 20/4/2019.

In the May 2015 budget, the Australian Government announced the establishment of the Community Child Care Fund (CCCF) as part of the New Child Care Package. The budget committed $304 million to the CCCF, a grants program to assist services to reduce barriers to accessing child care, as well as $843 million over two years to ensure all Australian children have access to a preschool program in the year before formal schooling (Education 2016a).

2.1.2 Closing the Gap

The CB Program is also aligned with the Council of Australian Governments (COAG) commitments, set out in the seven Closing the Gap policy targets (Australian Government 2015). These targets include reducing inequalities in Aboriginal and Torres Strait Islander life expectancy, mortality, education and employment.

Closing the Gap policy has a focus on childhood interventions and its targets include:

- 95% of all Indigenous four-year-old children are enrolled in early childhood education by 2025
- Halving the gap between Indigenous and non-Indigenous Australians in:
  - Reading, writing and numeracy achievements by 2018
  - Mortality rates for Indigenous children under five by 2018
  - Year 12 attainment rates for Indigenous students by 2020
- Closing the gap in school attendance by 2018 (Department of the Prime Minister and Cabinet 2015).

Four of the seven Closing the Gap targets were scheduled to expire in 2018. As a result, the Australian Government has developed the Closing the Gap Refresh, jointly with Aboriginal and Torres Strait Islander people as well as state and territory governments. This is a new framework building on the original Closing the Gap targets, and represents a continued commitment in effort and accountability from all Australian Governments for a further ten years (Council of Australian Governments 2019).

2.1.3 The National Framework for Protecting Australia's Children

The National Framework for Protecting Australia's Children (the National Framework) was endorsed by COAG in 2009 (Council of Australian Governments 2009). It is a long-term approach for ensuring the safety and wellbeing of Australia's children. It aims to deliver a substantial and sustained reduction in levels of child abuse and neglect over time through six supporting outcomes. The National Framework includes a priority to implement an integrated approach to service design, planning and delivery for children and families across the lifecycle and spectrum of need, such as integrated and co-located child and family services models.

CB is closely aligned with the National Framework, in particular the Third Action Plan under the National Framework. In this Plan, the Australian Government commits to supporting the integration of childcare, child and maternal health, and family support services in Aboriginal and Torres Strait Islander communities experiencing disadvantage through the CCCF (Department of Social Services 2015).

2.1.4 Program development

Initial CB Program design was approved by the Child Care Reform Implementation Committee (CCRIC), which was established to implement the early childhood recommendations of *Creating Parity*. The CCRIC:

- Determined the key design elements of the CB funding and operational guidelines
- Established the principles for CB site selection
- Provided advice on the selection of the first 10 CB sites.

The 'Forrest Review of Indigenous Training and Employment Early Childhood Recommendation IDC' was formed with representatives from the Departments of Health, Education, Social Services and the Prime Minister and Cabinet. The IDC was later renamed the 'Place-based Joint Investment IDC'.

The design and development of the Program has been supported by an expert reference group (Critical Friends advisory group) which has provided specialist policy advice on integrated early childhood services.

2.2 Objectives and design

2.2.1 Objectives

The overall Program objective, common to both Education and Health is as follows:

> *"…support the integration of early childhood, maternal and child health, and family support services with schools in a number of Indigenous communities experiencing disadvantage so that children are healthy and well prepared for school."*[8]
> (Health 2017, p.7)

Education and Health also have specific objectives relevant to their respective funded organisations.

Education has a focus on achieving service integration in order to:

- Improve the ability of Aboriginal and Torres Strait Islander children in areas of high need to achieve the learning and development outcomes necessary for a positive transition to school
- Reduce the disparity in school readiness and educational outcomes between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander children
- Connect families to services across health, education and family support systems tailored to their need
- Address particular needs that are specific to a location
- Maximise government investment with an expectation that philanthropic and/or non-government contributions will form part of the CB Program (Australian Government Department of Education and Training 2016).

[8] Education Program guidelines do not include "healthy and" (Education 2016a, p. 5).

Health has a focus on achieving CB objectives in the context of the *Indigenous Australians' Health Program* (IAHP) grant guidelines. The IAHP is designed to increase Aboriginal and Torres Strait Islander people's access to safe and effective essential health services. Improved outcomes are expected in:

- The health of Aboriginal and Torres Strait Islander people
- Access to high-quality, comprehensive and culturally appropriate primary health care
- System-level support to the Aboriginal and Torres Strait Islander primary health care sector to increase the effectiveness and efficiency of services (Australian Government Department of Health 2018, p.5).

2.2.2 Design features

The Program was designed to provide flexibility for sites to develop their own approach and initiatives. This allows the community to define what is required and decide how best to deliver the Program in their setting. **Key features of the Program design were:**

- Two funded organisations at each site (Education and Health)
- Co-location
- Sustainability
- Health-specific features
- Integrated service model.

These features are described below. *Chapters 5 and 6* describe the evolution of these features over the past three years and presents AHA's findings and recommendations for the future.

Two funded organisations at each site

It was envisaged that each site would have **two funded organisations, with the following roles and responsibilities**:

- **Education-funded organisation** (either a state/territory-funded school, child and family centre or early childhood education service) **to provide leadership and strengthen the integration of services**. This includes bringing stakeholders together to:
  - Build a common agenda in alignment with Program objectives
  - Develop and implement a model of shared governance with partners and the community
  - Lead the integration model and develop site-specific plans
  - Build community engagement to connect children and families to available services.
- **Health-funded organisation to provide the health services** needed to support improved health outcomes and the achievement of developmental milestones so that Aboriginal and Torres Strait Islander children are ready to start school, learn and thrive. All but one of the current Health-funded organisations are Aboriginal Community Controlled Health Organisations (ACCHOs).

Co-location

Two levels of co-location were envisaged:

- Co-location of the Education-funded organisation on or adjacent to school grounds (Australian Government Department of Education and Training 2016, p.14)
- Services (Health-funded and others) were required to have strong links with the schools and be co-located on or adjacent to school grounds *(Figure 2-1*). Health guidelines specify that early childhood [health] services should be on or adjacent to the Education-funded organisation grounds (Australian Government Department of Health 2017, p.7).

Sustainability

It was expected that Education-funded organisations would demonstrate sustainability and operate independently of Australian Government funding at the end of three years, through philanthropic or non-government funding sources (Australian Government Department of Education and Training 2016, p.6).

Health-specific features

Health-specific **CB design features included:**

- Appointment of Aboriginal Community Controlled Health Organisations (ACCHOs), or relevant primary healthcare organisations[9], that are located practicably close to the relevant Education-funded organisation site (Australian Government Department of Health 2017, p.9)
- Identification of additional health services that may be required to complement the Education-funded organisation's integration activities (Australian Government Department of Health 2017, p.7)
- Utilisation of existing infrastructure to support CB integration and collaboration processes (Australian Government Department of Health 2017, p.9).

Integrated service model

The Education-funded organisation was expected to take a leadership role; bringing services and initiatives together to build a common agenda in alignment with Program objectives, lead the integration model and develop site-specific plans.

It was expected that an integrated service model and plan would be developed using a place-based initiatives (PBI) approach, that is founded on community ownership and which suits the unique needs of each location (Australian Government Department of Education and Training 2016, p.9). The success and sustainability of the model was seen as reliant on the co-design of goals and strategies with the community.

Education guidelines articulate the elements of an integrated service model through *The Good Practice Framework* (*Figure 2-1*) (Australian Government Department of Education and Training 2016, p.9).

[9] Relevant primary health care organisations include state and territory governments and organisations, or their subsidiary service providers (Australian Government Department of Health 2017, p.9).

2. Program design

Elements are identified for the service setting, mix, ethos and methodology as well as integration strategies and staffing considerations. Education does not expect that all elements will be present in every community, but that CB funding would enhance existing good practice.

Education guidelines support the use of Collective Impact (CI) or place-based approaches but provide insufficient guidance to sites on how to apply this approach. Education's guidelines describe the CI approach as guiding its thinking about what could make a successful integration model and note that the success and sustainability of the CI approach is reliant on co-design of goals and strategies within the community. This allows each model to be community owned and developed to suit the unique needs of each location.

CI focuses on collaboration between all stakeholders in the community to integrate services and achieve significant and lasting social change, as well as reliance on co-design of goals and strategies within the community. This allows for each PBI to be community developed and owned to suit the unique needs of each location. CI is explained in further detail in *Section 5.1*.

Education guidelines were not intended to be prescriptive or limit the arrangements that communities establish to integrate service delivery. To this end the Good Practice Framework in the guidelines (page 9) provided a broad sketch of the elements of good practice in place-based initiatives.

This evaluation considers elements from the *Good Practice Framework* that relate to service integration. The evaluation did not consider elements from this Framework that relate to direct service delivery, which is outside the scope of this evaluation and include:

- Service ethos – evidence based with reflective practice
- Service methodology:
  - Comprehensive assessment of family, their kinship networks, individual needs, expectations and preferences
  - Relationship based care
  - A planned and structured learning curriculum from age 3 years.

Figure 2-1: The Good Practice Framework

Service Setting

- Early childhood, health and family support services co-located or in close proximity to school
- Services are provided in defined locations/catchment.

Service mix

- Combinations of services that could include primary maternal child and family health services, early childhood services, parenting support programs, allied health and social services, childcare and early learning services and related support services such as housing, transport, community activities
- Strong links with and clear pathways to local schools.

Service ethos

- Culturally safe and welcoming settings
- Child and family centred – parents engaged as well as children
- Evidence based with reflective practice.

Service Methodology

- Early engagement with mothers and other family members during pregnancy and from birth
- Comprehensive assessment of family, their kinship networks, individual needs, expectations and preferences
- Early diagnosis of developmental issues and immediate access to specialist services
- Strengths-based approach promoting family choice and control
- Relationship-based care
- Consultation with and involvement of the local community in design and ongoing management of services
- Service outreach and support, flexibility, testing new ways of keeping families engaged and getting their children ready for school
- A planned and structured learning curriculum from age 3 years
- Strategy and support for transition to the formal school system.

Integration strategies

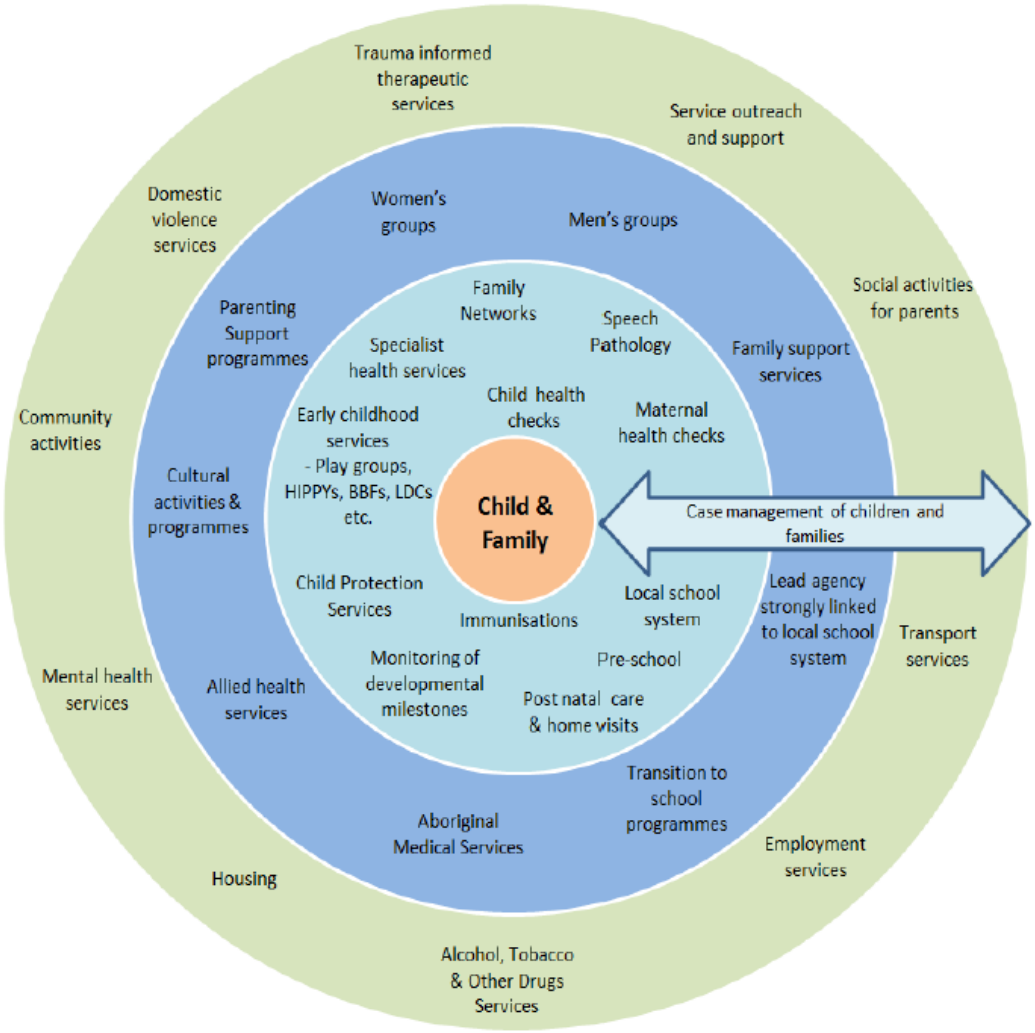
- Shared governance with an Education-funded organisation that has a common vision for holistic service delivery
- Communication and information sharing between agencies is facilitated with privacy protections
- Information and data sharing between professionals and across agencies, both de-identified community level and personal child/family level (with privacy protections).

Staffing

- Dedicated coordination positions, shared governance arrangements, strong leadership
- Other positions designed to increase Indigenous participation in early childhood services with a focus on transition to school
- Local Aboriginal and Torres Strait Islander staffing opportunities and professional development are strongly encouraged
- Staffing opportunities will not be funded by CB on an ongoing basis so they should either be fixed-term positions or, if intended to be ongoing, will need to be funded from another source in the longer term.

Elements of an integrated service model are also presented diagrammatically (*Figure 2-2*) in the Education guidelines (Australian Government Department of Education and Training 2016, p.8). This diagram places the child and family at the core of all activities and uses case management of children and families as a key mechanism for achieving integration.

Figure 2-2: Service integration model



Source: Australian Government Department of Education and Training 2016a.

Findings and recommendations in relation to case management are provided in *Chapter 5*.

2.3 Program governance

A unique feature of the CB Program is the multi-departmental and multi-jurisdictional governance structure in the selection, governance and administration of the Program.

At the national level, Education and Health are responsible for delivery of their respective components of the CB program.

Education is responsible for the following Program components:

- Assessment of CB sites, including consultations with state and territory governments, Health and other stakeholders. CB Education sites are approved by the Minister for Education
- Administration of the CCCF CB application and contracting processes with Education-funded organisations.

Health is responsible for the following Program components:

- Approval of Health CB sites, in consultation with Education, and its respective health organisations in states and territories. This includes Aboriginal Health Partnership Forums which inform, when possible, Health's site selection
- State and territory governments are represented on all Health forums. The forums provide information on the community needs, issues and challenges, and the service ecology at each site, and help Health identify potential implementation risks
- Administration of the Health application and contracting processes with Health-funded organisations.

Overall **policy coordination** is undertaken at a national level through the Place-based Joint Investment Interdepartmental Committee (IDC) which is comprised of representatives from the Departments of Health, Education, Social Services and the Prime Minister and Cabinet (with representatives from Indigenous Affairs, Social Policy Division and the Regional Network).

State and territory jurisdictions are involved in different ways in the Program including:

- Education consults with state and territory education departments (and Health and other stakeholders) about the selection of CB sites
- Education departments in the NT, SA, Tas. and NSW administer CB site funding on behalf of the sites in their jurisdiction
- Where CB services are delivered by state or territory funded education organisations, state and territories are also involved in site-level administration including CB staff employment.

2.4 Site selection

Administration of the CB Program included:

- Site selection processes, through the IDC
- Grant applications and contracting, under separate Education and Health grant programs.

Site selection is initially tested with an Interdepartmental Committee (IDC)[10] (with representatives from the Departments of Health, Education, Social Services and the Prime Minister and Cabinet) and engagement sought from the relevant state and territory government departments, prior to seeking Ministerial approval.

Once a site is approved, further consultation occurs with the above agencies through pre-meetings, and a community scoping exercise is undertaken to assess community readiness, capability, capacity and willingness, and recommended providers.

2.4.1 Selection of Education sites

The Education Minister selected the CB site locations on the advice of Education. Consistent with the recommendations of the *Forrest Review*, site selection focused on identifying communities with multiple and complex social and economic challenges impacting on Aboriginal and Torres Strait Islander children as evidenced by high levels of measured developmental vulnerability upon starting school. Consideration was also given to communities with existing services to which CB could integrate, rather than result in service duplication.

To support the selection process, Education:

- Analysed AEDC data for Aboriginal and Torres Strait Islander children to identify the 200 communities with the highest levels of vulnerability in two or more domains in its population of children in their first year of full-time schooling to establish a shortlist of possible CB locations
- Held bi-lateral discussions with state and territory governments and PM&C Regional Managers
- Engaged a consulting firm to conduct site readiness assessments with service providers in selected communities
- Considered a mix of very remote, remote, regional and urban locations (Department of Education and Training 2017).

Assessment of developmental vulnerability

AEDC scores for Aboriginal and Torres Strait Islander children were a key consideration in site selection. Specifically, data on levels of vulnerability on two or more domains was a key indicator. This data is not publicly available, however an overview of AEDC data for the general population is provided below.

The AEDC assesses children who are entering school, and data has been collected every three years since 2009. Assessment is conducted in five AEDC domains:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge.

[10] The IDC was originally the 'Forest Review of Indigenous training and employment Early Childhood Recommendation IDC', later renamed the 'Place-based Joint Investment IDC', which has been expanded to include the Department of Infrastructure.

For each AEDC domain, children may be assessed as either 'developmentally vulnerable', 'at risk' or 'on track' depending on their score in relation to the cut-offs established for each age group and domain.

Children assessed as developmentally vulnerable in two or more domains, are considered to have a complex range of vulnerabilities which can affect school readiness and may require more intensive management and support.

Site readiness assessments

Site readiness assessments commenced in February 2016 and included community readiness to implement the integration of early childhood education, child and maternal health and family support services, at or near a school site. The following criteria were used in this assessment:

- **Service environment:** Whether the environment among governments and service providers was favourable and supportive, including forums for inter-agency and cross-sector collaboration, an effective school system, and linkages to services
- **Service mix:** Whether there was an appropriate mix of high-quality early childhood education, child and maternal health and family support services (including a structured 0-3 years education program) that engage children and families early and holistically, diagnose developmental issues early, and provide access to specialist services
- **Service integration**: Whether the preconditions for place-based integration that support pathways to the local school system were in place i.e. services with strong linkages that were prepared to:
  - Adapt and consciously improve through integration
  - Be accountable to shared governance and coordination arrangements
- **Family and community engagement:** Whether there was a shared vision for early childhood development among parents and families; whether service providers were trusted, involved parents, families and the community in the design of services, and whether services were considered to be family-centred, non-stigmatising and culturally safe (KPMG 2016).

Consultants were employed to conduct site readiness assessments. The consultant's role included:

- Visiting communities proposed for CB funding
- Consulting with relevant Australian Government, state/territory and local governments, and with organisational representatives in each of the locations visited. This included ACCHOs, schools and other service provider organisations
- Providing Education with a site assessment report that proposed an integrated early childhood services model for the location. The report included:
  - Assessment of the extent to which the preconditions were in place to support the development of an integrated response
  - Funding model and an outline of the proposed integration model for the site

Consultations with local community members, Elders and families with young children were not included as part of site assessment processes.

This lack of community member consultation resulted in gaps in understanding of the community context at some sites.

  - Governance arrangements, including proposed executive agencies, education partners and core service partners
  - Implementation risks and next steps
  - Analysis of options for organisations
  - Contextual information, including community profile, AEDC scores, school/s profiles and qualitative findings for service provision based on service provider consultations
- Assisting some sites to prepare grant applications.

The selection of sites was made progressively, with a mix of ministerial, departmental and jurisdictional input into the decision-making process. Final approval of Education sites was made by the Minister for Education.

2.4.2 Selection of Health sites

Education site selection processes were instrumental in Health's choice of sites. Considerations that specifically informed Health's selection of sites were:

- Health sought to fund local ACCHOs, if such services existed and/or had the capacity to be involved in CB
- Consultations with State Health Partnership Forums in each jurisdiction, comprised of representatives from:
  - Health – Indigenous Health Division in central office, and state/territory offices (Health Services Network)
  - State/territory governments
  - State/territory ACCHOs
  - representatives of both the PM&C Regional Network and a Primary Health Network (PHN) were also invited on a guest basis
- Health funding was provided to health services to participate in the integration and coordination processes led by the Education- funded organisation. This was to ensure that funded services could be better integrated and co-located with early childhood services on, or adjacent to, Education-funded organisation premises (Australian Government Department of Health 2016).

2.5 Grant applications and contracting

Education and Health each have their own Program guidelines in accordance with the legislative framework from which their respective components of the CB Program are funded. The grant application and contracting process for Education- and Health–funded organisations involved:

- Direct approach to selected education and health organisations, inviting them to apply for grant funding under the appropriate stream:
  - Education CB grants under the CCCF. Education-funded organisations were invited to apply on a progressive basis as sites were approved
  - Health funding is provided under the IAHP, via grant applications made for groups of sites (known as tranches)

- Contracting with Education-funded organisations and Health-funded organisations, negotiated independently by Education and Health.

Where possible, Education and Health invited organisations to apply for funding at the same time, with Health grant rounds following the Education process as soon as practicable. However, this did not always occur in practice and most organisations developed proposals independently.

2.6 Funding

For the three-years from 2016-17 to 2018-19, funding was allocated as follows:

- Approximately $30 million from Education ($10 million per year plus indexation) under the CCCF
- $12 million from Health under the IAHP.

Funding is provided to the Education-funded organisation through flexible CCCF grants, to lead and deliver integration activities. Funding for Health-funded organisations is focused on the provision of new, additional or expanded services and also includes some allowance to cover coordination and integration activities.

The monetary value of Education funding for each site varies based on the application submitted by the organisation and the proposed integration model. Education-funded organisations have grant agreements covering three years. Education funding is ongoing, subject to annual appropriation.

Health funding was provided in tranches with funds of up to $250,000 per year available for Health-funded organisations over the three years to 2018-19.

3 Evaluation methodology

This chapter addresses the following:

1. Scope and evolution of the evaluation
2. Ethics approval
3. Information sources
4. Evaluability considerations.

3.1 Scope and evolution of the evaluation

In April 2017, AHA was appointed to evaluate the CB Program. The evaluation aimed to inform any wider rollout of the Program or integration of its features within existing education and health services. AHA was tasked with identifying:

- The factors that contributed to the Program's success
- Which communities obtained the greatest benefit, in terms of education and health outcomes
- The capability and maturity of the service system within which the Program operates.

In consultation with the Health and Education over the two-year evaluation period, AHA adapted its evaluation methods in response to early evaluation findings and the evolution of the Program.

As described in the *Chapter 5*, an early learning was that it takes time to achieve service integration in communities experiencing complex social and economic challenges. Implementation has only recently commenced at some sites and is still underway at others. Population-level health and education outcomes were therefore not able to be addressed within the timescale of the evaluation.

As a result, the evaluation focussed on sites' progress towards early system changes and the integration of early childhood education, child health, and family support services. Where appropriate, AHA developed and applied tools to assist in assessing and comparing progress across sites.

Chapter 6 summarises sites' activities and achievements, analysed across the following three themes or streams of work required to progress integration:

- Community engagement and co-design
- Health, education and family support service engagement and readiness
- Development and implementation of a service integration model.

Case studies for each site are provided in a separate attachment to this report. These describe each site's story, i.e. the challenges faced and progress achieved.

The evaluation scope included development of an overarching Evaluation Strategy (ES). ES V1.0 was approved in June 2017, as a living document to be modified to reflect on-going Program developments. There have since been multiple iterations of the ES and the Program Logic (PL) that underpin each ES. This approach recognises that it is not uncommon for significant program change to occur when trialling complex innovative programs such as CB, which involve progressive roll-out and place-based innovations.

ES V4.0 will be submitted at the end of the evaluation period (June 2019) and will include a revised theory of change, PL, conceptual framework and evaluation questions to reflect a more developmental

approach. Information will also be provided about possible data sources for measuring the short, medium and long-term outcomes of the Program beyond the current evaluation. This will be based on co-design with sites to generate a locally-appropriate:

- Theory of change
- Measurement framework
- Data collection process and reporting going forward.

The PL underpinning the evaluation to date is provided in *Appendix A.*

3.2 Ethics approval

The Department of Health Human Research Ethics Committee (HREC) advised AHA on 4 May 2017, that ethics approval was not required to conduct the initial consultations with service providers. This decision was based on the consultations being used for the purposes of project planning and verification/clarification of existing information, rather than to generate new data.

Subsequently, ethics clearances were obtained for conduct the evaluation from:

- The Department of Health HREC. An ethics application was submitted on 9 August 2017 and approved on 19 September 2017
- The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) HREC[11]. An application was submitted on 31 October 2017 and approved on 18 January 2018. This approval meant that jurisdiction-specific HREC applications were not required.

3.3 Information sources

Information sources used to inform the evaluation and report include:

- Consultations with sites and other services
- Consultations with stakeholders with relevant topic expertise
- Review of site-related documentation
- Development and use of tools to assess site progress towards service integration.

[11] AIATSIS is responsible for reviewing research projects involving Aboriginal and Torres Strait Islander participants to ensure the appropriate ethical standards have been met, which is a requirement of the Guidelines for Ethical Research in Australian Indigenous Studies (2012).

3.3.1 Consultations with sites and other services

Over the two-year period of the evaluation, AHA maintained regular open communication with all CB sites. This included engagement with site staff and also with representatives from related service providers.

Consultations included:

- Site visits and formal telephone consultations, and informal email and telephone communications with:
  - Education- and Health-funded organisations and staff
  - Representatives from other related or associated service provider organisations, including teachers, principals and a wide range of service provision staff including Aboriginal Education Workers, Aboriginal Early Years workers and project management/service provision staff at other organisations
- Engagement with CB site representatives at other forums including:
  - The Collective Impact Symposium (Adelaide, February 2018)
  - *NT Together for Kids* (Darwin, September 2018)
  - *ChangeFest* (Queensland, November 2018)
  - The CB National Workshop (Canberra, March 2019).

AHA team members visited all contracted sites between one and three times depending on when sites joined the CB Program.

3.3.2 Consultations with stakeholders with relevant topic expertise

In addition to the above site-level consultation, AHA consulted with a range of topic experts, as summarised in *Table 3-1*.

Table 3-1: Stakeholders consulted, by area of expertise

Topic area	Stakeholder	
Early childhood health and education research and practice	• Anne Hollands, Australian Institute of Family Studies • Hayley Panetta and Matthew O'Sullivan, Minderoo Foundation • Professor Donna Cross and David Ansell, Telethon Kids Institute • Sue West, Murdoch Children's Research Institute • Dr John Guenther, Batchelor Institute of Indigenous Tertiary Education	• John Burton, SNAICC • Laurie Berryman, Ninti One • Bill Pheasant, Children's Ground • Greg McMahon, Principal (and other senior staff), Doveton College • Challis Community Primary School staff • Dr Margaret Heffernan, RMIT University
Philanthropy	• Krystian Seibert, Philanthropy Australia	• Chris Wooten, Philanthropy Australia

Topic area	Stakeholder	
Collective Impact	• Dr Michelle Lucas, Collective Impact – CMM Social Change	• Matthew Cox, Logan Together Project

3.3.3 Review of site-related documentation

AHA reviewed all available site related documentation including grant applications, contracts and financial reports. The six-monthly performance reports[12] provided by sites to Education (inclusive of Health-funded organisation data) were also reviewed (see *Section 3.4* regarding data quality).

The most recent performance report data available was for the May to October 2018 reporting period. This current report draws on the AHA site consultations held throughout the evaluation period, the most recent of which were conducted in April/May 2019 to ensure the findings reflect the most recent site achievements.

3.4 Evaluability considerations

This section identifies evaluability issues that may impact on the reliability of the findings presented in this report. These issues are presented by theme, as follows:

- **Process and communication visibility.** Analysis and evaluation findings are based on and limited to the information that was available to AHA during the course of the project.
- **Absence of community consultations**. Delays in Program implementation meant that most sites did not consider their site to be sufficiently advanced to warrant AHA engaging with community members. Consequently, AHA was provided with access to fewer than 10 community members who are the target of CB. Those who were consulted were unable to differentiate CB from other initiatives being provided in the area and business as usual by the service provider delivering CB. As a result, it was difficult to directly gauge the extent to which the Program involved and was meeting community needs.

  To partly address this limitation, proxy sources of information were used, such as feedback from teachers, service providers, etc.
- **Data quality and availability.** The performance report templates developed by Education did not adequately capture the work being undertaken at site level. Delays in implementation meant that sites were not able to collect the new quantitative and qualitative outcomes data proposed by AHA.

  The evaluation therefore relied primarily on qualitative data obtained through consultations with sites and a broad range of stakeholders. In some instances, the departure of key site level and government personnel, resulted in a loss of Program knowledge, particularly about the development and implementation phases. The richness and depth of the information provided may have been compromised as a result.

[12] These reports are designed to provide a mix of numeric and narrative service information to show progress against deliverables listed in the Activity Work Plan.

- **Changing scope of the evaluation.** When initially commissioned, the CB evaluation was framed as a formative and summative evaluation. Over the two-year evaluation period, as the Program evolved (see *Chapter 4*), so too did the evaluation approach. The Program reset that occurred in late 2018 (see *Appendix A*), was a pivotal development from an evaluation point of view as it:
  - Required an increased emphasis on the formative aspect of the original scope, despite the Program being operational for two years at some sites
  - Highlighted that a developmental evaluation approach was needed, which was not achievable in the remaining six months of the evaluation contract.

Mitigating strategies to minimise the impact of the above evaluability issues on the quality of the evaluation findings include:

- Triangulation of consultation findings, to optimise the strength and validity of the conclusions drawn from this information. For example, using proxy sources of information where community consultations were not able to be conducted
- Development of strong, trusting and personal relationships between the AHA evaluation team and site-based stakeholders, so that frank, open consultations occurred where possible
- In consultation with the Departments, AHA responded to the changing scope of the evaluation by:
  - Adapting the evaluation methods in response to early evaluation findings and the evolution of the Program
  - Developing and applying tools to assist in assessing sites' progress towards early system changes and the integration of early childhood education, maternal and child health, and family support services.

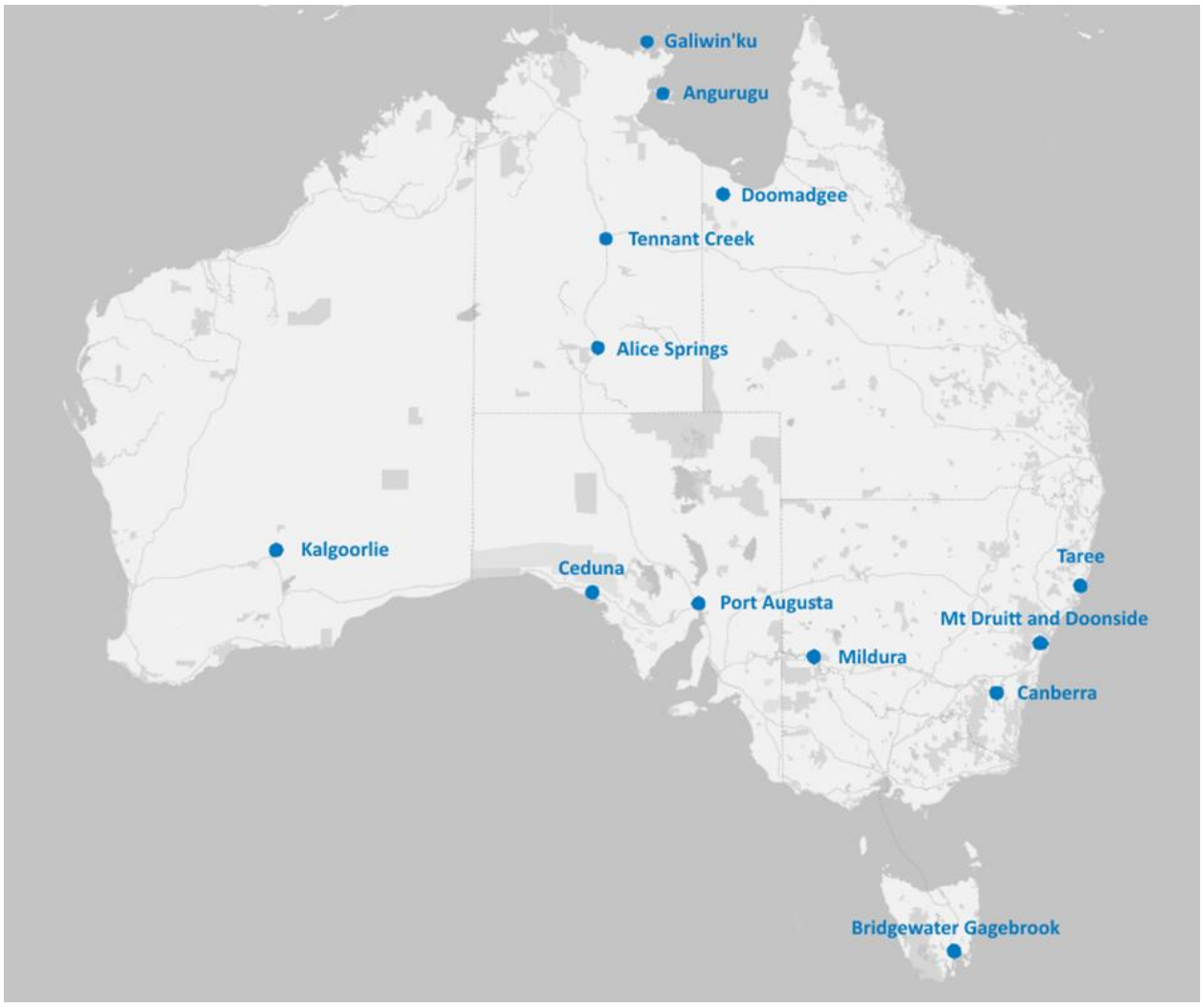
4 Connected Beginnings sites

This chapter provides a summary of each of the CB sites, including details of the Education- and Health-funded organisations by jurisdiction and contract dates, as well as a map showing the geographic spread of sites. Demographic data is also provided. For site-level information about the progress of sites, please refer to *Chapter 6* and *Attachment A – Case Studies.*

4.1 Site summary

Fourteen CB sites were contracted from July 2016 to May 2019. A map of the geographic location of sites across Australia is shown in *Figure 4-1.*

Figure 4-1: Location of Connected Beginning sites



4.2 Program rollout

Table 4-1 provides site information, including details of the Education- and Health-funded organisations by jurisdiction and contract dates. The number of AHA evaluation site visits to each CB site is also provided. As shown in *Table 4-1:*

- All jurisdictions of Australia are represented in the CB program, with multiple sites located in NSW, NT and SA
- Most sites were jointly funded by Education and Health, except for Tennant Creek and Kalgoorlie (Education only) and Canberra (Health only)
- Greater Western Aboriginal Health Service (GWAHS) in NSW is the only Health-funded organisation to simultaneously work with two Education-funded organisations (Ngallu Wal Aboriginal Child and Family Centre; and Ngroo Education)
- Health-funded organisations are all ACCHOs except for Angurugu which is a Primary Health Clinic operated by the NT Department of Health
- Education-funded organisations include seven schools and six child and family centres/services[13].

In jointly funded sites, there was often a lag between when each of the funded organisations were contracted. Gaps of up to 10 months existed in contract execution between the Education- and Health-funded organisations at the CB site (*Table 4-1*). Given the complexity of CB work, the availability of premises and recruitment challenges experienced at many sites, work did not always commence immediately after contracts were signed.

[13] Children's centres and child and family centres bring together care, education, health, community development activities and family services for families and their young children from birth to 8 years old.

Table 4-1: Funded organisations by jurisdiction and contract date

Site	Education-funded		Health-funded		Months between contracts	Number of AHA site visits
	Organisation	Contract date	Organisation	Contract date		
Canberra, ACT[1]	-		Winnunga	2017	N/A	3
Doonside, NSW	Ngallu Wal Aboriginal Child and Family Centre, auspiced through Growing Potential	Jul 2017	GWAHS	Mar 2018	7	2
Mount Druitt, NSW	Ngroo Education, located at Tregear Public School	Apr 2018	GWAHS		1	1
Taree, NSW	Taree Public School through NSW Department of Education	April 2019	Biripi	Jun 2018	10	1
Alice Springs, NT[2]	Braitling Primary School through NT Department of Education	Sep 2016	Congress	Jun 2017	9	3
Angurugu, NT[2]	Angurugu School through NT Department of Education	Jun 2018	Angurugu Health Centre	Apr 2018	2	1
Galiwin'ku, NT[2]	Shepherdson College through NT Department of Education	Dec 2016	Miwatj	Jun 2017	6	2
Tennant Creek, NT[2,3]	Tennant Creek Primary School through NT Department of Education	Feb 2017	-		N/A	1
Doomadgee, Qld	Dumaji Children and Family Centre through Save the Children Australia	Dec 2016	Gidgee	Jun 2017	6	3
Ceduna, SA[4]	Ngura Yadurrin Children and Family Centre through SA Department for Education	May 2017	Koonibba	May 2017	0	3
Port Augusta, SA[4]	Port Augusta Children's Centre through SA Department for Education	May 2017	Pika Wiya	Jun 2017	1	1
Bridgewater/Gagebrook, Tas	*tagari lia* Child and Family Centre through Tasmanian Department of Education	Jun 2018	TAC	Jun 2018	0	1

4. Connected Beginnings sites

Site	Education-funded		Health-funded		Months between contracts	Number of AHA site visits
	Organisation	Contract date	Organisation	Contract date		
Mildura, Vic	Mildura Primary School	May 2017	MDAS	Apr 2018	10	2
Kalgoorlie, WA[4]	Wanslea Family Services	Jun 2018	-		N/A	1

[1] Health-only site

[2] For all NT sites, the Education CB contract is with the NT Department of Education

[3] Education-only site

[4] In all SA sites, the Education CB contract is with the SA Department of Education

4.3 Site demographics

CB operates in communities facing multiple and complex social and economic challenges across Australia. As demonstrated in *Table 4-2,* CB sites vary considerably in overall population size and Aboriginal and Torres Strait Islander population specifically.

As shown in *Table 4-2*:

- The population of CB sites ranges from 855 in Angurugu to 397,397 for Canberra (the population for all of ACT, the stated catchment area for the Canberra site)
- The Aboriginal and Torres Strait Islander population in the site catchment ranges from:
  - 345 (Mount Druitt) to 6,508 (Canberra)
  - 2% (Canberra and Mount Druitt) to 97% (Angurugu) of the total population
- According to the Australian Statistical Geography Standard (ASGS):
  - Six sites are classified as Remote or Very Remote, including all NT sites as well as Doomadgee in Queensland and Ceduna in SA
  - Five sites are located in Inner or Outer Regional areas, including Taree in NSW, Port Augusta in SA, Mildura in Victoria, Kalgoorlie in WA and Bridgewater/Gagebrook (located in Hobart) in Tasmania
  - Three sites are located in Major Cities, namely Doonside and Mount Druitt (located in Sydney) and Canberra.

Table 4-2 also identifies for each site, the proportion of children who are developmentally vulnerable across two or more domains (as measured by AEDC scores in 2018). As shown, the proportions range from 8% for Kalgoorlie to 46% for Tennant Creek. It is noted that for site selection purposes, Education used more refined AEDC data about Aboriginal and Torres Strait Islander children, which is not publicly available.

Table 4-2: CB site population profiles (2016 Census)

Jurisdiction	Site	Total population	Aboriginal and Torres Strait Islander population	Aboriginal and Torres Strait Islander population as proportion of total population	Remoteness (ASGS*)	% of children who are developmentally vulnerable on two or more AEDC domain(s) in 2018
ACT	Canberra	397,397	6,508	2%	Major city	12%
NSW	Doonside	13,451	717	5%	Major city	9%
	Mount Druitt	16,726	345	2%	Major city	12%
	Taree	16,197	1,723	11%	Inner regional	17%
NT	Alice Springs	24,753	4,361	18%	Remote	15%
	Angurugu	855	828	97%	Very Remote	45%
	Galiwin'ku	2,088	1,970	94%	Very Remote	N/A
	Tennant Creek	2,991	1,536	51%	Very Remote	46%
Qld	Doomadgee	1,405	1,312	93%	Very Remote	N/A
SA	Ceduna	3,408	741	22%	Very Remote	21%
	Port Augusta	13,808	2,523	18%	Outer Regional	19%
Tas	Bridgewater/Gagebrook	7,288	1,088	15%	Inner Regional	30%
Vic	Mildura	53,878	2,065	4%	Outer Regional	13%
WA	Kalgoorlie	29,820	2,137	7%	Outer Regional	8%

* The Australian Statistical Geography Standard (ASGS) Remoteness Areas divide Australia into 5 classes of remoteness on the basis of relative access to services. These classifications are - Major Cities, Inner Regional, Outer Regional, Remote and Very Remote.

5 Findings: Program design, governance and administration

5. Findings: Program design, governance and administration

This chapter presents findings and recommendations in relation to:

- The Program framework and model of service integration (*Sections 5.1* and *5.2*)
- Administration of the Program, including (*Sections 5.3 to 5.8):*
  - Governance
  - Guidelines
  - Site selection
  - Grant applications and contracting
  - Funding
  - Data and reporting.

5.1 Program framework

Chapter 2 addresses the background, development and defining features the CB Program, i.e. how it was envisaged to operate. This section now examines how these features have evolved - focussed on the learnings which can guide the future direction of the Program.

Through trialling CB over the past three years, communities, services and government have gained substantial learnings and insights into CB Program implementation. It has emerged that the **defining features** of the CB model are:

1. Community-driven and flexible approach
2. Funded organisations have connections to the wider service system
3. Education-funded organisation and Health-funded organisation at most sites.

Although it is early in the implementation period, these features are likely precursors to supporting services to integrate and provide seamless services for Aboriginal and Torres Strait Islander children and families, to ensure that children have a positive transition to school. Findings in relation to each of these features are presented below.

1. Community driven and flexible approach

Program guidelines provide flexibility for sites to develop their own approach and initiatives. This is intended to enable the community to define what is required and decide how best to deliver the Program in their setting.

Community initiatives such as CB are designed with the purpose of targeting one or more specific geographical locations and/or population groups in order to bring communities together to collaboratively address a social concern. For CB, the goal is to integrate services locally to ensure that Aboriginal and Torres Strait Islander children are better prepared for school.

Community engagement and co-design are prerequisites for achieving 'buy-in' from the community. The success and sustainability of CB is reliant on meaningful engagement and co-design of goals and strategies with the Aboriginal and Torres Strait Islander and broader community, as it allows the community to gain a sense of ownership over the initiative. As part of this process, the Education-

funded organisation is expected to bring people together to build a common agenda in alignment with Program objectives and to lead the integration model and develop site-specific plans.

Education guidelines support the use of Collective Impact (CI) or place-based initiative (PBI) approaches but provided insufficient guidance to sites on how to apply this approach. Education's guidelines describe the CI approach as guiding its thinking about what could make a successful integration model and note that the success and sustainability of the CI approach is reliant on co-design of goals and strategies within the community. This allows each model to be community owned and developed to suit the unique needs of each location.

The Education guidelines were therefore intended not to be prescriptive or limit the arrangements that communities establish to integrate service delivery. To this end the *Good Practice Framework* in the guidelines (Education 2016, p.9) provided a broad sketch of the elements of good practice in PBIs.

Early evaluation findings indicated that some CB sites were uncertain about how to approach the task of service integration. Staff required more direction and guidance about the foundational work to be undertaken prior to developing and implementing a service integration model. This suggests that sites would benefit from more task/activity-oriented guidance and CI (or other PBI) support.

The need for direction and guidance was confirmed at the December 2017 CB workshop attended by Education, Health and AHA. Subsequent communication from Education and Health in October 2018 advised that '*Collective Impact is the approach underpinning the Connected Beginnings Program*'. CI had previously informed Program design and was now identified as a way to provide appropriate direction and guidance to sites.

Collective Impact approach to service integration

Collective Impact (CI) is a form of a place-based initiative (PBI) that provides a framework for facilitating and achieving large-scale social change in a community.

CI approaches, such as that used in the Logan Together project, focus on extensive community engagement and collaboration between all stakeholders to achieve significant and lasting social change.

CI provides direction to sites in relation to the activities and collaborations required to achieve the aims of the CB Program. CI also supports communities and services to work together to address broader health and education issues.

Several CB sites have now adopted this approach. For some, this post-hoc adoption of a CI approach led to a CB 'reset', prompting them to shift from a focus on service delivery towards engaging the community and service providers, and identifying new ways of working together.

To provide additional guidance, Education approved the use of CB funds for some sites to access CI training and engage a consultant for advice and support at site level. This provided an important way forward for Education-funded organisations to plan and deliver their CB initiative and was valued by the sites that accessed this support.

As a result of this support, a number of sites have now adopted a CI approach and have undertaken a range of initiatives to obtain community views and perspectives. Progress at sites over the past three

years has demonstrated that strategies to integrate services must be tailored to the community's needs, through a CI or place-based approach.

Early engagement and co-design with people experiencing the issues the Program is trying to solve was not initially a focus of the CB Program at site level. Site CB personnel focussed mainly on building relationships between the Education and Health-funded organisations. The education and guidance provided to sites highlighted the importance of obtaining local community buy-in and building trust, and this is now an ongoing focus for most sites.

Sites customised their PBI approach to reflect their community's local context and needs. Some CB sites had experience of CI initiatives previously delivered in their location. This proved beneficial for some sites, such as Mildura and Mount Druitt, where the CI groundwork is well advanced and is work that the CB site can connect into and build on.

At other sites, prior experience of CI initiatives led to negative perceptions among some stakeholders as to the value of this approach. In these cases, CI is not named, and aspects of the approach are built into a more broadly focussed PBI. An understanding of prospective sites' prior experience of CI (as well as similar previously tried initiatives) therefore should be taken into account in the site selection process for future CB initiative sites.

Recommendation

- Strengthen Program guidelines to reflect that CB initiatives should be community driven and provide further guidance on the role of CI/PBI approaches in the design and delivery of CB initiatives.
- Provide core funding for training, advice and guidance in implementing CI/PBI approaches.

2. Funded organisations have connections to the wider service system

The second defining feature of the CB Program is that funded organisations need to develop connections to the broader service system in order to deliver an integrated service system across health, education and family support services. Service connections and readiness are prerequisites for implementation of an integrated services model. This is consistent with a CI or PBI approach.

Each site has invested in building relationships that are specific to their local context. Key service providers and government organisations have been engaged in CB governance arrangements established by the Education-funded organisations. Sites have established connections with:

- State and territory education and health departments
- Local education, early childhood and childcare services including programs such as Families as First Teachers (FaFT) and Home Interaction Program for Parents and Youngsters (HIPPY) programs
- Local health services including ACCHOs, hospitals, state or territory education-funded allied health and school health services
- Child and Family support services including relevant state and territory Justice department or child protection services
- Aboriginal and Torres Strait Islander community organisations and services

- Local Government services
- Philanthropic organisations.

A precursor to implementing an integrated services model is ensuring that services are ready to deliver integrated services. At some sites, this work is still in the early stages of development. At other sites, such as Alice Springs and Galiwin'ku, this is well advanced.

Successful initiatives by sites to facilitate service readiness for service integration include:

- Development of referral pathways and common referral forms for use amongst service providers who are part of the Education- and Health-funded organisation referral networks
- Formation of service provider case coordination committees or working groups to facilitate case management and care coordination for individual children and families to streamline their access to services and monitor their progress
- Development of memoranda of understanding between Health and Education-funded organisations to facilitate data sharing about individual clients or families whilst maintaining privacy protections.

Challenges for sites include developing approaches where there are blocks in relationships between key service providers in the network. Despite these issues, all sites are progressing and developing connections with the wider service network, increasing the likelihood of achieving the system changes required to deliver integrated services. This work is still in early development at some sites, while other sites are well advanced. The CB-funded-organisations conference held in March 2019 was observed to be valuable in assisting sites to share learnings and successful approaches.

Further details about this aspect at a site level are provided in *Chapter 6*.

Recommendation

- Build regular forums into the CB Program agenda to bring Education- and Health-funded organisations together to share learnings and successful approaches, in particular about building connections into the wider service system.

3. Education-funded organisation and Health-funded organisation at most sites

Investment in both Education- and Health-funded organisations at most sites has proven to be an important feature of the Program. The new funding has helped Education- and Health-funded organisations to work together to begin to drive local integration of early childhood services. This is examined at site level in *Chapter 6* and in *Attachment A – Case Studies*.

Of the 14 CB sites, 11 sites have both Education- and Health-funded organisations. Tennant Creek and Kalgoorlie are both Education-only sites and Canberra is a Health-only site. At the two Education-only sites, a suitable health organisation was identified but did not apply for CB funding for reasons relating to their capacity or concerns about the time available to implement the program. At the Health-only site, it was determined that there was sufficient resources and education linkages in place with the Health-funded organisation to meet CB requirements.

Collaboration between Education- and Health-funded organisations has been an important step in integration of the early childhood services system at CB sites. Where Education- and Health-funded

organisations can come together to build a local governance group, support community engagement and co-design implementation and evaluation, local CB initiatives have the greatest chance of successfully embedding an integrated service model. These collaborations will develop in different timeframes depending on the local context and relationships at each site.

An important observation is that population level health and education outcomes have not been achieved in the timescale of this evaluation. The establishment of the initial conditions for achieving integration has only recently commenced at some sites, commonly in parallel with the delivery of services, and is still to be fully implemented at others. In line with CI/PBI literature, it is unlikely that population level impacts would be measurable until around five years after commencement. In the first 1-3 years of implementing CB at each site, the focus is on setting the foundations. This involves building community partnership and connection, facilitating partner relationships, working with policy makers, program designers, service providers and funders.

Current evidence indicates that CB should continue to support both an Education- and Health-funded organisation at each site, however it is not yet known whether this will lead to improved health and educational outcomes. Two funded organisations at each site may not be the only model that could be considered for CB PBIs going forward. The critical requirements are that an organisation is funded to drive the CI/PBI process and that funding is available to fill service gaps.

Integration of Education- and Health-funded organisations

Site consultations identified varying levels of integration between Education-funded and Health-funded organisations. For some sites, the CB model and requirements assisted the two organisations to work together, leading to greater integration of the services they provide. For other sites, funding and guidelines alone have not been sufficient to allow the organisations to bridge the barriers they face in working together. For a few sites, working relationships continue to be challenging and will require more time and effort to develop and become stable before the pathway to integration can become clearer.

Can a single-funded organisation be effective?

As indicated above, current experience indicates that having two funded organisations should continue to be supported at funded sites. There are two Education-only and one Health-only sites in the CB Program. However, these sites are not sufficiently mature to clearly assess these variants from the 'two funded-organisations' CB model.

In the Education-only sites, the absence of Health-funded CB service involvement may make community engagement and service integration harder. ACCHOs can bring considerable cultural capital and community links and without this, community consultation may prove challenging.

The absence of a Health-funded CB organisation should not limit the Education-funded organisation from working to integrate existing services. It remains however, that Education-funded organisations need to forge a relationship with local ACCHOs if the Program is to be successful.

A Health-only model is entirely different to an Education only model. In Canberra (Health-only site), there is less focus on integration with the education system (although they do liaise with Koori preschools and a local primary school) and more focus on service delivery. CB funding has funded a 0.5FTE paediatric nurse, which has enhanced their existing case management system for children under

five. CB fits well into the organisation's service delivery model which can wrap health and family support services around children with developmental or other needs.

Health CB funding has resulted in improved linkages with other health services, more clearly defined referral pathways and improved timeliness of services, however it is unclear whether the system changes will be lasting in the absence of CB funding.

CB staff reported that, as a direct outcome of Health CB funding, 'simple' health issues that affect school readiness (such as issues associated with hearing and sight), are now largely addressed for the target cohort. This allows CB staff to focus on children with longer term and more complex developmental and behavioural issues. However, without backbone support, this model is unlikely to result in lasting system change. There is need for an organisation to provide leadership and support for Koori preschools and local primary school to participate in governance arrangements and to work with Winnunga to design and implement system changes.

Recommendation

- The funding timeframe for each CB site be extended to support the development and implementation of a self-sustaining service integration model.
- Funding continues to be provided for CB models that include an organisation to drive the CI/PBI process and funding for services to address gaps in availability for children under five years old.

Role of the Education-funded organisation

The Education-funded organisation's role is to provide leadership and strengthen the integration of services. In the language of CI this 'backbone' role is the axis of all CB processes, leading the integration by bringing stakeholders together, developing and implementing a model of shared governance with partners and the community, and building community engagement to connect children and families to available services.

The Education-funded organisations were conceived as providing the 'glue' to help a community come together to provide integrated child and family centred services.

Program timeframes

The evidence indicates that establishment of CB PBIs can take many months - from application stage to having two funded organisations contracted and operating. Considerable time is needed to:

- Establish the initiative at site level including grant application, contracting and staff recruitment processes
- Engage with the Aboriginal and Torres Strait Islander and broader community to develop governance arrangements, develop a shared plan and co-design the initiative
- Engage with the health, education and family support services to gain their 'buy-in' and ensure their readiness for integration
- Implement new referral and service system arrangements.

In addition, at many sites, staff recruitment and retention has led to delays, particularly in remote locations where delays in recruitment and shorter retention periods are common.

A key learning is **that it takes time** to achieve service integration in communities experiencing complex social and economic challenges. The CI literature concurs with AHA findings reporting that it takes time and sustained effort for CI initiatives to create lasting change, with time between inception and impact for such initiatives ranging from 4 to 24 years depending on the scale of the change being affected (Jewlya et al. 2018). Models such as Logan Together, for example, work on 10-year timeframes in planning their initiatives and measuring change. Given the complexity of the CB project, this may be more realistic timeframe for some sites.

Role of the Health-funded organisation

The Health-funded organisation's role is to participate in the governance arrangements led by the Education-funded organisation and to provide the health services needed to support improved health outcomes and the achievement of developmental milestones so that Aboriginal and Torres Strait Islander children are ready to start school, learn and thrive.

With the exception of the Health service at Angurugu, all CB Health-funded organisations are Aboriginal Community Controlled Health Organisations (ACCHOs). Services are delivered by an Aboriginal Community Controlled Health Service (ACCHS). An ACCHS is a primary health care service initiated and operated by the local Aboriginal and Torres Strait Islander community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).

Where the Health-funded organisation is engaged in the Program, they bring necessary local cultural insights, knowledge and experiences to the CB initiative. Community controlled services place culture at the centre of their strengths-based approach to service delivery, which is key to overcoming historical service access barriers. However to ensure services are available to all community members, different models of service provision may need to be considered in some locations.

5.1.2 Sustainability

Education-funded organisations are expected to demonstrate sustainability and to source necessary funding from philanthropic or non-government funding sources within three years. This is not expected of Health-funded organisations.

Education guidelines envisaged that "*Grant Agreements may continue for up to three years, allowing successful grant recipients sufficient time to become established and achieve sustainability. The integrated service model should demonstrate sustainability and be able to operate independently following the expenditure of the funding*" (Education 2016).

A key finding over the past three years has been recognition that it takes time to achieve service integration in communities experiencing complex social and economic challenges.

As Program implementation has been slower than originally anticipated and no sites have yet been able to secure philanthropic funding. Sites have concentrated on establishment and integration CB activities and consequently pursuing philanthropic funding has not been prioritised.

Two sites have indicated they may be able to access philanthropic funding in the future. These sites both had links to potential sources of funding prior to the establishment of CB, as follows:

- Ngroo Education in Mount Druitt secured ongoing funding from a philanthropic organisation for non-CB activities. This organisation attended early CB meetings and indicated that they would also provide funding regarding the CB Program
- Kalgoorlie has discussed with the local mining companies about potentially supporting the CB initiative in the future.

Sustainability of CB is a concern for many sites. Education- and Health-funded organisations expressed concern that without ongoing funding, the significant progress they made during the first three years would not be sustained.

Identified barriers to securing philanthropic funding include:

- CB staff do not necessarily have the skills or experience in fund raising through the philanthropic or non-government sector, nor the marketing and proposal development resources that securing philanthropic funding may require
- The philanthropic sector often seeks to invest in new rather than existing projects.

CB staff will require more support and time to build their CB initiatives and to develop the necessary skills to attract philanthropic investment. Continued government investment (Australian Government and/or jurisdictional) will be needed over the medium to long term to achieve significant change. While the philanthropic funding is a desirable outcome, it is unlikely that philanthropic or non-government funding will be available or sufficient to maintain CB projects in the short to medium term.

Recommendation

- Education review the requirement that Education-funded organisations achieve sustainability within 3 years
- Education consider providing additional support to assist sites to secure philanthropic and/or non-government funding.
- Provide greater funding certainty to sites, reflecting the lengthy time required to implement an effective CB initiative.

5.2 Model of service integration

It has been demonstrated that CB can provide an effective framework to support the integration of services across health, education and family support systems. As well as supporting the integration of early childhood services, it has been demonstrated that CB can support communities and services to connect and work together to address broader entrenched health and education issues.

Chapter 2 summarises how the CB service integration model was designed and intended to operate. This model is built around connecting services so that the child and family is placed at the centre of all activities, with case management of children and families used as a key mechanism for achieving service integration.

5. Findings: Program design, governance and administration

The achievement of service integration means shared outcomes for a child and a family, which will reduce duplication and encourage professionals to work across disciplines.

Education's model of service integration, as outlined in *The Good Practice Framework* (refer *Section 2.2*), is useful for funded organisations in articulating the elements of an integration model. Elements are defined for the service setting, mix, ethos and methodology as well as integration strategies and staffing considerations. Some of the key elements of CI such as shared governance are embedded in this *Good Practice Framework.*

Some organisations have indicated that they would also benefit from task/activity-oriented guidance. Specifically, guidance about the tasks and activities needed to implement integrated services, including a community-driven approach with consideration of local contexts.

Evaluation findings indicate that additional focus or clarification is required in relation to:

- Using a wide range of innovative strategies and existing services to reach 'hard-to-reach' communities
- Case management.

Reaching 'hard to reach' communities

Reaching disengaged or hard-to-reach families, children or communities can make a fundamental difference to improving the school readiness of children in the community as a whole. An aim of CB is to overcome historical barriers to service use through the delivery of culturally-based services that work together more effectively in a way that disengaged families can relate to. In these circumstances, Education- and Health-funded organisations are seeking to focus on ways to bring the community together that can both reach out to these communities and overcome challenges and barriers. A common vision that is centred specifically on the children and what is best for them is one way to unite a community to achieve its priorities.

Reaching 'hard to reach' communities

Some CB sites have found innovative ways to begin to break down these barriers. For example, at one site, children are explicitly placed at the centre of the initiative in the following ways:

- Fun activities such as a unicorn party are advertised in the town so that children will want to attend and ask their parents/grandparents to take them
- Welcome to Country ceremony - where children who are born in a city away from town and then come home to their community, are welcomed to their local community once per year with a big party attended by a range of Elders, which has proved successful in bringing community members into the service.

CB is an opportunity for the participating Health- and Education-funded organisations to collectively develop solutions to the complex social and economic determinants of school readiness which historically lay outside the scope of their traditional funding. While initially focussing on the more tangible challenges such as lack of accessible transport or distrust of service providers, CB may be able to drive broader community approaches to these determinants to some degree.

However, for CB initiatives to significantly improve school readiness, reaching hard-to-reach children and families will remain a priority in the future. Multi-layered approaches and the trialling of new strategies may be needed. This could include for example, funding of new outreach services or contracting of organisations with established links into these communities to deliver community engagement activities and/or provide services.

Recommendation

- Funded organisations, through their governance structures, work together with key stakeholders in the community to develop strategies and a work plan to identify and engage with community members that services are not reaching.

Case management

Case management provides the ability to wrap services around the needs of children and families and is therefore central to the CB model of integrated service delivery. Both Education and Health recognise the importance of case management.

The Forrest Review argued that "*service delivery to the most disadvantaged locations is rarely cohesive, lacks coordination between government agencies and service providers, and lacks any comprehensive case management of clients*" (Forrest 2014).

There are many different models of case management/case coordination. Traditionally, case management involves a case manager working with an individual client or family. The case manager's role is to undertake assessment, monitoring, planning, advocacy and link the client with the services they need (Intagliata 1982).

Where multiple agencies are involved with an individual or family, case coordination is used and involves communication, information sharing and collaboration between case managers and other staff working with the individual or family, and between agencies in the community (Marfleet et al. 2013).

Case management and case coordination are seen to be particularly important for vulnerable children with complex needs relating to developmental delay, health or family support, to ensure they have access to the services they need.

During the initial stages of the CB Program, two Education-funded organisations commenced case managing children because existing services were at capacity and were unable to take on children identified through CB as needing support. These organisations were advised that direct service delivery is outside the scope of the CB Education-funding and that case management should be facilitated through existing services.

Several Education-funded organisations have reported that they undertake case coordination (as opposed to case management). In some cases, an interim arrangement exists whereby the Health-funded organisation is providing care coordination for children 0-3 years old, with the Education-funded organisation providing care coordination for children who are not being managed by other services. The Education-funded organisation reported:

> *"The Connected Beginnings Project Team are directly involved in outreach engagement, supporting data sharing and coordinating case management of around 80 children in the catchment area. Initially there was a direct service delivery component associated with this work.*

> *These are the hard to reach children and families who have previously not been engaged with local services effectively and have, prior to Connected Beginnings, fallen between the gaps in support and care, diminishing their start to school.*
>
> *The project team have been actively identifying strategies and alternatives to direct case management responsibilities for the past five months. This has been very challenging, due to gaps in family support services, however significant progress has been made to reduce the number of children subject to direct case management by the project team."*[14]

Other sites have a 'watch list' of children, so that children not accessing services can be guided into the system by the appropriate organisations.

In some sites, CB has placed additional case management service support demands on other service agencies, which these agencies have been unable to meet. This caused tension among partner organisations where Health-funded organisations and other service providers expect that the Education-funded organisation's role should encompass case management.

This perception may have been reinforced by Health grant guidelines, which state that "*Education will fund selected organisations to perform the 'lead agency' role and lead case management at lead agency sites, identifying developmental and health needs of identified children*" (Health 2018).

Further, Education guidelines permit the Education-funded organisation to, "*where required, purchase and coordinate services to ensure effective implementation of the grant activities*". This statement does not align with advice given to sites by Education that the Education-funded organisation is not permitted to be involved in providing services.

Clarification of expectations regarding the role of Education-funded organisations in providing or procuring case management and case coordination services is required because of its important role in service integration.

Recommendation

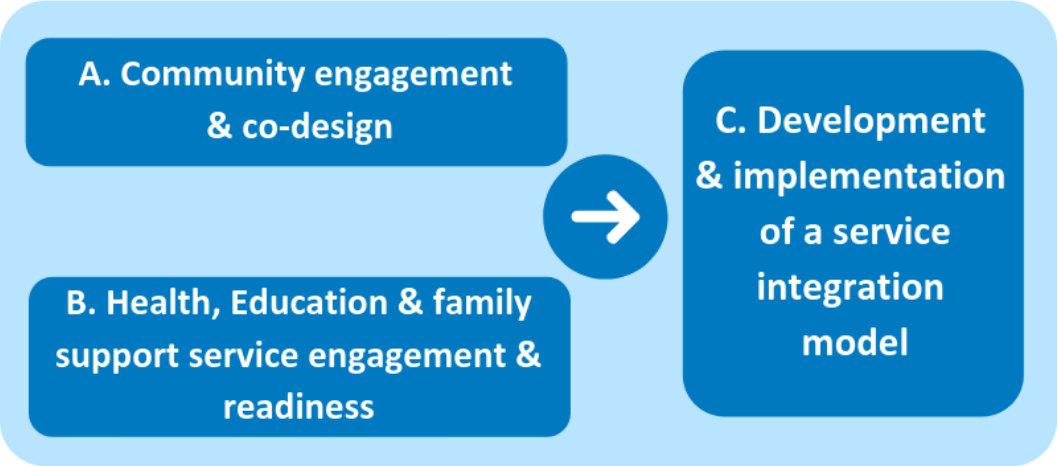
- Revise Program guidelines to clarify expectations in regard to case management and case coordination responsibilities. In particular, clarify that Health-funded organisations can provide case management and/or case coordination as part of their health service delivery responsibilities.

Progress towards service integration

AHA's work with sites has helped identify the key tasks necessary to achieve service integration. These can be grouped into three themes or work streams (*Figure 5-1*).

[14] Source: Alice Springs Performance Report May 2018 (addendum)

Figure 5-1: Integration progress work streams



The first two themes are the foundation work for developing an effective integration model. The third is the activities needed to successfully deliver integrated services.

Section 6.1 provides details of these work streams, which are consistent with a CI approach and include the elements of the *Good Practice Framework*. *Section 6.1* describes sites' activities and progress and the key learnings, grouped under these themes.

5.3 Program governance

The establishment of CB sites in every state and territory has demonstrated that interdepartmental coordination can occur to overcome traditionally siloed Education and Health sector boundaries.

From a site perspective however, the CB Program is mostly seen as operating under separate Education and Health guidelines using separate grant procurement processes.

In many instances, this has not led to a consistent and integrated Program on the ground. The complexity of funding streams and associated requirements has affected the ability of many sites to move rapidly in decision making and action.

5.3.1 Australian Government and jurisdictional administrative arrangements

Education- and Health- funded organisations are funded at the Australian Government level for CB, while schools are funded at a jurisdictional level.

Various arrangements were established that led to some potential governance challenges. For example:

- In Queensland, Victoria and WA, funding is provided directly by Education to the Education-funded organisation. However, in NT, SA, Tasmania and NSW, Education funding is provided to the respective jurisdictional Education Department to manage on behalf of the CB sites
- In the NT, at one stage an overall Territory-wide Director of CB was appointed within the NT Department of Education, to ensure the Department had appropriate oversight of the work being undertaken in its education facilities

- Education facilities, which host Education-funded organisations, are jurisdictional government-funded. These facilities did not have a clear understanding of their role and responsibilities in overseeing, governing and supporting decision making for the Australian Government-funded teams located at their facility.

As a result, for some Education-funded organisations staff, especially those employed directly by schools/jurisdictional education departments, there was not a clear understanding of who should take the lead in driving change, and who in the education/early childhood sector should take control and make decisions.

A continuing challenge remains ensuring that all jurisdictional representatives are active, involved and informed of CB matters.

5.4 Program guidelines

The CB model expects that Education- and Health-funded organisations work together at each site. Education- and Health-funded organisations are funded under separate grants programs (CCCF and IAHP) which operate under separate guidelines.

The Program has evolved over the past three years, and questions regarding the intent of the guidelines, and the scope of the funded-organisations' work, have been clarified by Health and Education over this time. However, the guidelines have not been updated to reflect the learnings and experience of the Program over this period, and there has been some confusion at site level where Health and Education guidelines are inconsistent or lack clarity.

Section 5.1 highlights the need for update of the guidelines in relation to:

- Co-location
- Case management/case coordination responsibilities
- Service funding and sustainability
- Guidance about tasks and activities to implement integrated services, including a community driven CI/PBI approach with consideration of local contexts.

The use of different terminology in Education and Health guidelines has been a source of confusion, for example the use of 'Lead Agency' and 'lead organisation'. This may explain why at one site, a stakeholder remarked that "It's confusing having two Lead Agencies."

Other matters raised at site consultations relate to the CB Program's target groups. Education guidelines specify that the Program is designed to also assist non-Aboriginal and Torres Strait Islander families. The guidelines specify that the Program is designed to assist:

- Aboriginal and Torres Strait Islander children from birth to school commencement
- Pregnant Aboriginal and Torres Strait Islander women and mothers, and families with Aboriginal and Torres Strait Islander children up to school commencement age
- Non-Aboriginal and Torres Strait Islander families where they access the services provided through the Program.

Health guidelines describe the Program as providing early childhood services to Aboriginal and Torres Strait Islander children up to school age. The guidelines do not address service provision to non-Aboriginal and Torres Strait Islander families.

Some Health-funded organisations reported that, in line with their individual ACCHS policies, services could not be provided to non-Aboriginal and Torres Strait Islander children and families, and that this has led to a gap in services for non-Aboriginal or Torres Strait Islander children in some sites.

Recommendation

- Develop a unified set of Education and Health operational guidelines that reflect CB's goal of integration, and provide clarification as to:
  - Program objectives and desired outcomes
  - How to implement a community-driven approach with consideration of local contexts, including expectations regarding the application of CI and the funding available to support these approaches
  - Expectations and the application of Program funding in regard to:
    - Roles and responsibilities of Education- and Health-funded organisations
    - Co-design and community engagement
    - Co-location
    - Case management/case coordination responsibilities
    - Service funding, and the requirement to secure philanthropic funding and sustainability
    - Service provision to the expected target groups
  - How funded organisations, through their governance structures, work together with key stakeholders in the community to develop strategies and a work plan to identify and engage with community members that services are not reaching.
  - Clarify the respective role of jurisdictional governments in CB Program delivery, to define state/territory and Australian Government responsibilities in the administration and governance of the Program.

5.5 Site selection

The site selection process involved analysing AEDC data (for Aboriginal and Torres Strait Islander children) to identify the 200 communities with the highest levels of vulnerability in two or more domains in its population of children in their first year of full-time schooling to establish a shortlist of possible CB locations. Site selection was initially tested with an Interdepartmental Committee (IDC) (with representatives from the Departments of Health, Education, Social Services and the Prime Minister and Cabinet) and engagement sought from the relevant state and territory government departments, prior to seeking Ministerial approval.

Once a site was approved, further consultation occurs with the above agencies through pre meetings, and a community scoping exercise was undertaken to assess community readiness, capability, capacity and willingness, and likely providers.

Aspects that were not fully explored or insufficiently considered were:

- The quality of the relationships between key partners

- Ability of the potential Education-funded organisations and/or Health-funded organisations to work with sectors of the community and community members that are not currently connected into services
- Role of other CI or other PBI with the same target cohort operating in the same location.

Some Education and Health sites were approached multiple times after declining an initial offer to participate. Some of these sites subsequently became CB-funded while others maintained their decision not to participate. Reported reasons for not participating included:

- Lack of capacity to manage and implement an additional service program
- Anticipated difficulties with staffing
- Program implementation fatigue
- Being unaware of who the respective Health-funded partner organisation would be
- Concern at the remaining term of funding to achieve the Program's objectives.

Recommended improvements in site selection processes are provided at the end of the next section.

5.6 Grant applications and contracting

Both Education and Health guidelines indicate the expectation that, at the time of submitting their application, the applicants will have consulted with and secured the support of other service providers.

Review of the Education funding applications received indicate that the extent of consultation and/or support from other organisations generally, is not clearly stated in their applications. For example:

- Two Education applicants make references to 'working with' and 'integrated services alongside other organisations', but no explicit agreements or plans had been devised prior to applying for funding
- Three other sites indicated that they had informal or preliminary discussions about possible approaches with other service providers/stakeholders such as the local Land Council or Red Cross, but do not provide details.

The models of integration did not necessarily have community input at the time of application, nor were proposals necessarily developed jointly by the Education- and Health-funded organisation. This appears to have been a key factor contributing to delays in implementing CB initiatives.

As CB has evolved, it has become apparent that service integration initiatives must be founded on community input. Initiatives must be community-driven and with agreement by both the Education- and Health-funded organisations on a common approach to their integration model.

There is the need for greater focus on community co-design and strong service partnerships, in the development of a service integration plan and CB funding applications.

A staged approach to site selection and funding is recommended, as follows:

- Education and Health release a joint call for Expressions of Interest (EOI) for seed funding to develop a CB integration model for each site that is co-designed with the community and key service providers and stakeholders. EOI responses should describe the joint Education and

Health service partnership and identify other potential service partners. Proposals should also address all family/clan groups in the catchment area.

- Successful sites are granted seed funding to:
  - Conduct community and stakeholder consultations
  - Develop the integration and governance model and budget proposals for implementation
  - Detail how the nominated services intend to connect with disengaged people or those not connected to them
- Selected sites would then be invited to apply for funding to implement their CB integration service model, as follows:
  - Education organisation apply for implementation funding under current CCCF arrangements
  - Health organisation apply for implementation funding under the IAHP program.

This approach is designed to ensure that:

- Community and stakeholder voices are captured at the model development stage
- Education- and Health-funded organisations work closely on their proposal development, embedding integration from the beginning.

Recommendation

- Revise the funding process to include a staged approach to site selection, whereby organisations initially receive seed funding to conduct community and stakeholder consultations and develop a CB integration model for their site.

5.7 Funding

As detailed in this report, a key learning is the recognition that it takes time to achieve service integration in communities experiencing complex social and economic challenges. The progress of CB sites over the past three years indicates that three years of funding is insufficient time for sites to fully implement a CB initiative and to measure impact.

Some sites reported that funding uncertainty has caused significant issues and concerns, in particular in relation to the ongoing employment of staff and continuity in CB health services. Greater funding certainty would allow additional time for CB Education and Health funding processes, and for CB site establishment and implementation.

Recommendation

- That greater funding certainty be provided to sites, reflecting the lengthy time required to implement an effective CB initiative.

5.8 Program data and reporting

The original evaluation scope included to:

- Evaluate CB projects including their design element, processes and outcomes
- Advise on a CB Outcomes Framework to collect qualitative and quantitative data
- Advise on the measurement of the long-term outcomes of the Program.

In light of the Program evolution and changes over the past three years, AHA has focused on the first two points above, and will address the final point in a separate document – *Phase 2 Connected Beginnings Evaluation Strategy*.

5.8.1 Changed scope of data reporting

The evaluation strategies initially developed by AHA provided information about short-term outcomes to be measured within the scope of the evaluation and medium and long-term outcomes to be measured after the first three years.

Throughout the evaluation, AHA maintained regular communications with Education and Health, mindful that the CB Program was evolving in relation to understanding of CI and PBIs. This resulted in ongoing review and revision of the Evaluation Strategy over the course of the evaluation.

Key changes followed an October 2018 evaluation meeting with Education and Health representatives, where AHA highlighted that:

- Implementation of the Program was slower and more complicated than expected. Given the timeframe of the evaluation, a stronger focus on short-term progress and achievements was agreed
- CB sites were not yet mature enough, nor did they have common data-sharing agreements in place, to begin collecting their own data
- The six-monthly Performance Reporting templates used by the Departments, did not meet the needs of the evaluation in enabling sites to demonstrate the extent of their achievements.

The establishment of the initial conditions for achieving integration has only recently commenced at some sites, commonly in parallel with the delivery of services, and is still to be fully implemented at others. Findings in this report are therefore based on sites' activities and progress towards service integration.

5.8.2 Performance reporting challenges

Review of sites' Performance Reporting data indicates that reporting has been exceptionally challenging for sites, with no Education-funded organisation able to collect and report on performance information as expected. Reasons for this include:

- Lack of small area population information at catchment level, for reasons that include:
  - CB catchments do not always concord with ABS population catchment areas
  - Populations are so small that ABS small area data is not available

  - The transience of the population means that fluctuations in population numbers occur
  - Data quality issues noted by the ABS in Census collections including an undercount of the Aboriginal population and non-response to the Indigenous Status question in the census. (Australian Bureau of Statistics 2018).
- Local service systems constrain what data CB sites can collect and report, and this differs across all sites. As a result, consistent quantitative data was not available to the evaluation across all sites
- Absence of common performance measurement framework. Reaching agreement with health providers and other service organisations has proved challenging in some sites, especially in overcoming data-sharing and privacy concerns. However, two sites in particular have made significant progress, with memoranda of understanding in place to share limited data.

A further challenge for the measurement of outcomes, is the extent to which any change can be attributed to the CB Program. Attribution is difficult for programs where there are:

- Broadly defined target populations
- Multiple programs or initiatives designed to support each other
- Complex social environments in which there are varied and dynamic variables that affect how the program operates (Mayne 2012).

Even where intended outcomes can be measured, it can be difficult to determine whether outcomes are attributable to a specific program. For example, while it is clear that target populations at CB sites have high levels of developmental vulnerability, this data provides no indication about why the vulnerability measures fluctuate or the causes of change across locations.

It is suggested that rather than focusing on attribution, that future data collection focuses on measuring the contribution that CB has made to the outcomes for children and families as well as measurement of the progress towards service integration. This approach will be expanded upon in a separate document – *Phase 2 Connected Beginnings Evaluation Strategy*.

Work is required to support funded organisations to collect the data needed to measure activities and outcomes. This includes a focus on data sharing arrangements, whilst recognising privacy issues between organisations. As CB sites become established, there should be an increased focus for funded organisations to begin to collect data that will monitor and track progress.

Recommendation

That data collection and management be strengthened through:

- Development of a site-specific theory of change that will identify what changes are expected and guide how they are to be measured
- Development of a short standardised minimum dataset that is co-designed with sites focusing on key inputs, activities and outcomes
- A bespoke minimum dataset for each site, based upon the specific aims and objectives of the initiative identifying targeted outcomes co-designed with input from community and local stakeholders
- Resourcing for a centralised position to assist with dataset development, collection, tracking and reporting.

6 Findings: Site-level progress and learnings

This chapter summarises site level progress and findings.

Section 6.1 describes sites' activities, progress, and the key learnings.

Section 6.2 provides an assessment and analysis of sites' progress towards integration. Further details about each site are provided in *Attachment A – Site Case Studies.*

6.1 Progress and learnings

Sites' activities and progress are described under three themes or work streams, as follows:

- Community engagement and co-design
- Education, health and family support service engagement and readiness
- Service integration model development and implementation.

The first two themes are the foundation work for developing an effective integration model. The third comprises the activities needed to successfully deliver integrated services.

6.1.1 Community engagement and co-design

Place-based initiatives are designed to target one or more specific geographical locations and/or population groups in order to bring communities together to collaboratively address a social concern (Wilks et al. 2015). For CB, the goal of the PBIs is to integrate services locally to ensure that children are better prepared for school.

Implementing a PBI with community leadership and engagement through a locally developed governance structure has a much better chance of successfully driving service integration. This structure enables self-determination and facilitates the community's agreement on a common purpose and engagement in CB.

For this evaluation, community engagement and co-design activities were examined under the following aspects:

A.1 – Local needs are identified through meaningful community engagement

A.2 – The community supports the development and implementation of the PBI

A.3 – Education- and Health-funded organisations provide a culturally-safe and welcoming environment.

A.1 Local needs identified through meaningful community engagement

Key learnings

Sites that were successful in this area have Program managers and staff who:

- Are connecting with, listening to and engaging with a wide range of community members. This includes Elders and other community members who experience the difficulties CB aims to address. Engagement may be through governance boards and advisory committees, and is one way CB's importance can be conveyed to the community to enhance its local acceptability
- Employ local people in the CB team, to engage with the community, participate in local meetings, share an understanding of the service network, and conduct outreach, thereby increasing Program reach.

A range of approaches have been used depending on site level needs. In Tennant Creek, for example, using visual aids and having communication in local language was an important consideration for improving community engagement over time. The following vignette describes one of their approaches to community engagement.

Relationship building and awareness raising through a Connected Beginnings poster project

The Tennant Creek Connected Beginnings team knew they needed a visual and practical way to build community awareness so that community engagement could improve over time.

A local artist was approached to develop the artwork for use in the posters. A local Elder employed as the CB Family Liaison Officer, added health and education slogans to the bright, coordinated suite of pictures which targeted parents and children. The positive messages at the core of the posters include slogans such as 'I'll have a try', 'Pick me' and 'I'm ready to learn' were then translated into four languages (Warumungu, Warlpiri, Alyawarr and Wumperani English) in partnership with the local language centre, Papulu Apparr-kari.

The posters will be displayed in various community settings including the supermarket, health centre and in a large format on the side of what the community described as the 'previously old and boring looking' school bus.

Another example is the 1000 Voices community engagement/co-design exercise, a CI approach that uses multiple methods to engage with community members to understand their aspirations and priorities for their children. Engagement can be through one-on-one conversations (door knocking or approaching people in the street), attending community events such as football and netball games to talk with community members and convening yarning circles.

Bridgewater-Gagebrook started their 1000 Voices work soon after they were contracted as part of the CB Program. In March 2019, they had spoken with around 220 people. CBAS also completed 1000 Voices, the data from which will contribute to the Child Friendly Alice Community Profile being released in 2019. CB Mildura has access to 1000 Voices work undertaken in conjunction with Hands Up Mallee.

Several sites have undertaken variations of the 1000 Voices strategy. In Galiwin'ku, Education-funded organisation staff door-knocked in the town and interviewed members of 30 families, gathering data and sharing knowledge about local services along the way. In Alice Springs, a community survey was undertaken by CBAS in collaboration with the Alice Springs Town Council to gather information about the key issues in accessing education, health and support services for children. An example of the CBAS community engagement work is presented in the vignette below.

In Bridgewater/Gagebrook, staff advertised a local community meeting through social media (Facebook) under the name "Chats for Change". Members of the Bridgewater, Gagebrook, Herdsmans Cove and Brighton community were invited. The stated purpose was "to start talking about what we can do as a community for our small children and their families".

Engaging with communities through 1000 Voices

Using CB funding, CBAS engaged with Tangentyere Council, an organisation that provides services directly to the town camp populations near Alice Springs. CBAS identified early on that they would need to work closely with Tangentyere Council to assist them to build trust with community living in town camps.

1000 Voices

1000 Voices is a CI community engagement activity which aims to collect 1000 Voices from the community about what is important to them. This strategy that has been used across several CB sites, each with their own approach to collecting the voices.

In Alice Springs, the CBAS team has worked alongside Tangentyere Council research hub in gathering the 1000 Voices data for the Child Friendly Alice Community Profile. CBAS has collected voices of community members on what they love about Alice Springs, what they would like Alice Springs to have, and what would make Alice Springs a safer place to live.

A.2 The community supports the development and implementation of the PBI

Key learnings

Sites that were successful in this area have Program managers and staff who:

- Have the skills to bring members of the community together to reflect the diversity of the community
- Create a sense of local urgency for addressing the issues associated with improving school readiness in new and different ways.

Having commenced with community engagement activities and having heard the voices of the community, the next challenge for the CB sites is to sustain the local community engagement in the development and implementation of the PBI.

A range of approaches have been trialled to sustain community involvement in PBI development and implementation. One strategy used to garner community buy-in has been sharing results of the 1000 Voices (or similar) community engagement work with the community. This has enabled funded organisations to validate their findings and demonstrate they have listened to the community.

Following is a description of several activities Ngallu Wal in Doonside have undertaken to improve community involvement and build trust in CB.

Building trust with the community – the Doonside story

When AHA first visited Doonside in June 2018, the Education-funded organisation (Ngallu Wal, an integrated Child and Family Centre that provides childcare services to children up to six and support services to children up to eight) was working closely with seven families with young children. Case workers were providing weekly home visits and liaising with parents to ensure children attended appointments, had access to the programs they needed and adequate transport arrangements were in place. At that time, the Health-funded organisation had not been appointed, so the Education-funded organisation undertook case-coordination which was and is a core element of Ngallu Wal's work with families.

The Health-funded organisation (Greater Western Aboriginal Health Service, GWAHS) commenced its CB work in October 2018. The Education- and Health-funded organisations worked together on a strategy to engage more families with young children and provide them with integrated services.

By February 2019, the Education-funded organisation had 36 active families involved in its CB program and GWAHS had 63 enrolled participants. Some of these were shared participants. This increased engagement with families and young children was attributed to the following factors:

- **Providing parent engagement opportunities to make parents aware of CB and the services** it offered. For example, a parent may visit Ngallu Wal for a playgroup or to access the OzHarvest food bank, and CB staff will introduce themselves and the services available
- **Trust building** with families by being able to:
  - Provide timely referrals that did not involve long waiting lists
  - Support parents in attending some referrals e.g. Family and Community Services
- **Promoting CB in the community** through attendance at community events and hosting events such as National Aborigines and Islanders Day Observance Committee week, etc.
- **A holistic approach to family engagement** through:
  - Assessing children to Identify any health or developmental needs
  - Offering referrals to services such as audiology, speech therapy, etc. as required
  - Identifying family needs such as housing, and connecting families with services and advocating for them if required
- CB staff adopting a **holistic approach to child health** and, using a strengths-based approach:
  - **Informing parents of their child's areas of developmental strengths and weakness**, rather than focusing solely on any deficits that may exist (e.g. the child may have good social skills but needs speech therapy)
  - **Supporting/accompanying parents** to access the services needed
- **Being flexible and responding to community needs.** CB child screening is held each Monday at Ngalla Wal. If parents are unable to attend screenings on Monday, alternative arrangements can be made for a Wednesday. Parents are also offered access to services at a location where they feel most safe (e.g. at home, at Ngallu Wal or at GWAHS).

The Education-funded organisation in Galiwin'ku drew on the tradition, knowledge and language of the local Yolngu people to inform communication material and their activities to engage families in a sustained way. Key aspects of community life that were considered in the development of the local initiative were:

- The Yolngu people have a very strong kinship system that supports the community
- Children are taught from a very early age who they can rely on if they are troubled or need help
- "Gurrutu" is the traditional Yolngu way of child-rearing, where raising a child is the entire community's business.

The following vignette shows how local language and knowledge has been instrumental in engaging with families in a sustained and meaningful way and ensuring that CB is based in culture.

The Galiwin'ku approach to involving community in CB development and implementation

The CB team (two local Aboriginal and Torres Strait Islander employees, assisted by a Fly-in Fly-out community development consultant) visualised the Gurrutu model of child rearing as a system of concentric kinship circles to represent the relationships that a child needs to grow up, from infancy to adulthood.

The CB team's Yolngu staff then mapped services on to this "Gurrutu" system, arranging services needed at each life-stage in the circles.

This approach allowed the team to communicate to community members and service providers about their place (and responsibilities) in a child's life-stages. It also allowed the team to visually communicate the direct and indirect impact of services on a child's development, based on the service's location in the system.

In the Gurrutu model, the innermost circle contains the child's parents and grandparents representing the people most intimately involved in caring for a baby/infant. The circles grow to include immediate family, then the family group, kinship group, clan group and finally broader society, each larger circle corresponding to the next stage of a child's life. The outermost circle represents that an adult is expected to know their responsibility to and interact with all relationships in the smaller circles as well as society at large.

In the service model that was developed as an overlay to the Gurrutu model, maternal and child health and early childhood services were in the innermost circle, followed by school, immunisation services in the next and so on, with broader services and themes such as employment, tertiary education and government support in the outermost circle.

A.3 Education- and Health-funded organisations provide a culturally-safe and welcoming environment

Key learnings

Sites that provide a culturally safe and welcoming environment:

- Demonstrate a commitment to working in partnership with Aboriginal and Torres Strait Islander peoples in all aspects of the Program
- Provide outreach services as appropriate, to connect people with services in a culturally-safe environment
- Understand that some members of their target population may be hard to reach for a variety of reasons, and they make specific plans to connect these individuals and families with access to culturally-safe services
- Recognise that recruitment, retention and professional development of Aboriginal and Torres Strait Islander personnel is a fundamental factor in providing culturally-safe services
- Communicate in local language where appropriate
- Provide a welcoming environment at the Education-funded organisation (where members of the community are expected to visit)
- Ensure that ACCHOs are culturally safe for the Aboriginal and Torres Strait Islander population of the whole of the catchment area and/or ensure services are provided to people who do not feel culturally safe at the ACCHO are provided at a location that considered safe by them (e.g. their home, through outreach activities).

Through CB work, several sites have made new connections or strengthened pre-existing connections with local Aboriginal and Torres Strait Islander communities and Elders. This work has contributed to developing culturally-safe and welcoming environments within the funded organisations. Obtaining the support of the Elders is particularly important in building trust and conveying to community members that CB and/or its staff are accepted. In some cases, Elders have accompanied CB staff in outreach to families.

At several sites, CB supports activities that facilitate Elders being involved with children in activities such as gardening (Doonside), traditional craft groups (Alice Springs), and painting classes for children (Bridgewater-Gagebrook). This provides opportunities for cultural education and for Elders to connect with the children. Furthermore, by working closely with a CB team, Elders can gain greater understanding about the linkages needed between health, education and members of the community to support children being healthy and ready to start school.

The display of local artwork, flags and iconography is used at many sites to present a culturally-safe and welcoming environment. This can also be extended to meetings and engagement activities. In the early stages of Program development, the Mount Druitt CB team used traditional song and dance, performed by local children, to officially launch their Program to the community and local service providers.

Providing a culturally-safe and welcoming environment has also been strengthened through employing local community members in CB teams. The success of such activity is demonstrated in the vignette

below, which describes how Ceduna's Community Cultural Mentors have contributed to a culturally-safe and welcoming environment.

Harnessing local knowledge in the workforce

The Education-funded organisation in Ceduna (NYCFC) has focused on building the capacity of the local community by recruiting Community Cultural Mentors for CB and providing them with extensive training opportunities. The NYCFC Community Cultural Mentors and the CKAHSAC AHW are members of the local Aboriginal and Torres Strait Islander community and have strong rapport with the community. These personal connections have led to pregnant women and mothers actively seeking out these CB staff when needed as it is a culturally safer alternative than approaching the hospital.

Their position has enabled the Cultural Mentors to reach out to members of the community outside of NYCFC in more relaxed settings where they ask community members questions about their lives, their needs, their children and whether or not their children were attending school and getting health checks. This approach has increased awareness of CB within the community and enables more organic contact with community to take place.

Cultural Mentors also conduct home visits for families of children enrolled at NYCFC who have difficulties with attendance, sickness, lack of routine or family breakdown. Cultural Mentors help new parents manage the transition to parenthood and support preschool enrolment.

All sites understand the crucial need to employ and work in partnership with Aboriginal and Torres Strait Islander peoples. Employing Aboriginal and Torres Strait Islander peoples on PBI teams is not only important in the context of the Health-funded organisation but also the Education-funded organisation, because of the cultural capital and insight the community members bring to the Program.

In rural and remote locations, CB team members use visits to outlying communities to build relationships and understand the specific needs of the children and families living in these areas. Critical to this approach is ensuring that when outreaching to these communities the funded organisation is doing so in a culturally respectful manner. In Alice Springs, the CBAS team has partnered with Tangentyere Council, a social services organisation with strong links to the surrounding town camps to build their trust with these communities and demonstrate their culturally-safe and welcoming approach.

In Ceduna, the Ngura Yadurirn Children and Family Centre is developing a cultural garden, one of the key features of which is the Waterhole Storyteller artwork. Developed by local artists, and based on consultation with the community, it includes animals, bush tucker and other environmental features around a waterhole. This tactile, mosaic style artwork was unveiled at a community event organised by the CB team during Reconciliation Week in 2019.

Figure 6-1: Waterhole Storyteller artwork, Ceduna

Source: Ngura Yadurirn Children and Family Centre, Ceduna, SA

Similarly, the foyer of the Ngallu Wal Aboriginal Child and Family Centre (Doonside) is furnished in Aboriginal and Torres Strait Islander art-inspired décor and opens out on to a bush garden, where children can sit with Elders. For those members of Aboriginal and Torres Strait Islander communities that are not already well connected into available services, outreach services generally provide a more culturally-safe and welcoming environment. This allows community members to utilise services in a location that is more familiar or convenient for them, rather than having to visit a location that causes them discomfort or has a negative historical past.

6.1.2 Education, health and family support services engagement and readiness

The CB Program is predicated on education, health and family support services exhibiting a strong appetite for service integration. For service integration to be achieved, participating organisations must understand their respective roles in the PBI.

In this evaluation, education, health and family support service engagement and readiness are examined under the following themes:

B.1 – Consultative and collaborative local leadership of the PBI is in place, with robust and representative governance arrangements

B.2 – Organisations have the capacity to liaise with stakeholders to achieve service integration

B.3 – The workforce possesses effective skills to implement the PBI.

B.1 Consultative and collaborative local leadership of the PBI is in place, with robust and representative governance arrangements

Key learnings

Sites that are successful in this area have a local Program management team that:

- Is actively supporting aligned activities through convening stakeholders and recruiting new partners
- Has established decision-making and reporting processes
- Has developed or joined with a transparent governance structure that is sufficiently representative of those with a stake in the system
- Have built or joined strong service provider networks that will facilitate the engagement of a broad, cross-sector group of stakeholders.

All sites have made progress towards achieving strong consultative and collaborative leadership. This has been achieved in three distinct ways:

- The Education-funded organisation has driven consultation and collaborative leadership as a result of the CB Program
- The Education-funded organisation has joined an existing consultation/collaborative leadership forum that existed prior to CB
- Work has commenced to develop a strong consultative and collaborative local leadership initiative.

Sites where the Education-funded organisations have driven consultation and collaborative leadership include Mount Druitt and Galiwin'ku.

In the early stages of implementation, Ngroo Education in Mount Druitt held several consultative and collaborative meetings with a broad range of sector stakeholders (education and health service providers, family and community services, local community members and representatives of a

philanthropic organisation). These meetings supported an integrated approach to defining the problem and brainstorming of how organisations could work together.

The Education-funded organisation in Galiwin'ku has revitalised a Child, Family and Youth network of service providers which lost momentum and stopped meeting several years ago. The Education-funded organisation's CB staff (who are local Yolngu Elders) developed communication resources and strategies, including a CB and early childhood services information kit for service providers. This allowed CB staff to effectively engage with service providers to widen and deepen early childhood service coordination and reconvene the Child, Family and Youth network.

Sites where the Education-funded organisation has joined an existing consultative forum include Alice Springs and Mildura.

In Alice Springs, the local CB management team is actively supporting aligned activities through convening stakeholders and recruiting new partners through their work in the Child Friendly Alice initiative. This has taken the form of consulting with the broader service sector on bolstering service integration and highlighting the role one CB staff member is playing in case coordination between agencies for those children requiring linked up services.

Mildura's progress is highlighted in the vignette below.

Leveraging an existing Collective Impact initiative – Mildura

At the commencement of CB in Mildura, the Education-funded organisation became aware of Hands-Up Mallee, a well-resourced CI initiative for the broader Loddon-Mallee region. Hands Up Mallee was established to gather local service providers, leaders and the community together to address social issues and improve health and wellbeing outcomes for children, young people and their families in the region. Hands-Up Mallee has several long-standing working groups responsible for the 0-8-year-old age group.

The Education-funded organisation recognised the synergies between Hands Up Mallee and CB's goals. It also became apparent that establishing a separate reference group for CB would duplicate the existing Hands Up Mallee working groups and be counterproductive. As a result, CB in Mildura became a permanent agenda item for all relevant Hands Up Mallee working groups. These working groups have enabled MPS to identify opportunities to improve service coordination.

During working group meetings, it was brought to the Education-funded organisation's attention that some families in Mildura and the surrounding area do not receive any services due to a lack of formal identification. This was illustrated in a case discussed at a meeting by a representative of one of the schools in Mildura:

> *We had a case where a child come to school without a birth certificate and with signs of developmental delays. When the child was born, the family walked out of the hospital and didn't register the birth. They did not know they were supposed to do it, let alone how to register the birth. This meant that they had no proof of identity for the child.*

This prompted Education-funded organisation staff to visit the hospital and other health facilities to talk to expecting mothers, fathers and families to raise awareness about the need for registering births. The team also discuss available services and ways they can assist the family.

Some sites are in the early stages of setting up a consultative and collaborative leadership entity, including Doomadgee and Tennant Creek. Of all the dual-funded CB sites, Doomadgee's governance of the PBI is not yet sufficiently representative of the target community. However, a recent public meeting is expected to increase momentum for change and a representative governance structure at this site.

Tennant Creek's achievements in this area are highlighted in the vignette below.

Tennant Creek – Getting people together and building momentum for change

The Tennant Creek (CB) Early Years Reference Group has been meeting monthly since the start of 2019. Local service providers working with the 0-5-year-old cohort are well represented. Meeting attendees include primary school teachers, Families as First Teachers workers, Julalikari playgroup, HIPPY staff, NT Health workers (including Maternal and Child Health nurses), staff from Anyinginyi Health Corporation family programs and local NGOs.

AHA staff attended the March 2019 meeting as observers. The CB Director and Family and Community Engagement Manager are clearly well liked and respected in the community. There were high levels of buy-in observed and a genuine feeling of an emerging cohesion among group members. There was a group understanding of the need to work differently and move away from siloed approaches.

B.2 Organisations have capacity to liaise with a wide range of stakeholders to achieve service integration

Key learnings

Sites that are successful in this area have:

- An Education- and Health-funded organisation that have the capacity to liaise with government, service providers and also the flexibility and skills to authentically engage and respond to all parts of the local community including different Aboriginal and Torres Strait Islander families/kinship groups
- Changes occurring locally through their collaborative work and/or multi-sector collaboration that is helping to join up local services
- Been able to build a culture of collaboration (or capitalise on an existing one) among organisations more broadly involved in the Program.

CB-funded organisation staff and management must have the requisite skills to liaise with varied levels of government and local stakeholders. This has been important at sites where the service landscape is complex and multiple government initiatives are taking place. For example, in Alice Springs the CBAS team must work within a complex service landscape in which services have jostled for funding over many years. Often these services will be sceptical of any new initiative and being able to engage with these services effectively and sensitively is essential for progressing the PBI.

In Mount Druitt, early consultations attracted a wide range of service providers in the community. Of note was the attendance of Family and Community Services (FACS). Acknowledging that it had a poor reputation within the community, FACS communicated its desire to reset relationships and work alongside the community in the CB project. Ngroo Education were able to welcome FACS to early meetings and balance what can be at times tense meetings between services and community.

In Tennant Creek, the CB team has had to ensure its work sits within the broader Barkly Regional Deal. The Regional Deal provides a $78.4 million funding commitment from the Australian Government, the NT Government and the Barkly Regional Council. This funding is focussed on overcoming key issues that have been identified through community consultation.

As the Regional Deal is still in the planning phase, it is currently unclear what role the CB team will play (although it intends to be closely involved). It has been suggested that they will support the Decision-Making Table of the Regional Deal in any community-led initiatives concerning children in the early years. There are synergies between the Deal and CB's work, but the Deal also presents a challenge to ensure duplication of effort is minimised. This will rely on the CB team being able to liaise closely with all levels of government involved.

Engaging with stakeholders to improve outcomes for children has been a strong focus of work for some sites. In Doonside, the Health-funded organisation has used CB funding to direct resources in innovative ways. This work is highlighted in the vignette below.

Doonside – Building trust to achieve service integration

Prior to Connected Beginnings (CB), the Health-funded organisation (Greater Western Aboriginal Health Service, GWAHS) and the Education-funded organisation (Ngallu Wal) had limited interaction. As a result of CB, these two organisations have developed strong working relationships which, in turn, has seen a marked increase in service uptake by the community.

As part of CB, GWAHS and Ngallu Wal have established **effective partnership arrangements** with:

- **Westmead Hospital**. As a result, audiology and ear, nose and throat (ENT) services are being provided by staff from Westmead Hospital and GWAHS at the GWAHS facility location since December 2018
- **Sydney University**. GWAHS provides Sydney University speech therapy students with opportunities for gaining experience in working with Aboriginal and Torres Strait Islander families.

Collectively, these two partnerships have resulted in reduced wait times to access an audiologist, from 18 months in 2018, to a maximum of two weeks in early 2019. CB funding has enabled both funded organisations to focus on innovative ways to address service gaps in the community. Importantly, these innovative approaches require dedicated resourcing and collaboration, two fundamental areas supported by the CB Program.

B.3 Workforce has the appropriate composition and effective skills to implement the PBI

Key learnings

Sites that were successful in this area have:

- Been able to attract and retain staff to ensure their team can work towards effectively establishing the PBI
- Staff who are continuously learning and managing the process of building a successful PBI
- Aboriginal and Torres Strait Islander team members (preferably from a range of family/clan groups as appropriate to the setting) who are an integral part of the PBI
- Built organisational and human resource capacity that is sufficient to foster sustainability within the Program
- A workforce with a variety of skills and experience to suit the needs of the PBI including a skilled and experienced leader who has community development, CI or other PBI model experience.

CB leaders require a wide range of skills including an ability to connect, be accepted and trusted by local people in their communities. While appointing local people with the requisite skills in management positions can overcome challenges of trust and staff attrition, the pool of candidates for such positions is small.

Most sites have faced difficulties in attracting and retaining a skilled workforce. The most progressed sites tend to have highly skilled management teams, often with CI or community development backgrounds. To optimise workforce development in CB PBIs, the following strategies have been employed at various sites:

- Where possible, local Aboriginal and Torres Strait Islander peoples are employed in CB roles. These team members can be mentored and supported to continuously improve their skills and provide community connection
- Aboriginal Health Workers and other members of the community are supported to complete and formalise education (Ceduna, Doonside and Doomadgee)
- Highly skilled staff in management positions that can leverage their experience working within complex service environments to bring all stakeholders to the table
- Appropriate incentives are offered to work in very remote and challenging conditions
- Lateral thinking about how community members could be employed and trained – with the aim of providing jobs and training and importantly, stability of the initiative
- Leaders with a background in community development or CI are appointed and trained.

6.1.3 Develop and implement a service integration model

Upon establishing meaningful and sustained community engagement, and a service sector that has the capacity and willingness to support the initiative (work streams A and B), service integration can then become a key focus of the PBI (work stream C).

Service integration can take many forms and a tailored approach is needed at each site to meet the unique needs of each community. The extent to which a service integration model has been developed and implemented at each site is discussed under the following headings:

C.1 Data is being collected and shared to inform decisions and drive service integration

C.2 Service delivery is coordinated and integrated.

C.1 Data is being collected and shared to inform decisions and drive service integration

Key learnings

Sites that were successful in this area have:

- Discussed, agreed and planned a shared measurement strategy and have started to discuss possibilities for its development
- Systems in place to track the Program progress from a process and system level perspective
- Started to collect data to inform decisions and enable evaluation of the Program
- Stakeholders who are sharing information and results
- The ability to use their data to adapt to the challenges and opportunities.

Several CB sites have started to discuss the data they may be able to collect to measure their progress. However, for most sites, data collection and measurement strategies are in the very early stages of development. In several cases, this is because CB teams are trying to understand the data that may be relevant and address the privacy issues associated with the collection of data.

In Doonside, stakeholders are sharing results and data is being used to understand and adapt to emerging challenges and opportunities. The Education- and Health-funded organisations meet weekly to share information and identify barriers to service provision such as wait times to see allied health practitioners. The CB team leverage relationships with local providers to rapidly put supports in place when required. For Doonside, the development of a shared understanding of data collection and a protocol for data sharing has been important in developing trust between the funded organisations.

At the other end of the data spectrum is Mildura, which has yet to commence work in the area of data collection. The Education-funded organisation is an active participant in Hands Up Mallee which has a clear roadmap for a shared measurement system. Hands Up Mallee has achieved substantial progress in this work, employing a resource and measurement enabling team which has mapped available data sources and is building local capacity in data measurement and sharing. However, this work is still developing and stakeholders are not yet sharing results or learning from data to improve the Program. In contrast, there is currently no shared measurement strategy between the Education and Health-funded organisations. Stakeholders attributed these challenges in data sharing to a lack of common

understanding about CB and the roles of Education and Health-funded organisations in relation to each other.

C.2 Service delivery is coordinated and integrated

This section presents findings from AHA's assessment of the contribution co-location has made to service integration. As originally envisaged, CB service co-location would occur at two levels at each site:

- Co-location of Education-funded organisations with a school
- Co-location of Health-funded organisation services at the Education-funded organisation site.

Co-location of Education-funded organisations with a school

Ten of the 13 Education-funded organisations are located on or in close proximity to school grounds. At the outset, co-location of Education-funded organisations with a school was seen as a crucial element of CB PBI development. However, this has not always been possible or desirable. As the Program has matured, co-location was given less prominence as a required feature of the CB PBI. The funded Child and Family Centres located away from school grounds appear to be working towards a successful PBI in much the same ways as sites co-located with schools.

In Angurugu, the Education-funded organisation is having discussions about not being based at the school as the school has had a very low attendance rate (25-30%) for many years. Of the 14 clans on the island, some are more likely to have their children attend school than others. For these reasons, situating the Education-funded organisation at the school may result in minimal reach into the community, particularly for the hardest to reach families.

Overall, however, co-location of Education-funded organisations on or near school grounds has been largely achieved.

Co-location of Health-funded organisation services at the Education-funded organisation site

To facilitate integrated service provision, there was an expectation that Health-funded organisations would provide services on the Education-funded organisation site.

This level of co-location has proved to be challenging for several reasons. Education-funded organisations may not offer enough privacy or adequate space for families to feel safe, and they are often not designed for clinical consultations (noise or lack of hand basins and examination couches). Furthermore, Education-funded organisations may have small waiting areas that do not provide a quiet environment (a difficult space for some children with behavioural issues) or are not suitable for accreditation for the delivery of safe, quality health care. Despite these challenges, some co-location has taken place.

Four of the nine Health-funded organisations are delivering services at least weekly at Education-funded organisation sites. At Taree and Angurugu, services are delivered at the Education-funded organisation site on most days of the week. Bridgewater-Gagebrook and Doonside host service delivery for some time each week at the Education-funded organisation site, while in Mildura, services are delivered at least monthly.

One-off Health-funded organisation services have been delivered at the Education-funded organisation premises in Ceduna and Alice Springs. At these sites, CB has facilitated one-off screening sessions for preschool children. It is planned that this will happen each year for the pre-school cohort of children. The Health-funded organisations in Doomadgee and Galiwin'ku are not delivering any services at the Education-funded organisation site. However, in Galiwin'ku there is a new Health-funded organisation nurse who will be visiting FaFT and the Baby Hub each week as part of her CB work.

Where Health-funded organisations are not providing services regularly on Education-funded organisation premises, other strategies have been put in place to ensure they are providing an improved service offering.

At Galiwin'ku, mothers with young children prefer to visit the newly built facilities housing FaFT and the Baby Hub rather than the Education-funded organisation premises. Consequently, the CB nurse provides services in the new facility. In Mildura, MDAS employs a CB MCH nurse for one day per week at the Education-funded organisation. In Ceduna, rather than provide a regular nursing presence at the CFC, Koonibba provides on-site health checks at the CFC, as well as outreach to other early childhood sites concentrating on hearing health, 715 health checks and immunisations for young children. At Doonside, clients are seen at Ngulla Wal, GWAHS and at their home as suits the clients.

Key learnings

- Co-location of an Education-funded organisation on or in close proximity to a school does not, at least at this early stage of implementation, seem critical for PBI success in progressing towards integration of services.
- Given the different priorities and contexts at each site, it does not appear that co-location is important to integration of services aside from the messaging that the 'working together' aspect conveys. In some circumstances, such as Mildura and Galiwin'ku, it seems more prudent to provide the services off-site where they are most needed, at least until such time as there are members of the community are regularly visiting the Education-funded organisation.
- Relatively little progress is evident in the co-location of health services provided by the Health-funded organisation at Education-funded organisation sites. It is unclear if this is meeting the needs of the community, and this will require investigation at some stage in the future.
- Provision of Health-funded organisation services on the Education-funded organisation grounds does not seem to be critically important if there are other mechanisms in place to ensure children are receiving adequate health screening and other health services including appropriate referrals and timely follow-up.
- All sites are progressing towards integration, whether or not they are co-located with an Education-funded facility or the extent to which Health-funded organisations are providing Health services on Education-funded organisation grounds.

6.2 Measuring progress towards service integration

This section provides an assessment and analysis of sites' progress towards integration.

6.2.1 Assessing integration

The CB Program was designed to support the integration of early childhood education, maternal and child health and family support services with schools, in order to deliver services seamlessly to the child and family at the centre of all activities.[15] To assess the extent to which service delivery is integrated at site level, AHA developed an Integration Assessment Tool using Moore and Skinner's (2010) five-point continuum. This continuum includes, in order of increasing integration:

- Coexistence – services operating independently of one another, with no sharing of information or resources
- Cooperation – involving low-intensity, low-commitment relationships in which parties retain their individual autonomy but agree to share information (e.g. networking)
- Coordination – involving medium-intensity, medium-commitment relationships in which the parties retain their individual autonomy but agree to some joint planning and coordination for a particular time-limited project or service (e.g. regional referral committee)
- Collaboration – involving high-intensity, high-commitment relationships in which the parties unite under a single auspice to share resources and jointly plan and deliver particular services
- Integration – a complete merging of services to form a new entity (Moore & Skinner 2010).

Service integration was assessed from two perspectives:

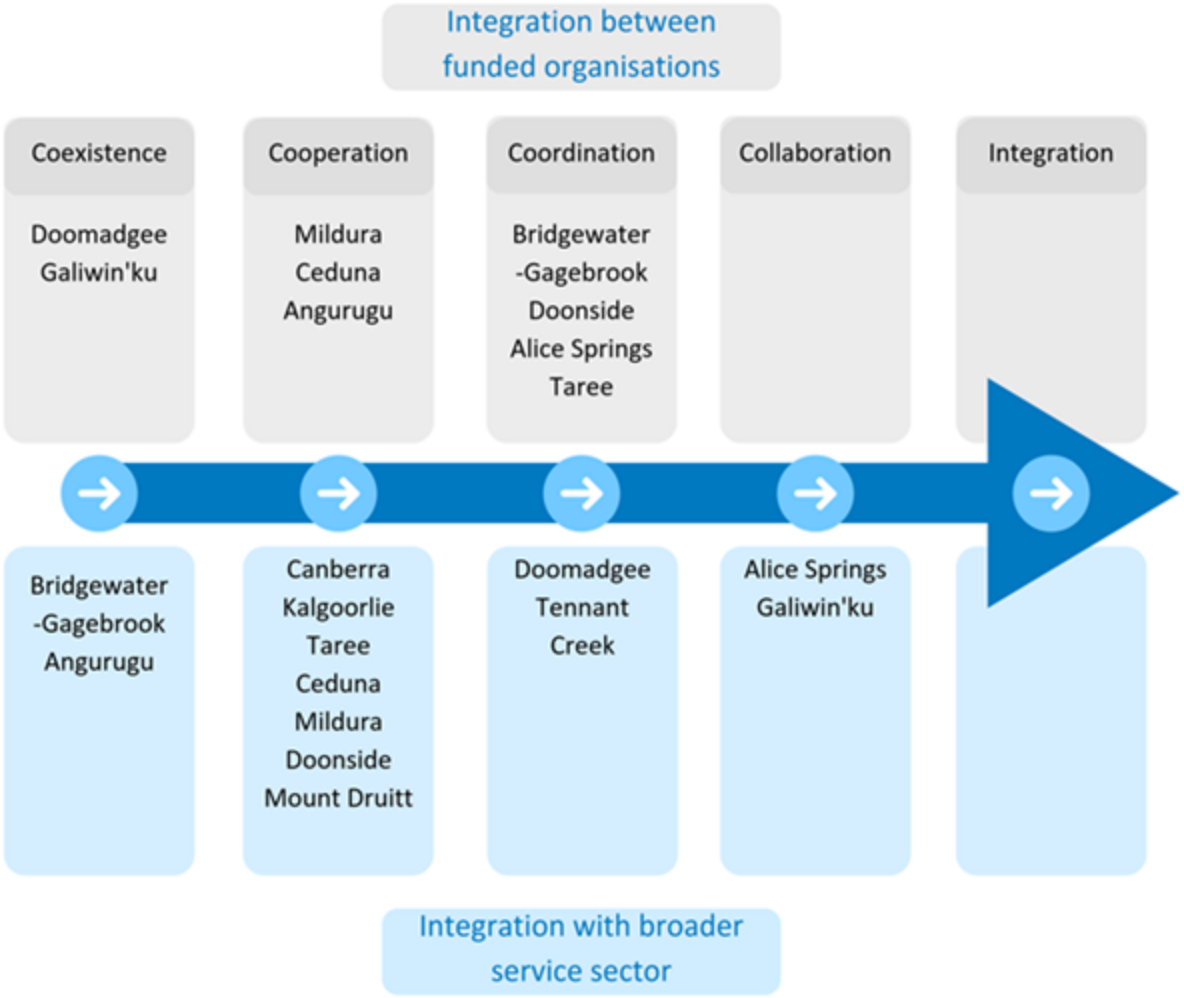
- Integration between the two CB-funded organisations (where applicable)
- Progress made by Education-funded organisations in integrating service provision with the broader service sector in the CB catchment area.

Figure 6-2 illustrates the results of the two assessments of service integration. This figure does not account for the length of time CB has been funded in these communities as this factor does not appear to be a primary consideration in achieving integration progress at either the site or broader community level. This aspect of integration progress is discussed in more detail in *Section 6.2.4*.

At the top of the figure, the sites are placed according to the extent the Education- and Health-funded organisations are integrated as of April 2019. At the bottom of the figure, under the arrow, the sites are placed according to the assessment of the Education-funded organisation's progress in integrating service provision with other organisations at the CB site as of April 2019.

[15] Kalgoorlie and Tennant Creek are Education-only sites and Canberra is a Health-only site, so measures of integration are not relevant related to other CB-funded organisations. Mount Druitt and Port Augusta are not rated as their programs are currently on hold as a result of staff changes

Figure 6-2: Integration continuum – Education- and Health-funded organisations and the broader service sector in a CB site location



Tennant Creek, Canberra and Kalgoorlie are not included above as these sites are funded by only Health or Education. Integration was not assessed for Port Augusta and Mount Druitt due to current local program resets being undertaken.

6.2.2 Integration of Education- and Health-funded organisations at site level

As illustrated in *Figure 6-2* several sites are at the **coordination stage** of integration:

- Bridgewater-Gagebrook, where TAC approached the Education-funded organisation to ensure they were able to provide onsite services quickly after contract signing. The organisations work together to plan and coordinate service provision
- Doonside, where the Education-funded organisation and Health-funded organisation regularly meet for joint planning of service integration for children and their families
- Alice Springs, where regular meetings are being held to work through any CB related issues and concerns, and to continue building stronger relationships between traditionally siloed service providers. Privacy of data is managed to the satisfaction of both organisations and is discussed regularly
- Taree, where there is a history of the Health-funded organisation being located on school grounds and providing services to young children attending the centre at the school for playgroups.

Mildura, Ceduna and Angurugu are at the **cooperation stage**:

- Mildura – Clinical facilities have been built at the Education-funded organisation and the Health-funded organisation has only recently agreed to attend for service provision
- Ceduna – There is limited interaction between the Education- and Health-funded organisations. Both parties are attending meetings associated with early childhood, but interaction is limited
- Angurugu – Although co-located on school grounds, there has only been basic interaction between the staff. This is primarily due to the Education-funded organisation only recently employing CB staff.

Doomadgee and Galiwin'ku are currently at the **coexistence stage** of integration, with the Education- and Health-funded organisations operating independently of one another without sharing data or resources.

Key learnings

The level of CB-funded organisation integration appears to be independent of the time that a site has been operational and more likely to be associated with site contextual factors.

Factors such as the early establishment of a working relationship (or the leveraging of already established relationships), the presence of, suitable physical facilities, understanding of and management of potential or actual privacy concerns, and levels of trust established all appear to facilitate progress towards integration.

6.2.3 Integration with the broader service sector at site level

The integration continuum assessment was also applied to each Education-funded organisation's progress in integrating service provision with the broader service sector in the CB catchment area.

Linkages and connections are a key aspect of the Education-funded organisation's CB work as it is the 'glue' that is essential for service integration. This is achieved by linking and connecting between CB organisations and other community service providers. Achievements in linkages and connections include engaging with other service providers through:

- Working with local service providers and other associated programs
- Establishing referral pathways
- Improving the numbers of children being referred to and seen by other professionals
- Relationship building with local community organisations
- Investing time in collaborating with non-CB schools and ACCHOs
- Staff getting into the community and hosting/attending/contributing to events, thus making CB more visible and raising awareness of the Program
- Partnering with other service providers to collect community voices.

Integration findings for the broader service sector in the CB catchment area:

- Alice Springs and Galiwin'ku are at the **collaboration stage** of the integration continuum. Both sites are united under a single auspice to share resources and jointly plan the delivery of services.
- Doomadgee and Tennant Creek are at the **coordination stage** of integration. Both sites are convening meetings where there is some joint planning and coordination happening. The meetings are well attended and held regularly.
- Canberra, Kalgoorlie, Taree, Ceduna and Mildura are at the **cooperation stage**. They are doing some networking with stakeholders more broadly than just the Education- and Health-funded organisations. Doonside is also at the cooperation stage, but report being constrained by the catchment area of their CB work and the broader work of the Ngallu Wal organisation. When Mount Druitt was last assessed, prior to the end of 2018, it was at the cooperation stage with a wide group of service providers.
- Bridgewater-Gagebrook and Angurugu are currently at the **coexistence stage** of wider service sector integration. Both sites are in the very early stages of implementation and are currently concentrating on relationships between the Education- and Health-funded organisations before broadening their reach.

6.2.4 Progress towards service integration at CB site level

Figure 6-2 shows that although it was assumed that CB-funded organisation service integration would, by example, assist with broadening service integration to other service providers in the CB site location, this has not been the case.

As can be seen in *Figure 6.2*, integration between the Education- and Health-funded organisations, and integration with the broader service network can occur independently of one another. This illustrates that relationship development and integration do not progress at the same time for the two funded organisations and the broader service sector. Nor is the progress along the integration continuum steady or predictable, or related to time elapsed since Program commencement – at least not in the early stages of a Program such as CB.

The progress on the integration continuum for the funded organisations at site level is most closely related to the skills and experience of the CB management teams at the Education- and Health-funded organisations. Sites that are most progressed along the integration continuum generally have pre-existing relationships at organisational or site staff level (Taree). In the case of Bridgewater-Gagebrook and Doonside, to ensure CB work could commence as soon as possible after funding was confirmed, site staff formed new relationships as quickly as possible. In the case of Alice Springs, the CBAS team methodically and jointly worked through issues preventing service integration to a point where progress has been made with the agreement and buy-in of both funded organisations.

The progress on the integration continuum for the Education-funded organisation and the broader service sector at site level is most closely related to the connections the CB Director has in the community of service providers due to prior work in the area (Alice Springs and Tennant Creek). Further facilitators of integration include the engagement of Elders and a skilled facilitator to lead the broader service integration work in a small community (Galiwin'ku) and the CB Education-funded organisation connections to other service providers (historical and family related connections). In Tennant Creek, the Barkly Regional Deal has also ensured the service providers are motivated to bring about community level change for children (including those not old enough for school).

Key learnings

The progress on the integration continuum for CB-funded organisations at site level is most closely related to the skills and experience of the Education- and Health-funded organisation CB management teams. There are several factors that have resulted in most progress on the integration continuum between funded organisations:

- Relationships existed prior to CB funding commencement (Taree)
- Site staff have forged new relationships as quickly as possible after funding was confirmed to ensure CB work could commence (Bridgewater-Gagebrook, Doonside)
- Site staff have methodically and jointly worked through issues preventing service integration to a point where progress has been made with the agreement and buy-in of both funded organisations (Alice Springs).

The progress on the integration continuum for the Education-funded organisation and the broader service sector at site level is most closely related to:

- The connections the CB Director and other staff have in the community with service providers due to prior work in the area (Alice Springs and Tennant Creek)
- The engagement of Elders and a skilled facilitator to lead the broader service integration work in a small community (Galiwin'ku)
- The CB Education-funded organisation staff have connections to other service providers (historical and family related connections) (Doomadgee)
- Concurrent initiatives taking place alongside CB, for example the Barkly Regional Deal which has ensured the service providers are motivated to bring about community level change for children (including those not old enough for school).

Appendix A Program logic

A.1 Iterations

As indicated *in Chapter 2* of this report, the evaluation of CB has used a program logic approach. The progressive roll out of CB has resulted in multiple iterations the Program Logic (PL) diagrams that underpin each Evaluation Strategy (ES). The following summarises these iterations.

ES V1.0 (June 2017) was developed during the early stages of the Program. It provided an initial high-level overview of AHA's approach to evaluating the short-, medium-, and long-term achievements and outcomes of the Program within the two-year evaluation timeframe to mid-2019. Preliminary indicators/measure and potential data sources were also included in what was considered to be a formative and summative evaluation at that time.

ES V2.1 (Sept 2017) further refined the approach proposed in the ES V1.0 and was informed by findings from AHA's initial consultations with key stakeholders and ongoing discussions with the Departments. While the ES continued to consider the Program from inception to the achievement of its targeted longer-term outcomes, delayed Program implementation progress meant that the Evaluation could only measure short-term outcomes within the evaluation timelines.

Accordingly, ES V2.1 was modified to:

- Focus specifically on all elements of the program logic up to and including short-term outcomes
- Include evaluation and sub-evaluation questions, as well as data sources for use in assessing whether short-term outcomes were being achieved
- Provide advice on potential indicators and data sources for use in measuring medium and long-term outcomes.

PL V3.0 (August 2018) was developed to support further refinement of the ES to reflect the ongoing evolution in the Program, as identified through extensive engagement with the Departments and funded sites via site visits and teleconferences. Several key changes had occurred since September 2017 which were incorporated in V3.0:

- Program interest in CI. The CI Symposium in Adelaide in February 2018, which was attended by representatives from several CB sites, Education, and AHA's evaluation team, provided the impetus for articulating more clearly, Program interest in CI approaches. At some sites, this approach was operationalised through mentoring by CI consultants
- Increased jurisdictional department involvement in the Program. For example, a CB Director was appointed in the NT. This meant that the four NT CB sites had a level of management oversight and capacity building that differentiated them from sites in other jurisdictions
- The clarification that case management should not be delivered by Education-funded organisations but arranged within existing services

Collectively, these changes resulted in a redistribution of items within the Inputs, Assumptions and Context elements of the PL diagram. A revised PL diagram was presented to the Departments in August 2018 for approval prior to submission of ES V3.0, which was under development at the time.

A Program reset occurred in late 2018, brought about by Education and Health agreeing that the PL needs to reflect:

- That CI is the approach underpinning the CB Program
- The stronger focus on short-term achievements at site level (Evaluation Working Group (EWG) fortnightly teleconference 3 October 2018).

The Program reset resulted in two further versions of the ES:

- **ES V3.1** that sets out the evaluation response to the Program reset. It covered the period January – June 2019 and included further revisions to the PL V3.1
- **ES V4.0** that will be submitted at the end of the current contract period (June 2019) and provide information to guide the evaluation of the Program going forward.

A.2 Program logic version 3.1

The changes incorporated into the inputs and assumptions of V3.1 reflect discussions between AHA, Education and Health in Canberra on 17 December 2018. These incorporate a more developmental, placed-based evaluation design, concentrating on the early stages of Program implementation.

These changes provided the foundation for developing additional evaluation questions to:

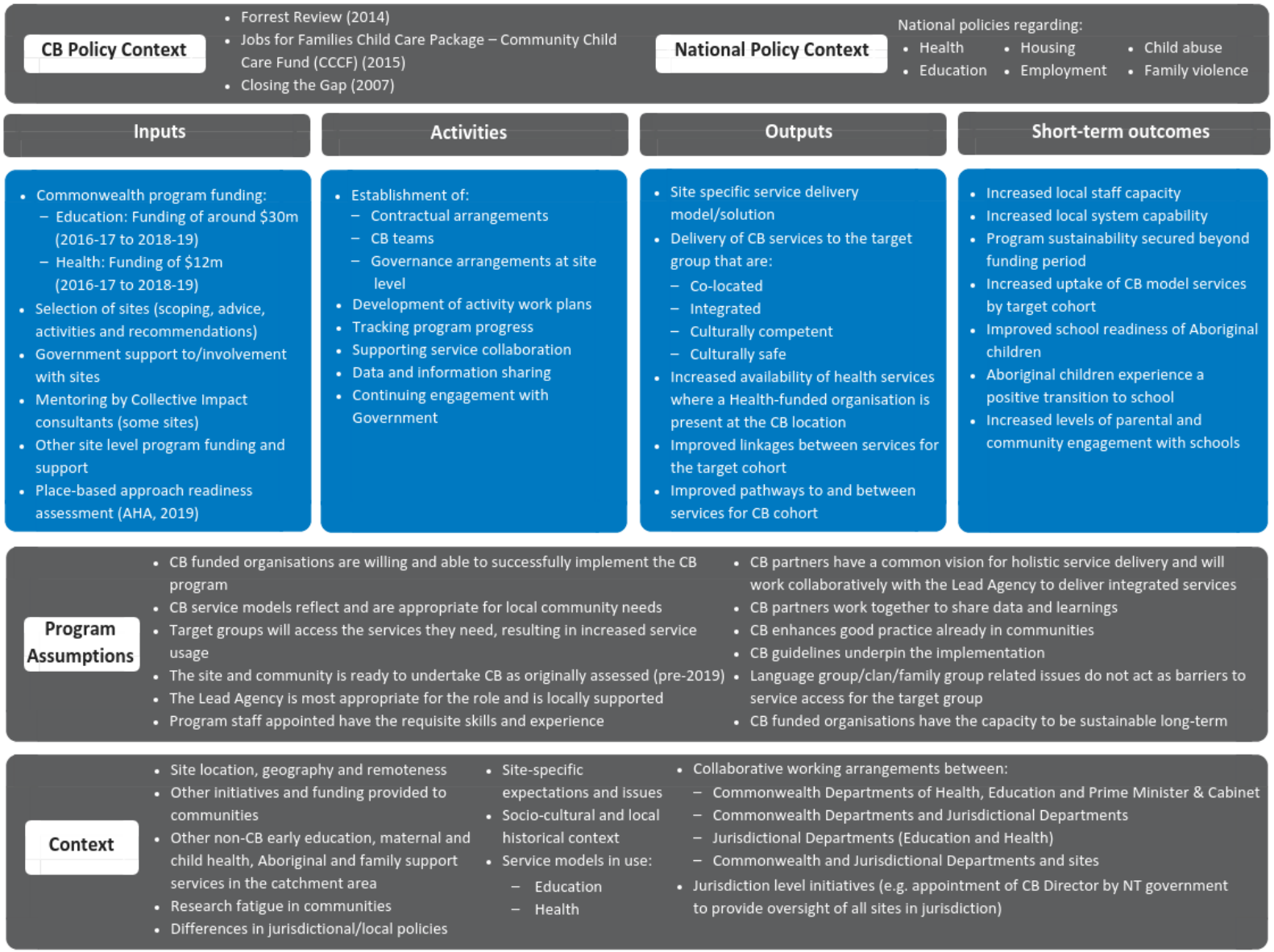
- Be used during the final round of site visits
- Concentrate on the early work being undertaken in building the momentum of a PBI implementation and assessing progress towards achieving integration.

Figure A-1 presents the updated version of the CB PL V3.1. Changes include:

- Inputs now include an additional item, '*Placed-based approach readiness assessment (AHA, 2019)'*, to reflect the activities to be undertaken during the final round of site visits.
- One Program Assumption was modified for clarification purposes. '*The site and community is ready to undertake CB as assessed'* was changed to '*The site and community is ready to undertake CB as originally assessed (pre-2019)*', to differentiate the KPMG/Health assessment from the *Placed-based approach readiness assessment (AHA, 2019)* now included as an Input.

Appendix A Program logic

Figure A-1: Program Logic V 3.1 for inclusion in Evaluation Strategy



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