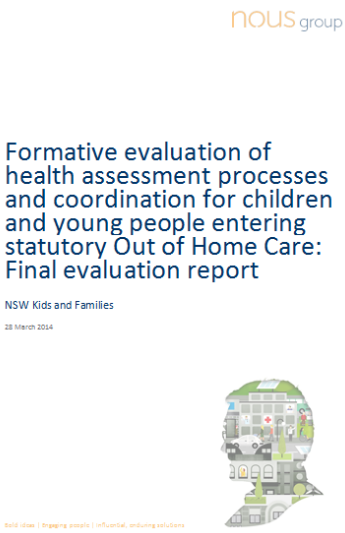
Formative evaluation of health assessment processes and coordination for children and young people entering statutory Out of Home Care: Final evaluation report

NSW Kids and Families

8 April 2014

This *Final Evaluation Report* on the *Formative evaluation of health assessment processes and coordination for children and young people entering statutory Out of Home Care* is accompanied by a *Technical Supplement.* An outline of the contents of the two documents is provided below.



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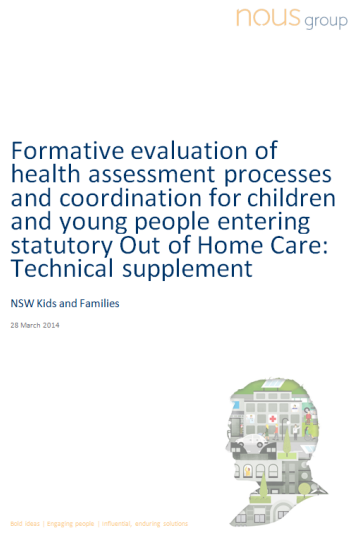

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Glossary

Term	Description
ADHC	Ageing, Disability and Home Care, NSW Department of Family and Community Services
AMS	Aboriginal Medical Service
ASQ	Ages and Stages Questionnaire
ASQ-SE	Ages and Stages Questionnaire – Social and Emotional
Carer	A person who is authorised as a foster or a relative/kinship carer by a designated agency
Child	A person under the age of 16 years, as per the *Children's Care and Protection Act (1998)*
Clinical Practice Guidelines	Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care (NSW Health 2013)
Community Services	Community Services, NSW Department of Family and Community Services. Abbreviated to FACS:CS for tables and figures
CYP	Children and young people
DEC	Department of Education and Communities (NSW)
'Framework'	National Clinical Assessment Framework for Children and Young People in Out of Home Care
GP	General Practitioner
HEADSS	An assessment framework for teen health risks that covers the following: H – Home; E - Education, Employment, Eating, Exercise; A – Activities, Hobbies, Peer Relationships; D – Drug use; S – Sexual activity and sexuality; S – Suicide, depression and mental health
HMP	Health Management Plan
IPC	(Community Services) Interagency Pathway Coordinator
IWG	(OOHC Health Pathway Program) Implementation Working Group
LHD	Local Health District
Model Pathway	A pathway developed by NSW Health in collaboration with Community Services to support the health assessment process of children and young people in Out of Home Care (see OOHC Health Pathway Program)
MoU	Memorandum of Understanding between Community Services and NSW Health on Health Screening, Assessment, Intervention and Review for children and young people in statutory OOHC
'National Framework'	Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020
NGO	Non-government organisation

Term	Description
NSW K&F	NSW Kids and Families
OOHC	Out of Home Care - the care and control of a child or young person at a place other than their usual home by a person who is not their parent. It includes care and control under an order of the Children's Court or when they are a protected person for more than fourteen days or for a total of more than 28 days in any 12-month period. Children in OOHC may be in foster care, relative/kinship care or a residential placement.
OOHC Health Pathway Program	The health assessment and coordination processes for children and young people entering statutory OOHC Note: Abbreviated to OOHC Health in tables and figures.
OOHC PPS Team	(Community Services) OOHC Policy, Programs and Strategy Team
SCHN	Sydney Children's Hospital Network
SDQ	Strengths and Difficulties Questionnaire
Statutory OOHC	A situation in which the Minister for Community Services has parental responsibility for a child or young person by virtue of an interim or final order of the Children's Court. Most children and young people in statutory OOHC live with an authorised foster carer, relative carer or kinship carer, but in some cases, may live in a residential care unit such as a group home.
Young person	A person aged 16 years or above but under the age of 18 years, as per the *Children's Care and Protection Act (1998)* *Note: Children 14 years and over can give consent to participate in the OOHC Health Pathway Program*

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1 Executive summary

Since the first implementation stage of health assessments commenced in April 2010, the OOHC Health Pathway Program[1] has significantly improved the provision of timely and priority access to health services for children and young people entering statutory Out of Home Care (OOHC) in New South Wales. This formative evaluation has established that clinicians, service providers and NSW Government agencies believe that the OOHC Health Pathway Program has made a difference in improving health outcomes for this vulnerable group of children and young people.

NSW Kids and Families engaged Nous Group (Nous) to conduct a formative evaluation of the implementation of health assessment processes, service delivery models and care coordination for children and young people entering statutory out-of-home-care (the OOHC Health Pathway Program), including an appraisal of the economic benefits to the NSW Government. This evaluation, undertaken three years following the commencement of implementation, comprises one of NSW Kids and Families' commitments under the funding arrangements for the OOHC Health Pathway Program.

Nous conducted this evaluation from May 2013 to March 2014. The evaluation collected and analysed comprehensive quantitative and qualitative data to respond to the three key evaluation questions outlined below. We have identified the key findings in response to each evaluation question:

1. **To what extent are intended service related outputs and short to medium term outcomes of the OOHC Health Pathway Program being achieved and how effective and efficient are they?**

   In the three years since the OOHC Health Pathway Program commenced in 2010, more than 4600 children and young people in statutory OOHC have gained access to health assessments, clinical services and interventions delivered through a state-wide coordinated health pathway.

   Most eligible children and young people have been referred to the OOHC Health Pathway Program although the timeliness of referrals has remained at a low level.

   - In 2010/11, the number of children and young people referred to the OOHC Health Pathway Program was equivalent to 51% of the number of people entering statutory OOHC. This rate essentially doubled in 2011/12 and 2012/13.
   - In 2012/13, only 18% of referrals were received within the benchmark of 14 days of an interim order. This has put pressure on achieving the benchmark of a child or young person receiving a 2a primary assessment within 30 days of the interim order being issued. In 2012/13, 29% of 2a primary assessments commenced within 30 days. However, a majority of children and young people - 56% in 2011/12 increasing to 68% in 2012/13 - commenced a 2a primary assessment within 30 days of being referred to the OOHC Health Pathway Program.

   The number and rate of children and young people being referred to the OOHC Health Pathway Program has increased since the start of the program.

   Development of a Health Management Plan (HMP) is a critical component of the OOHC Health Pathway Program. HMPs were generally completed within 90 days of the initial 2a primary assessment (91% based on audited case files). However, less than half of the HMPs were reviewed within the recommended time frames (based on the same audited case file data).

[1] OOHC Health Pathway Program refers to the provision and coordination of health screening, assessment and intervention for children and young people in statutory Out of Home Care (OOHC) based on the *Model Pathway for the Comprehensive Health and Development Assessments for All Children and Young People Entering OOHC.*

Aboriginal and Torres Strait Islander children and young people are over represented in the OOHC population. In terms of access to assessments and services under the OOHC Health Pathway Program, Aboriginal and Torres Strait Islander children and young people in the 6-12 and 13-18 age groups were consistently low on most measures. For example, these groups had lower rates of 2a primary assessments completed within 30 days of the interim order (21% for the 6-12 age group and 7% for the 13-18 age group). The rates for non-Aboriginal children and young people in the same age groups were 30% and 29% respectively. In contrast to rates observed in the 6-12 and 13-18 year age groups, 2a primary assessment rates were similar between Aboriginal and non-Aboriginal people in the 0-5 age group. Stakeholder consultations pointed to the difficulty in effectively engaging Aboriginal NGOs and carers of these children and young people, in part to ensure they were taken to appointments.

Nous has conservatively estimated that the OOHC Health Pathway Program will deliver a net financial benefit to the NSW Government of $12.6m in terms of avoided health and non-health service costs for children and young people who entered statutory OOHC between 2010/11 and 2012/13 over the duration of their time in OOHC[2]. On average, each child and young person in the OOHC Health Pathway Program saved $10,000 in terms of service costs, with the greatest benefits accruing from children aged 0-5 due to the effectiveness of early diagnosis and intervention. The OOHC Health Pathway Program was also estimated to provide a benefit of up to $700,000 per child over their lifetime after they have left OOHC, from improvements to their overall health, education and social outcomes.

2. What service models (including linkages), protocols, tools and resources have been used in supporting the OOHC Health Pathway Program, and how effective are they?

A range of service models, protocols, tools and resources have been used in supporting the OOHC Health Pathway Program. Some are highly effective and others less so.

The Clinical Practice Guidelines, released in 2013, provide clear guidance on what is expected for the delivery of effective services. They will provide a valuable reference point to pursue continued improvement in clinical practice and stronger engagement with clinicians and service providers.

Consistent with the devolved health model, each Local Health District (LHD) has adopted a service delivery model attuned to their local circumstances. LHDs have invested the additional OOHC funding to address service gaps e.g. employing a speech therapist.

This evaluation found that local service delivery models, protocols and processes were most effective in the delivery of health assessments and referral to services but less effective in the follow up component through the review of HMPs.

In this evaluation, Nous found numerous examples of best practice service delivery. These are detailed in this report and include building relationships to continuously improve coordination, mechanisms to prioritise access to services and activities to improve clinician and other stakeholder engagement. In this report Nous has outlined a number of 'best practice initiatives' drawn from initiatives already in operation and others being successfully applied elsewhere based on a review of comparable national and international service delivery models.

OOHC Coordinators have provided a critical linkage point for service delivery in each LHD. Sustained effective implementation of the OOHC Health Pathway Program is dependent on these roles continuing and attracting and retaining the right staff.

[2] The analysis strictly assumed that these children and young people remained in OOHC to the age of 18.

The success of the OOHC Health Pathway Program is also dependent on effective engagement with clinicians. Overall Nous found that there was stronger engagement with clinicians in the public system compared with the private system. In addition, paediatricians and allied health practitioners consistently reported higher levels of engagement, with lower levels of engagement reported for GPs.

3. **What governance and engagement structures have been set up for the OOHC Health Pathway Program, and how effective are they?**

   The multi-level program governance structures established for the OOHC Health Pathway Program have provided a strong foundation for effective delivery of the program. These structures have established partnerships between NSW Kids and Families, the Sydney Children's Hospital Network (SCHN), Community Services and LHDs. At the local level, LHDs have established and are operating local management and governance arrangements including local implementation interagency working groups and multi-disciplinary care teams.

   As outlined earlier, the Health OOHC Coordinators have been an important element of delivery of the OOHC Health Pathway Program. They have been supported by an OOHC Clinical Advisor located in the SCHN, appointed to 30 June 2014. There were a range of views on the effectiveness of the OOHC Clinical Advisor role. Twenty-two percent of the surveyed health practitioners were aware of the role, with allied health practitioners among those most likely to be aware. The clinicians who were aware of the position indicated the role had been effective in providing them with advice and support. With the release of the Clinical Practice Guidelines late last year, maintaining a clinical advisory role will be important, at least for the next 12 months.

   During this evaluation Community Services ceased central funding for their Interagency Pathway Coordinators. From 1 July 2013 Community Services put in place alternative arrangements with each Community Services Region allocating a central contact point for the OOHC Health Pathway Program. Maintenance of these central contact points and ensuring they work effectively is a critical success factor for the ongoing implementation of the OOHC Health Pathway Program.

The remaining sections of this executive summary are structured as follows:

- Section 1.1 provides a brief overview of the OOHC Health Pathway Program
- Section 1.2 lists the recommendations to enhance the OOHC Health Pathway Program and its outcomes that build on the key findings identified in the report.

1.1 The OOHC Health Pathway Program is an interagency approach to support the health assessment process for children and young people entering statutory OOHC

The implementation of the OOHC Health Pathway Program commenced in April 2010 and was an action arising from *Keep Them Safe: A shared approach to child wellbeing 2009-14* (Recommendations 16.3 and 16.4). Prior to the introduction of the OOHC Health Pathway Program as a state-wide program, health assessments and services for children and young people in statutory OOHC were provided through location-based initiatives. The variable nature of the initiatives was recognised by the Honourable James Wood, AO, QC, in his report on the Special Commission of Inquiry into Child Protection Services in NSW.

The OOHC Health Pathway Program provides for ongoing age-appropriate assessments and provision of health services across the key domains of health (including physical, psychosocial and mental health) and development. It also provides for the development of a HMP and scheduled reviews of that HMP.

1.2 Twenty-four recommendations are proposed to enhance the OOHC Health Pathway Program and to support sustainable delivery of the program

Nous developed the recommendations through examining key findings from this report on what is working well, and what could be improved. The recommendations, shown in Table 1 below, cover the following areas:

- Sustainable and continually improving service models
- Improved enrolment in the OOHC Health Pathway Program
- Better and more equitable access to services
- Improved engagement of carers
- Improved engagement of service providers
- Development of a better evidence base
- Strengthened governance and coordination
- Further investigation to be completed.

The key findings that support each recommendation are included in Section 4 of the report.

Table 1: Recommendations

No.	**Recommendation (responsibility is in bold)**
Sustainable and continually improving service models	
1.	**LHDs** should continue to implement all steps of the OOHC Health Pathway Program as per the Clinical Practice Guidelines (including the adoption of the assessment and HMP templates).
2.	**LHDs** should assess their current service delivery models against the best practice initiatives (section 4.2) and identify any improvements they could make. These best practice initiatives include: • allocation of a clear Primary Medical Contact for each child and young person • earlier engagement of carers to assist them to provide appropriate support throughout the process • utilisation of formal multidisciplinary teams • co-location of health assessment and intervention services • clearer responsibility and accountability for the completion of HMP reviews • development of mechanisms to manage high volumes of referrals.
3.	**LHDs** should identify opportunities to make OOHC Health Pathway Program roles, particularly the OOHC Coordinator role, either permanent positions or extended contract periods to reduce turnover and to maintain continuity in these roles.
4.	**NSW Kids and Families and LHDs** should establish and maintain mechanisms (eg through the IWG) to periodically collate and distribute examples of effective best practice components of local service delivery models across all LHDs.

No.	Recommendation (responsibility is in bold)
5.	**NSW Kids and Families** should establish and maintain mechanisms (eg through the IWG) to periodically collate and distribute examples of NSW Health OOHC Coordinator best practice throughout the network.
6.	**LHDs** should investigate additional mechanisms to increase awareness and understanding of the OOHC Health Pathway Program within the LHD including identification of local champions and key clinical leaders.
Improved enrolment in the OOHC Health Pathway Program	
7.	**Community Services** should ensure referrals from Community Services occur in a timely manner: i.e. within the first 14 days of entering statutory OOHC to allow sufficient time for 2a primary assessments to be conducted.
8.	**Community Services** should give priority to increasing enrolments of young people entering statutory OOHC in the 13-18 year age group in the OOHC Health Pathway Program, for example through the expansion of, or better linkages with youth services.
9.	**Community Services** should improve the quality of referral data (including ensuring all required data is provided) to LHDs for each child/young person.
Better and more timely access to services	
10.	**LHDs** should improve access to assessments and services for children/young people living in rural/remote areas, including through the greater use of telehealth and web-based technologies.
11.	**NSW Kids and Families and Community Services** should leverage the outcomes of the economic appraisal to prepare a jointly authored business case to increase funding for the OOHC Health Pathway Program.
Improved engagement of carers	
12.	**LHDs** should, where possible, work to ensure that the assessment staff profiles match the diversity of the communities in which the OOHC Health Pathway Program initiatives are being implemented.
13.	**Community Services, NGOs and LHDs** should examine ways in which the existing processes for engagement of carers can be enhanced to increase their awareness and understanding of the OOHC Health Pathway Program and to provide appropriate support.
Improved engagement of service providers	
14.	**LHDs** should improve engagement of Aboriginal Medical Services and Aboriginal NGOs by establishing formal linkages such as regular meetings and MoUs (where they don't already exist).
15.	**NSW Kids and Families** should use the planned communication and education strategy for the Clinical Practice Guidelines to improve engagement of service providers (GPs, GP Practice Nurses, AMSs) with a particular focus on: ◦ the effects of trauma, abuse and neglect and the associated needs of this target population ◦ clarifying responsibility for developing HMPs and undertaking periodic reviews ◦ streamlining arrangements to facilitate timely GP referrals to a paediatrician.

No.	Recommendation (responsibility is in bold)
16.	**LHDs** should adopt the following principles to guide effective engagement with clinicians: • clinicians have a sound knowledge and understanding of the OOHC system and the OOHC Health Pathway Program • clinicians have a strong understanding of the impacts of trauma (including abuse and neglect) on children and young people in OOHC • effective communication, coordination and feedback occurs throughout the OOHC Health Pathway Program • appropriate clinical and administrative resources are available to support the OOHC Health Pathway Program • clinicians are aware of the Health OOHC Coordinator role which provides effective support to clinicians • managers support clinicians to provide services under the OOHC Health Pathway Program • the importance of continuity of staff in roles is recognised and maintained • clinicians have one point of contact within their LHD for OOHC Health Pathway Program related matters • proactive approaches to building relationships between clinicians and NSW Health are implemented • carers receive adequate information about and support children and young people in their care to participate in the OOHC Health Pathway Program and particularly attend appointments.
Development of a better evidence base	
17.	**Community Services** should ensure that all relevant data, including CALD status, is entered into the Community Services database and integrated with the NSW Kids and Families data.
18.	**NSW Kids and Families and Community Services** should jointly review the most effective way to collect data and the appropriate data sets necessary to monitor implementation and to support periodic evaluations. The review should include consideration of the best mechanism to record and collect data on: • the number and proportion HMP reviews • the extent to which medical interventions have been delivered in accordance with the HMP.
19.	**NSW Kids and Families and Community Services** should explore the adoption of the electronic health record system as soon as practical. This may include proposing that the population of children and young people enrolled in the OOHC Health Pathway Program could participate as a pilot group.
Strengthened governance and coordination	
20.	**Community Services** should ensure that a consistent single point of contact for the NSW Health OOHC Coordinators and NGO case managers is maintained within Community Services in each region.

No.	Recommendation (responsibility is in bold)
21.	**Community Services and NSW Kids and Families** should review the effectiveness of the relationships, systems and processes between the NSW Health OOHC Coordinators, regional Community Services designated contacts and NGO service providers by the end of 2014 and address any areas identified for improvement. The review should include consideration of any changes to: ◦ the quality of data collection ◦ the quality of referrals to the OOHC Health Pathway Program ◦ the administrative load on other stakeholders, particularly the Health OOHC Coordinators ◦ the capacity to track changes in the placement details and circumstances of children and young people enrolled in the OOHC Health Pathway Program.
22.	**NSW Kids and Families** should consider extending the funding of the OOHC Advisor for a further 12 months to 30 June 2015. The future focus of the role should incorporate the following: ◦ act as a state-wide clinical leader, providing advice and clinical support to clinicians including GPs ◦ provide clinical advice to raise awareness of and support implementation of the Clinical Practice Guidelines ◦ continue to raise awareness of the role and the support it can offer ◦ provide regular updates about OOHC progress and changes to clinicians ◦ provide guidance on the needs of carers and how to best support them.
Further investigation to be completed	
23.	**NSW Kids and Families** should commission further research to determine the effectiveness and cost-effectiveness of individual service models and to support a comparison of the models in operation.
24.	**NSW Kids and Families** should commission a comprehensive summative evaluation of the OOHC Health Pathway Program prior to the end of 2015 and to be completed by 30 March 2016.

2 Background

Child protection is a major priority for the NSW Government and governments in all Australian jurisdictions. In 2012, there were 17,192 children in out-of-home-care (OOHC) in NSW which equates to 10.5 per 1,000 children. NSW has the highest rate of Aboriginal and Torres Strait Islander children in OOHC at 83.4 per 1000. Each year, more children are admitted than discharged.

Children and young people in OOHC are acknowledged to be a highly vulnerable population, often with high, unrecognised and unmet physical, developmental, psychosocial and mental health needs (Community Services, NSW Department of Family and Community Services and NSW Health, 2011). They also tend to have limited access to resources and are less likely to access preventative health services. The complexity of the health system further compounds these issues.

In recognition of the importance of adequately and appropriately caring for this vulnerable population, in 2007 the NSW Governor commissioned the Honourable James Wood, AO, QC, to lead the Special Commission of Inquiry into Child Protection Services in NSW. The Special Commission released its report in 2008. The NSW Government responded to this report with *Keep Them Safe: A shared approach to child wellbeing 2009-2014*. An action arising from *Keep Them Safe* that aims to improve the relatively poor health status of children and young people in OOHC was the implementation of an improved health assessment and coordination process for this population (the OOHC Health Pathway Program) which commenced in April 2010.

Prior to the OOHC Health Pathway Program, a range of formal health screening and assessment initiatives were in place with mixed results

The Report of the Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008) identified that, at that time, there were a number of initiatives in place aimed at improving the access of children and young people in OOHC to health assessments and services. The report recognised these initiatives had not been implemented in all areas of the state and, where they had been implemented, were achieving good results in some locations but not others, due to variable capacity within local areas (e.g. Area Health Services, Department of Community Services regions).

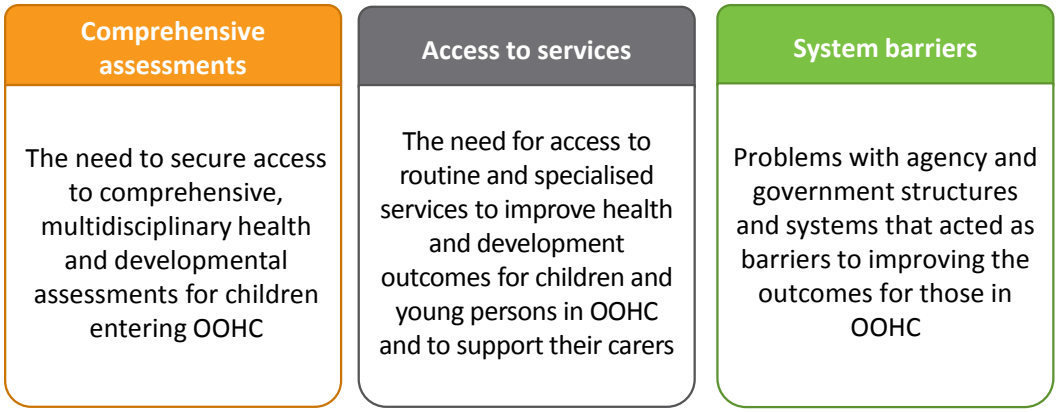
These formal health screening and assessment initiatives included:

- Memoranda of understanding between various NSW Government departments including the then Department of Community Services, Department of Health, Department of Education, and the Department of Ageing, Disability and Home Care.
- A Department of Health policy indicating referrals of children and young people in OOHC to public health services were to be prioritised ahead of all other referrals unless a clinical imperative necessitated another referral to be prioritised.
- Department of Community Services procedures which stated all children and young people were to have a health, developmental, mental health and behavioural assessment within 60 days of entering OOHC and their case worker was responsible for organising these assessments and obtaining the child or young person's Blue Book on behalf of the carer.
- OOHC Assessment Clinics located in NSW's three specialist children's hospitals: The Children's Hospital Westmead, Sydney Children's Hospital and John Hunter Hospital. These clinics provided specialist medical, developmental and psychosocial assessments and referrals for allied health assessments to children/young people in defined age groups within their catchment areas. For example, the Children's Hospital Westmead Clinic provided services to children aged 0-12 years living in the Sydney West Area who had been in OOHC for at least two years.

- The KARI Clinic which operated from three locations in the Sydney South West Area and coordinated comprehensive health assessments for Aboriginal children entering OOHC.

Justice Wood's report identified three main types of issues (shown in Figure 1) that related to the health needs of children and young people in OOHC in NSW.

Figure 1: Three main categories of issues related to the health needs of children and young people in OOHC in NSW (Wood, 2008)



The OOHC Health Pathway Program is one mechanism through which the NSW Government is addressing these issues.

The introduction of the OOHC Health Pathway Program was to involve an evaluation three years post-implementation

The OOHC Health Pathway Program provides for ongoing age-appropriate assessments and provision of health services across the key domains of health (including physical, psychosocial and mental health) and development. It also provides for the development and scheduled review of HMPs.

NSW Kids and Families engaged Nous in May 2013 to conduct a formative evaluation of the implementation of the OOHC Health Pathway Program, including an appraisal of the economic benefits to the NSW Government. This was in recognition that the Program had been operating for a short time and a summative evaluation was not appropriate at that point. This evaluation, undertaken three years following the commencement of implementation, comprises one of NSW Kids and Families' commitments under the funding arrangements for the OOHC Health Pathway Program.

The primary objectives of this evaluation were fivefold:

1. To determine the effectiveness of health assessment processes and systems in place to implement the OOHC Health Pathway Program including the provision of service information, service management and coordination and linkages.
2. To review the effectiveness of the OOHC Health Pathway Program service delivery across LHDs.
3. To determine the extent to which the OOHC Health Pathway Program is being implemented as intended and the impacts on service provision.
4. To determine the short to medium term outcomes associated with the introduction of the OOHC Health Pathway Program and the provision of early intervention for children and young people entering statutory OOHC.
5. To determine the economic benefit to government of implementing the OOHC Health Pathway Program.

External factors have had an impact on the implementation of the OOHC Health Pathway Program

Nous completed the evaluation over an extended period, between May 2013 and March 2014. Immediately prior to, and throughout the evaluation period a number of external factors impacted upon the implementation of the OOHC Health Pathway Program. These factors included:

- restructures of both NSW Health and Community Services
- the transition of case management responsibilities to NGO service providers
- cessation of funding for the Interagency Pathway Coordinator positions
- realignment of the NSW Department of Family and Community Services regions and the NSW Health LHD boundaries.

The evaluation provided an assessment of the implementation to date and identifies opportunities to continuously improve the OOHC Health Pathway Program

In this *Final Evaluation Report* Nous on the *Formative evaluation of health assessment processes and coordination for children and young people entering statutory Out of Home Care*:

- identifies key findings and offered insights on what is/is not working well with the implementation of the OOHC Health Pathway Program
- offers recommendations where opportunities were identified for enhancements or to make the implementation sustainable.

This *Final Evaluation Report* is accompanied by a *Technical Supplement*. The *Technical Supplement* includes the detailed literature review, methodology and supplementary data for each key evaluation question. The relevant cross-references to the *Technical Supplement* are included in this report.

3 Methodology overview

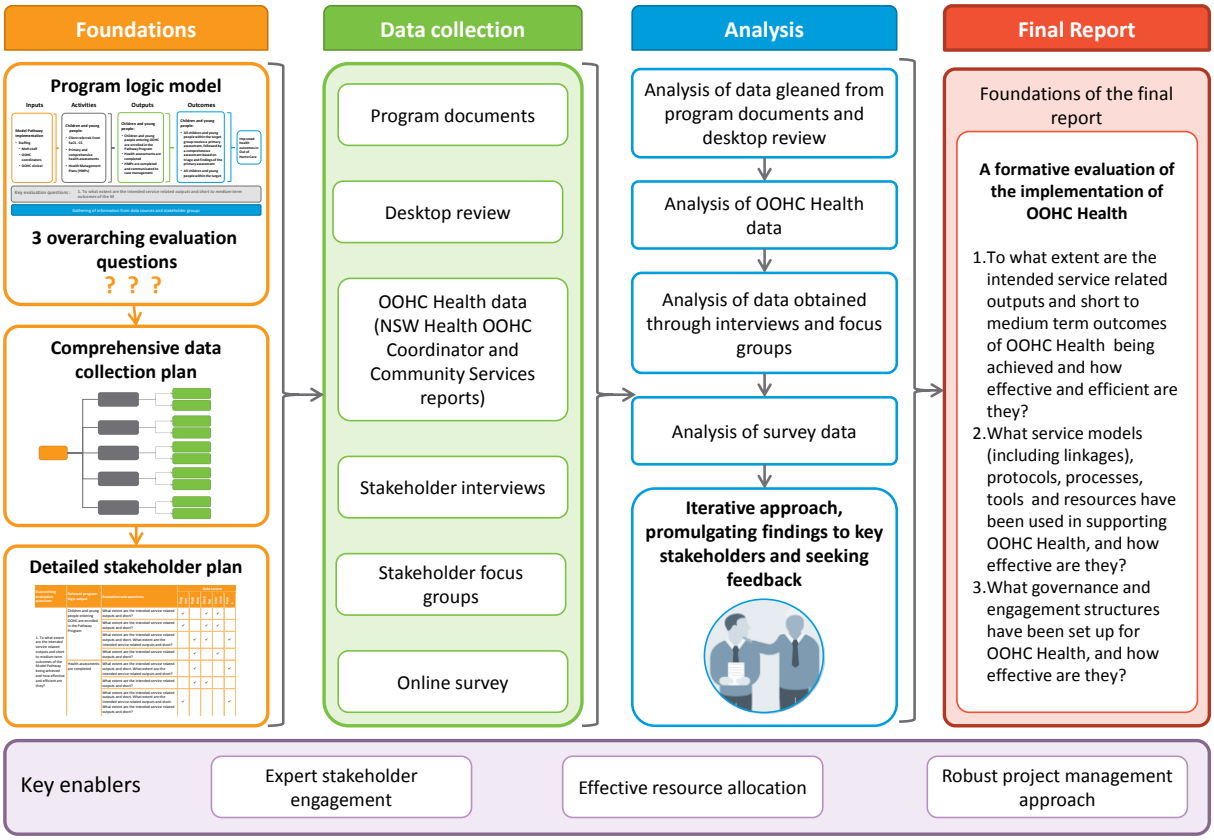
Nous applied a robust method to complete the evaluation. We developed a clear conceptual framework for the evaluation and our three staged approach was completed in accordance with an agreed evaluation plan. Each element of our method is described in the following sections:

- section 3.1 introduces our conceptual framework
- section 3.2 summarises the key components of our three stage approach
- section 3.3 describes each element of our comprehensive evaluation plan
- section 3.4 summarises our approach to the limited economic appraisal.

3.1 The evaluation was underpinned by a clear conceptual framework

Nous developed a clear conceptual framework, illustrated in Figure 2, on which this evaluation was based. The components of this framework are described in more detail in the remainder of section 3.

Figure 2: Conceptual framework for the evaluation



3.2 The evaluation was completed in three stages

The main activities in the three project stages are summarised below.

Stage 1: Project initiation and development of evaluation plan and data collection tools

Nous developed comprehensive project and evaluation plans that were used to guide the evaluation activities. Nous tested both plans with the project Steering Group. Nous also developed a range of data collection tools, primarily comprising focus group and interview guides and online surveys. These were endorsed by NSW Kids and Families.

Nous commenced the data collection and analysis process with the gathering and high level review of NSW Kids and Families and Community Services data and program documentation, and commencement of the literature review.

Stage 2: Conduct the evaluation

Nous continued the data collection and analysis activities commenced in Stage 1 by:

- obtaining and analysing further program data and documentation from NSW Kids and Families, Community Services and LHDs to fill identified data gaps
- finalising the literature review
- conducting and analysing outputs from extensive interviews and focus groups with stakeholders including NSW Kids and Families and Community Services central office and regional staff, clinicians, OOHC Advisor managers, Aboriginal Medical Service (AMS) staff and NGO representatives
- obtaining ethics approval from the Aboriginal Health and Medical Research Council (AHMRC) to be able to survey AMS staff
- undertaking an online survey of Aboriginal Medical Service staff in addition to Health OOHC Coordinators and clinicians
- designing the approach to the economic appraisal of the OOHC Health Pathway Program to determine the economic benefit to the NSW Government of its implementation.
- obtaining ethics approval from the ethics committees of four LHDs[3] to enable them to provide de-identified client data to inform the economic appraisal and provide answers to three evaluation sub-questions. This data included both high level de-identified client data for all children and young people referred to the OOHC Health Pathway Program in those LHDs and, following this, detailed de-identified client data for approximately 15 of those children. The three evaluation sub-questions were:
    - To what extent has the carer and child / young person received appropriate and timely intervention as a result of the HMPs?
    - To what extent are the relevant interventions delivered in accordance with the plan?
    - Have all children and young people within the target group who have received an assessment and a HMP then received a review of their HMP and health intervention as determined in the health care plan or within the target timeframe?

[3] LHDs providing case audit data for 2012/13 were: Hunter New England, Mid North Coast, Northern NSW and South Western Sydney

This stage also included the provision of the following three written reports to the project Steering Group:

- written progress report (28 June 2013)
- interim evaluation report (on 28 June 2013)
- report on emerging insights and areas for recommendation (18 September 2013).

Nous tested the reports with the project Steering Group. Feedback received on these reports, together with the results from any additional data collection activities completed in the intervening period, informed the development of the next deliverable.

Stage 3: Final Evaluation Report

During this final stage, Nous completed the remaining data collection and analysis activities, and developed this *Final Evaluation Report* and its companion the *Technical Supplement*.

The remaining data collection and analysis activities included:

- analysing the results of the Aboriginal Medical Service survey
- undertaking a detailed analysis of the client data to complete the economic appraisal
- synthesising all results to determine key findings.

A draft of the *Final Evaluation Report* and *Technical Supplement* was developed and tested with the project Steering Group. Similarly, Nous tested the draft documents with Professor Kim Oates (Nous Expert Adviser). This report was finalised based on the feedback received and submitted to NSW Kids and Families for endorsement.

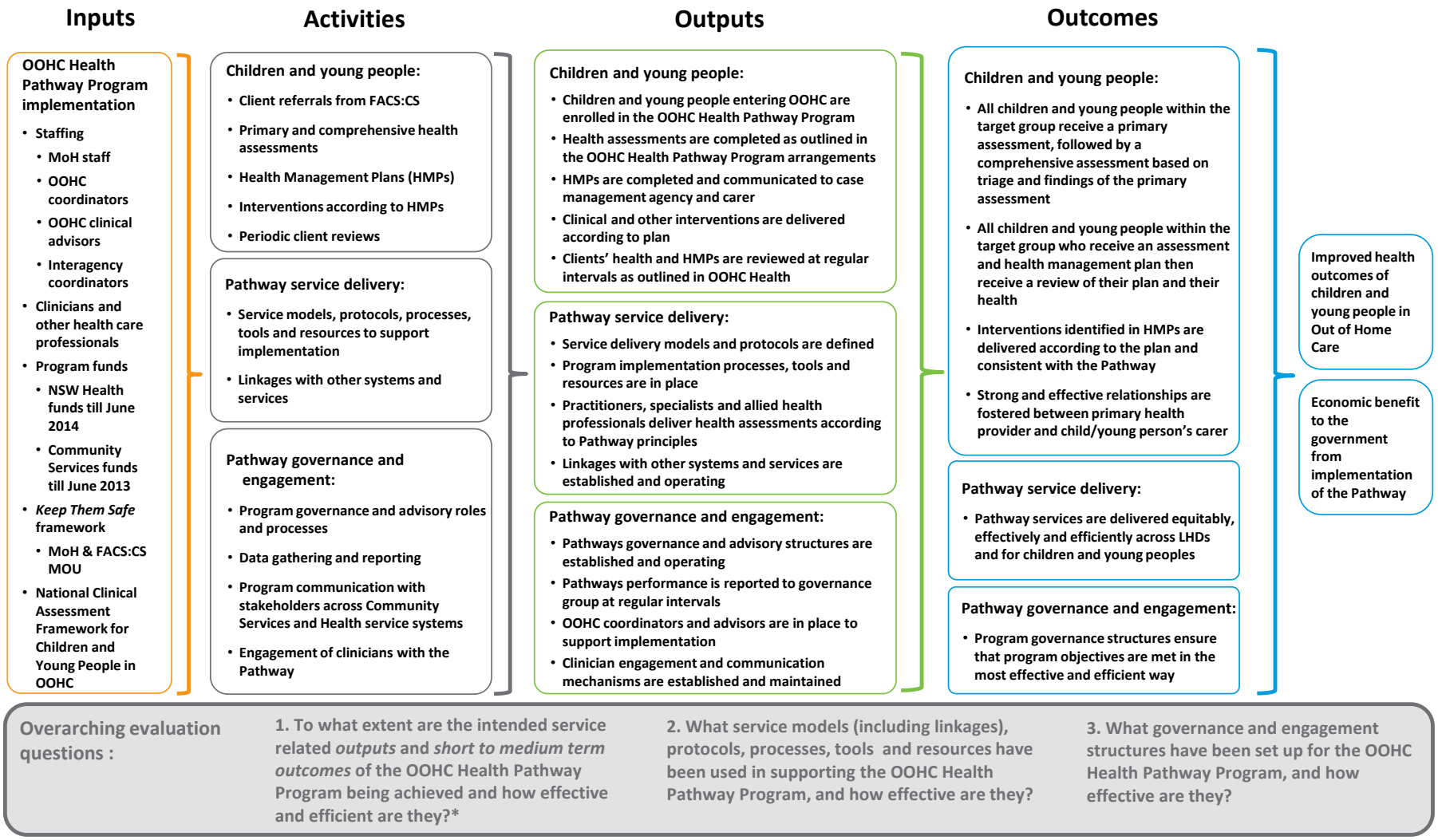
3.3 The evaluation was guided by a detailed evaluation plan

Nous developed a comprehensive evaluation plan to guide this project. The plan included the program logic for the OOHC Health Pathway Program, a data collection plan, a stakeholder engagement plan, and the approach to guide the economic appraisal. Each element is discussed in turn below with further detail included in the *Technical Supplement*.

3.3.1 A program logic model was used to identify key evaluation questions

Nous mapped the program logic for the OOHC Health Pathway Program (see Figure 3) to clearly identify the main inputs, activities, outputs, outcomes and impacts of this program. The program logic, together with the evaluation objectives, informed the development of three overarching evaluation questions.

Figure 3: Program logic for the OOHC Health Pathway Program



* This question encompasses an assessment of economic benefit of OOHC Health.

The three overarching evaluation questions were:

1. To what extent are the intended service related outputs and short to medium term outcomes of the OOHC Health Pathway Program being achieved and how effective and efficient are they?

   Note: This question encompasses an assessment of economic benefits to the NSW Government of the OOHC Health Pathway Program.

2. What service models (including linkages), protocols, processes, tools and resources have been used in supporting the OOHC Health Pathway Program, and how effective are they?

3. What governance and engagement structures have been set up for the OOHC Health Pathway Program, and how effective are they?

Nous used these overarching evaluation questions to develop sub-evaluation questions and to guide the data collection activities and stakeholder engagement activities.

3.3.2 A data collection plan underpinned the data collection activities

Nous conducted the evaluation according to a data collection plan based on the overarching evaluation questions and the program logic. For each overarching question, the plan identified the:

- relevant outputs from the program logic
- sub-questions that required an answer to enable the development of a comprehensive understanding of the program
- data sources that would answer those sub-questions, including program documentation, NSW Health OOHC Coordinator reports and Community Services referral data, the OOHC Health Pathway Program data, and consultations with a range of stakeholders
- the data collection activities used to obtain the required data, including a literature review, desktop review of existing documentation and data, interviews, focus groups and surveys.

The data collection plan used to guide the evaluation is included in the *Technical Supplement*.

Nous encountered several data limitations during the course of this evaluation. Briefly, Nous used a range of different sources for input data into this evaluation which were not consistent across all metrics (e.g. the number of entries into the OOHC Health Pathway Program) due to different reporting processes and definitions. Some data that were important for specific aspects of the evaluation were not collected by any of the relevant agencies (e.g. timeliness and appropriateness of interventions). There was also a low response rate to the survey of Aboriginal Medical Services and few or no GP respondents[4]. These limitations and others are discussed in further detail in the *Technical Supplement*.

3.3.3 A stakeholder engagement plan guided the consultation activities

Stakeholders had a crucial role in the evaluation. Our consultation activities were guided by a comprehensive stakeholder engagement plan which ensured the necessary information was obtained to enable insight, inform recommendations and ensure project outcomes were achieved.

The stakeholder engagement plan was informed by the data collection plan, and clearly articulated who was to be engaged during the evaluation, the information to be obtained, how and when. Further detail is provided in the *Technical Supplement*.

[4] No survey respondents identified themselves as GPs. There were a small number of respondents who did not identify their profession and these may include GPs.

The plan was updated throughout the evaluation to reflect additional stakeholders who were consulted and changes to the timings of consultations. Where possible, consultations were scheduled to coincide with existing meetings of stakeholders and the most appropriate mechanism of consultation (either face to face or by telephone) was applied to ensure the greatest possible audience was reached across NSW.

Consultations focused on stakeholders who were directly involved in the delivery of the OOHC Health Pathway Program: staff of NSW Health (in particular, NSW Kids and Families) and Community Services, OOHC Coordinators, clinicians, allied health practitioners, NGO OOHC case managers, representatives from NGO peak bodies and Aboriginal Medical Service staff.

The consultations and other data collection activities that were conducted during the evaluation were initially deemed to not require approval from a Human Research Ethics Committee because no identifiable data was to be obtained from children or young people in OOHC, nor from their biological parents or carers. However, part way through the evaluation, the AHMRC requested an application for ethics approval be submitted prior to the survey of AMS staff being undertaken.

In addition, individual (de-identified) client data was not to be collected under the original evaluation plan. However, this data was later sought to fill gaps identified during the evaluation. As such, ethics approval to enable collection of client data was sought from and provided by selected LHDs – Hunter New England, Northern NSW, Mid North Coast and South Western Sydney.

3.4 The evaluation was supported by a limited economic appraisal

A formal cost effectiveness analysis (CEA), as described in the *NSW Government Guidelines for Economic Appraisal*[5], was beyond the scope of this project. Nous completed a limited economic appraisal (cost-benefit) to assess the direct financial benefit to the NSW Government of implementing the OOHC Health Pathway Program. This approach was a cost-effective means of addressing the primary interest of NSW Kids and Families in the financial and economic impacts of the program.

Nous undertook an economic appraisal through the following steps:

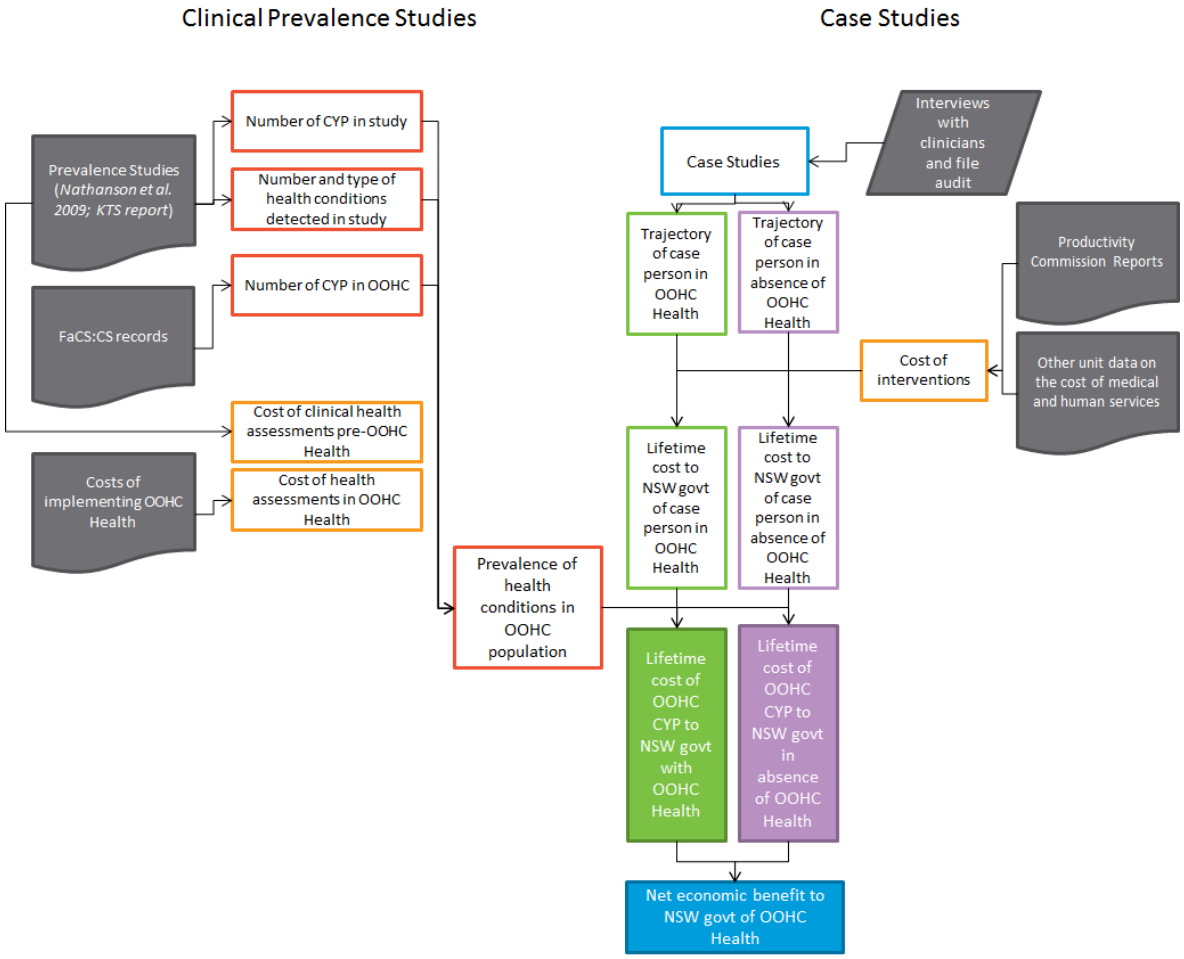
1. ***A high-level file audit of case file information was conducted on all relevant children and young people in statutory OOHC from specific LHDs.*** Nous used a limited file audit of patient records from four LHDs to determine the use of health assessments and medical interventions by children and young people within and outside the OOHC Health Pathway Program, during their time in OOHC. These LHDs were Hunter New England, Mid North Coast, Northern NSW and South Western Sydney.
2. ***Six case studies were produced to generate lifetime trajectories in terms of service usage.*** A subset of the audited files was further analysed to generate six 'typical' cases for children and young people within and outside the OOHC Health Pathway Program that represented a majority of the population within OOHC. These cases were used to produce 'lifetime trajectories' of their health and other government-funded service usage by extrapolating from their health statuses and interventions received during their time in OOHC, if any. They were informed by expert clinical advisors, Dr Elisabeth Murphy and Professor Graham Vimpani.

[5] NSW Treasury (2007) *The NSW Government Guidelines for Economic Appraisal*, TPP 07-05.

3. ***Direct services expenditure by the NSW Government for each of the six cases was estimated from available unit and overhead costs data***. Nous estimated the net direct cost to the NSW Government for each of the six cases from state-wide expenditure data. These costs included expenses to conduct primary and comprehensive health assessments, specialist clinics, medical interventions and on-going supports, and the overall administration of the program.
4. ***Total government expenditure of the implementation of the OOHC Health Pathway Program was extrapolated from the high-level case file audit and overall program data.*** The gross cost to the NSW Government was extrapolated from the six cases to match the demographic makeup of the OOHC population.
5. ***Overall net financial cost or benefit to the NSW Government from the OOHC Health Pathway Program was calculated by comparing the six cases and their counter-factual trajectories.*** The gross economic benefit to the NSW Government was calculated by subtracting the gross cost of OOHC children and young people in the OOHC Health Pathway Program from the corresponding cost for those outside the program. These benefits were driven from:
    a. expenditure savings in other programs focused on identifying and responding to the health status of children and young people in OOHC
    b. expenditure savings that will accrue from achieving better health outcomes for children and young people in OOHC, such as health services that are NSW Government responsibilities (public health, community health and acute health services) and education.

The approach to the economic appraisal – using the case studies and trajectories combined with current data from the OOHC Health Pathway Program and prior prevalence studies on the health of the OOHC population – is illustrated in Figure 4. A detailed methodology is provided in the *Technical Supplement*.

Figure 4: Economic appraisal approach to estimate the net benefit of the OOHC Health Pathway Program to NSW Government



4 Key findings

Overall, the evaluation found that the OOHC Health Pathway Program has made a difference in improving health outcomes for children and young people entering statutory OOHC by significantly improving the provision of timely access to health services for this population in NSW.

A cost-benefit analysis of the OOHC Health Pathway Program indicated the Program will deliver a net financial benefit to the NSW Government of $12.6m in terms of avoided health and non-health service costs for children and young people who entered statutory OOHC between 2010/11 and 2012/13 over the duration of their time in OOHC, assuming they stayed to the age of 18.

The evaluation has made a number of key findings against each of the evaluation questions and these have informed the recommendations. This *Final Evaluation Report* contains the key finding(s) against each evaluation question together with a synthesis of the relevant supporting evidence. The *Technical Supplement* contains a summary of the supporting data that informed the key finding(s) for each evaluation question.

The section numbering of the mirrored in the *Technical Supplement*. To find the relevant summary data for each evaluation question, refer to the corresponding section in the *Technical Supplement* – e.g. the summary data that support the key findings presented for question 'To what extent have health assessments resulted in the development of a HMP?' in Section 4.1.3 of this *Final Evaluation Report* is found in under the same question in section 4.1.3 of the *Technical Supplement*.

4.1 To what extent are the intended service related outputs and short to medium term outcomes of the OOHC Health Pathway Program being achieved and how effective and efficient are they?

In the three years since the OOHC Health Pathway Program commenced in 2010, more than 4600 children and young people in statutory OOHC have gained access to clinical services and interventions delivered through this state-wide program.

Most of the eligible children and young people entering statutory OOHC were referred to the OOHC Health Pathway Program by Community Services, although the timeliness of referrals has remained at a low level. In 2012/13, only 18% of referrals were received within the benchmark of 14 days of an interim order[6]. This has put pressure on achieving the benchmark of a child or young person receiving a 2a primary assessment within 30 days of the interim order being issued. In 2012/13, 29% of 2a primary assessments commenced within 30 days.

[6] The guidance for referrals to the OOHC Health Pathway Program being made by Community Services to NSW Health within 14 days was designed to enable NSW Health to complete 2a assessments within 30 days of the interim order being issued.

Development of a HMP is a critical component of the OOHC Health Pathway Program. HMPs were generally completed within 90 days of the initial 2a primary assessment (91% based on audited case files). However, less than half of the HMPs were reviewed within the recommended time frames (based on the same audited case file data).

In terms of access to program assessments and services, Aboriginal and Torres Strait Islander children and young people in the 6-12 and 13-18 age groups were consistently low on most measures. For example, they had lower rates of 2a primary assessments completed in 30 days (21% for the 6-12 age group and 7% for the 13-18 age group). The rates for non-Aboriginal children and young people in the same age groups were 30% and 29% respectively. Stakeholder consultations pointed to the difficulty in effectively engaging Aboriginal NGOs and carers of these children and young people, in part to ensure they were taken to appointments.

Nous conservatively estimated that the OOHC Health Pathway Program will deliver a net financial benefit to the NSW Government of $12.6m in terms of avoided health and non-health service costs for children and young people who entered statutory OOHC between 2010/11 and 2012/13 over the duration of their time in OOHC, assuming they stayed to the age of 18. On average, each child and young person in the OOHC Health Pathway Program saved $10,000 in terms of service costs, with the greatest benefits accruing from children aged 0-5 due to the effectiveness of early diagnosis and intervention. The OOHC Health Pathway Program was also estimated to provide a benefit of up to $700,000 per child over their lifetime after they have left OOHC, from improvements to their overall health, education and social outcomes.

4.1.1 Almost all children and young people entering statutory OOHC were being referred to the OOHC Health Pathway Program

Evaluation sub-questions	Key findings
To what extent are children and young people entering OOHC enrolled in the OOHC Health Pathway Program?	• The proportion of eligible children and young people being referred to the OOHC Health Pathway Program increased from 51% in 2011/12 to 117%[7] in 2012/13. • The timeliness of referrals has remained relatively static with 16% being received within 14 days of an interim order in 2011/12 and the proportion slightly increasing to 18% in 2012/13. • An improvement was achieved in referral rates to the OOHC Health Pathway Program for eligible Aboriginal and Torres Strait Islander children and young people. The referral rates for these children and young people increased to similar levels for children and young people who were not Aboriginal or Torres Strait Islander from 25% of referrals in 2011/12 to 36% in 2012/13. • Referral rates to the OOHC Health Pathway Program in urban and regional LHDs with large towns were greater than 87%, whereas several LHDs in more rural areas had lower rates, ranging between 67% and 79%.
Related recommendations	

[7] Values greater than 100% for OOHC Health Pathway Program referrals were due to children and young people entering OOHC in previous years but not referred to the OOHC Health Pathway Program. These children were then referred to the OOHC Health Pathway Program in subsequent years, leading to a greater number of referrals into the OOHC Health Pathway Program than the number of children and young people entering statutory OOHC in those years.

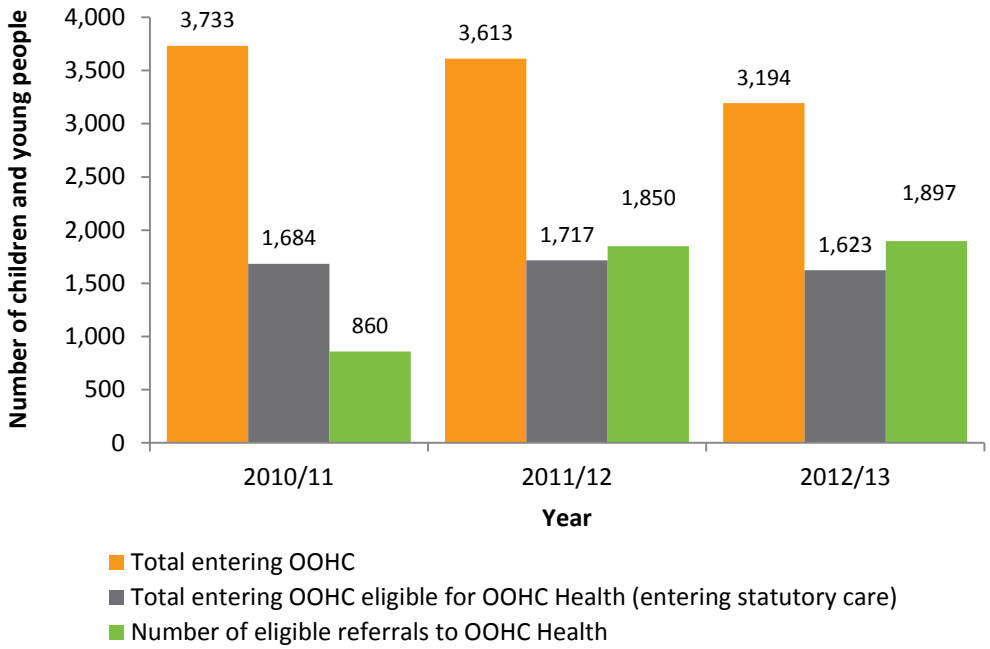
Evaluation sub-questions	Key findings
∘ 1 (Implementation of *Clinical Practice Guidelines*), 2 (Managing referral volumes), 7 (Timeliness of referrals), 8 (Focus on 13-18 year age group), 9 (Quality of referral data), 13 (Engagement of carers)	

To what extent are children and young people entering OOHC enrolled in the OOHC Health Pathway Program?

Proportion of eligible children and young people referred to the OOHC Health Pathway Program

The number and rate of children and young people being referred to the OOHC Health Pathway Program has increased since the start of the program.[8] In 2010/11, the number of children and young people referred to the OOHC Health Pathway Program was equivalent to 51% of the number of people entering statutory OOHC.[9] These ratios increased to 108% and 117%, respectively, for 2011/12 and 2012/13.[10]

Figure 5: Entries to OOHC, statutory OOHC and OOHC Health Pathway Program 2010/11 – 2012/13



***Source**: NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13; NSW Department of Family and Community Services: Community Services Annual Statistical Reports, and KiDS database extracts 16 September 2013*

[8] NSW Kids& Families, Quarterly Reporting Data 2010/11 to 2012/2013

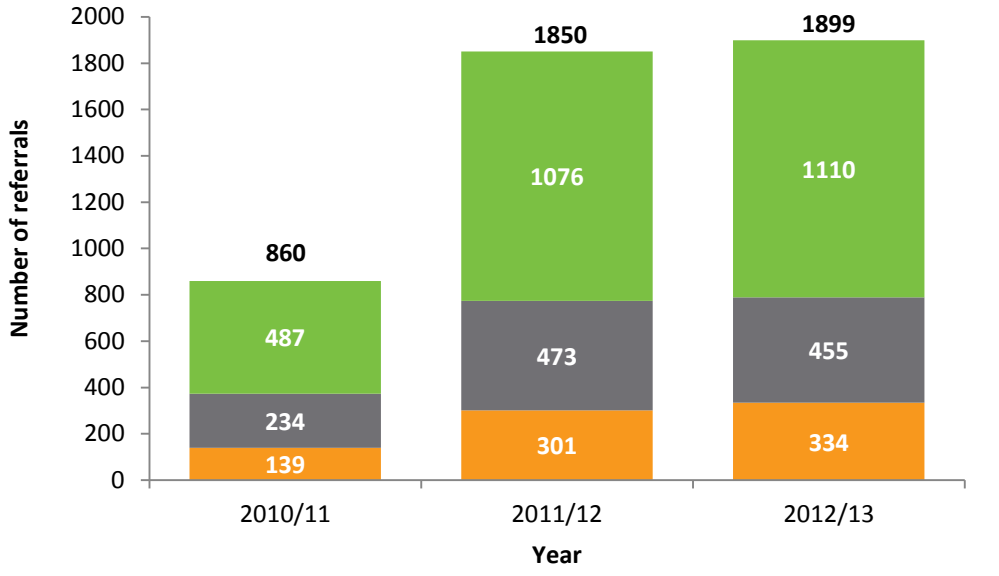
[9] Prepared by the Information Management Branch, NSW Family and Community Services, Sydney.

[10] Ratios in excess of 100% for OOHC Health Pathway Program referrals (i.e. more children and young people being referred to the OOHC Health Pathway Program than eligible people entering) are due to time delays between children and young people entering statutory OOHC in earlier reporting years receiving 2a assessments in a given year (e.g. children and young people being assessed in 2011/12 who entered statutory OOHC in 2010/11). Information on time delays was provided by NSW Kids & Families, 24 February 2014.

Timeliness of referrals

Fewer than 20% of the referrals for children and young people to the OOHC Health Pathway Program were completed within the 14-day timeframe stipulated in the program guidelines[11]. These ratios have been stable from 2010 to 2013. In 2010-11, 16% of referrals to the OOHC Health Pathway Program were received within 14 days. This proportion had increased marginally to 18% by 2012-13.

Figure 6: Referrals to the OOHC Health Pathway Program within 14 days, within 30 days, and after 30 days of interim order



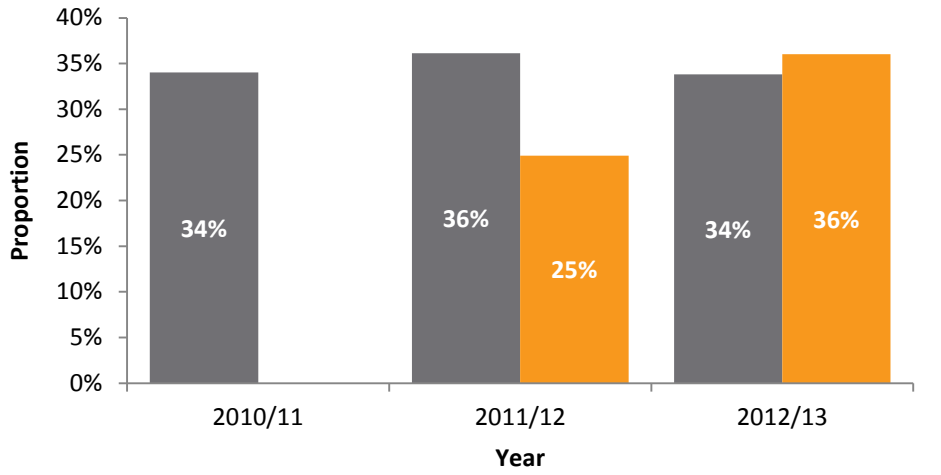
Source: NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13

Referral rates for Aboriginal and Torres Strait children and young people

Aboriginal and Torres Strait Islander children and young people are over-represented in the OOHC population but were referred to the OOHC Health Pathway Program at lower rates to their non-Indigenous peers in 2011/12. This situation had improved by 2012/13, to the same rates as for non-Aboriginal or Torres Strait Islander children and young people, as shown in Figure 7.

[11] The OOHC Health Pathway Program *Clinical Practice Guidelines* stipulate that a child or young person entering OOHC should be referred to the OOHC Health Pathway Program by Community Services within 14 days of the child or young person being the subject of an interim order to enter statutory OOHC. This then enables the OOHC Health Pathway Program to arrange for a 2a health assessment for the child or young person within 30 days of that person entering OOHC.

Figure 7: Proportion of Aboriginal and/or Torres Strait Islander children and young people entering OOHC and referred to the OOHC Health Pathway Program



***Source**: NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

The proportion of children and young people entering statutory OOHC who were Aboriginal or Torres Strait Islander was stable at around 35% from 2010/11 to 2012/13. However, the proportion of eligible referrals to the OOHC Health Pathway Program for children and young people who were Aboriginal or Torres Strait Islander was 25% in 2011/12, 10% less than expected from the number of entries into OOHC. This rate increased to 36% in 2012/13, similar to the proportion of Aboriginal and Torres Strait Islander children and young people entering OOHC.

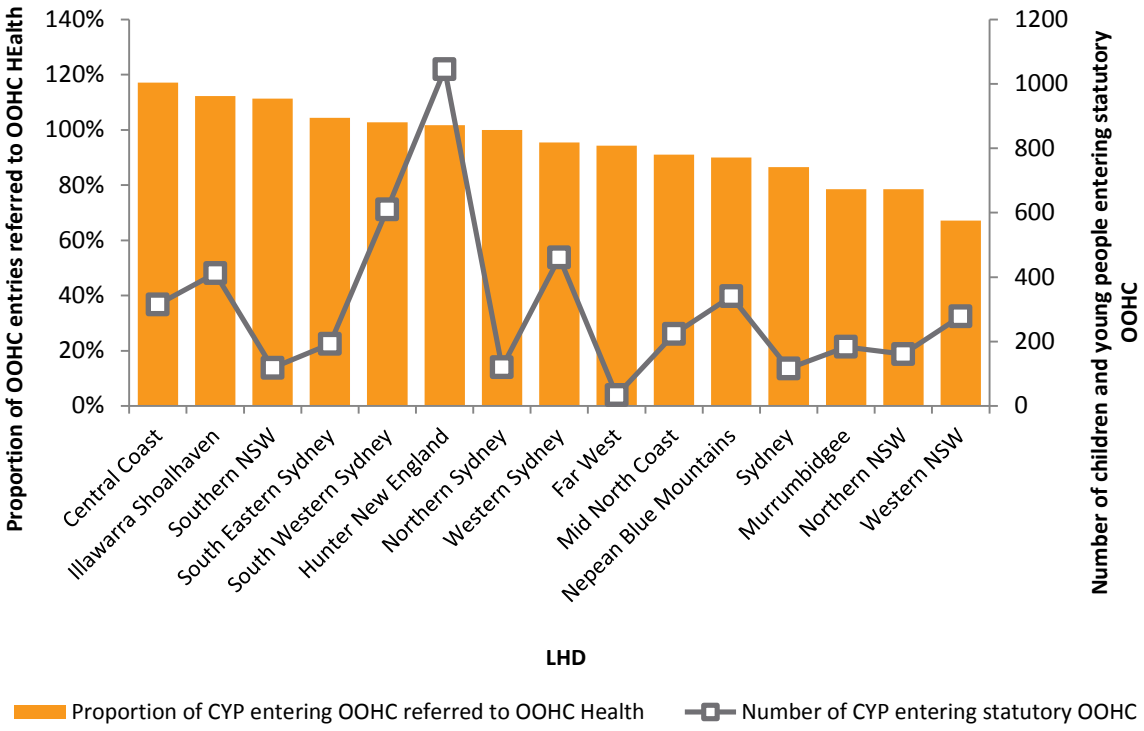
Referral rates across LHDs

Three out of the six urban LHDs had more children and young people referred to the OOHC Health Pathway Program than the number entering statutory OOHC (Northern Sydney, South Western Sydney and South Eastern Sydney). Four of the nine regional LHDs also had higher than 100% referral rates, and included the three LHDs with the highest referral rates across the state overall: Central Coast (117%); Illawarra Shoalhaven (112%), Southern NSW (111%) and Hunter New England (102%).

Rural LHDs had typically lower referral rates than their urban counterparts though some rural LHDs had high referral rates. Referral rates for rural LHDs ranged from 67% (Western NSW) to 94% (Far West).

There was no apparent link between the number of children and young people entering statutory OOHC in an LHD and the referral rates to the OOHC Health Pathway Program. The LHD with the highest number of entries into statutory OOHC, Hunter New England, is located in a regional area and also had one of the highest referral rates (102%), but urban LHDs with small numbers of entries also had high referral rates (e.g. Northern Sydney).

Figure 8: Proportion of OOHC Health Pathway Program referrals and number of entries to statutory OOHC, by LHD



Source: *NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

Referral rates of children and young people by age

Nous was unable to obtain data on the number of children and young people referred to the OOHC Health Pathway Program by age, as this information is not captured by either NSW Community Services or by NSW Kids and Families.

4.1.2 Most health assessments were performed equitably across the population of children and young people in OOHC

Evaluation sub-questions	Key findings

What, if any, differences have there been in the levels of support and access to the OOHC Health Pathway Program based on the age of children and young people? Why have these differences occurred?	According to the most recently available data, there were no differences in access to primary health assessments by age. Children aged 6-12 years had greatest access to comprehensive assessments and HMPs were commenced for 93-95% of children and young people in OOHC.
	• 2a primary health assessments:
	  ◦ 2a primary health assessments were completed within 30 days of entering OOHC at higher rates for children aged 0-5 (40%) and lower rates for young people aged 13–18 years (17%) at the start of the OOHC Health Pathway Program in 2010/11. These rates equalised across age groups in 2012/13 to approximately 22%.
	  ◦ Previous higher rates of primary health assessments for children aged 0-5 years were due their access to child and family health nurses while older age groups relied more heavily on GPs, according to IPC and

Evaluation sub-questions	Key findings
	Health OOHC Coordinator consultations. ◦ Previous lower rates of primary assessments for young people aged 13-18 years were due to their ability to opt out of the OOHC Health Pathway Program, a greater frequency of placement breakdown and placement change experienced in this age group, and a shorter time spent in OOHC than younger children (according to consultations). ◦ A majority of 2a primary assessments were completed within 30 days of being referred to the OOHC Health Pathway Program. In 2011/12, 56% of children and young people referred to the OOHC Health Pathway Program received a 2a primary assessment within 30 days. This figure had improved to 68% by 2012/13. ◦ 2b comprehensive assessments: ◦ Children aged 6-12 had the highest rate of 2b comprehensive assessments completed during the 2010/11 to 2012/13 period (28%), followed by children aged 0-5 (20%) and young people aged 13-18 (18%). No reasons for these differences were identified through the data, consultations or surveys. ◦ HMPs ◦ Young people aged 13-18 had the highest rates of commenced HMPs for the 2010/11-2011/12 period (95% completed or pending) but this represented a relatively small number of HMPs (37 recorded). HMPs for children under 5 (93% and 128 recorded) and those aged 6-12 (93% and 79 recorded) were also completed at high rates in the OOHC Health Pathway Program. No reasons for these differences were identified through the data, consultations or surveys.

Evaluation sub-questions	Key findings
What, if any, differences have there been in the rates of Aboriginal children/young people and non-Aboriginal children/young people receiving health assessments, HMPs and health reviews? Why have these differences occurred?	According to the available health data and compared to their non-Aboriginal counterparts, Aboriginal children and young people had similar rates of receiving primary health assessments, comprehensive assessments and HMPs except Aboriginal children and young people aged 6 years and above had lower rates for primary health assessments, those aged 13-18 years had lower rates for comprehensive assessments and those aged 0-5 years had higher rates of comprehensive assessments. Consultation participants expressed a contrasting view that the rates of receiving all components of the OOHC Health Pathway Program were likely to be lower for Aboriginal children and young people. • Aboriginal children and young people aged 6-12 and 13-18 had lower rates of 2a primary assessments completed within 30 days (21% and 7% respectively) compared to non-Aboriginal children and young people (30% and 29%). Rates were similar for Aboriginal children aged 0-5 (30%) to their non-Aboriginal counterparts (26%). • Aboriginal children and young people had higher rates of completed 2b comprehensive assessments as non-Aboriginal people for ages 0-5 (7% vs. 4%), similar rates for 6-12 (9%), and lower rates for 13-18 (0% vs. 7%). • HMPs commenced at similar rates for Aboriginal and Torres Strait Islander children and young people compared to non-Aboriginal people, on average (61% vs. 62% respectively). • The views of consultation participants were somewhat in contrast with the findings from the data as they indicated through consultations that the rates of assessments, HMPs and reviews for this population were likely to have been relatively low due to poor engagement of Aboriginal NGOs and carers, and the policies of some health services to not offer further appointments if two are missed without prior notice.
What, if any, differences have there been in health assessment, HMP and health review services based on the location of the children and young people, specifically differences between rural/remote and urban/regional locations? Why have these differences occurred?	According to available health data, there were no differences in the rates of receiving health assessments, HMPs and reviews based on the remoteness of the location of the children and young people. In contrast, consultation participants indicated the greater the remoteness of the child or young person, the likely greater the difficulty of accessing assessments and health services and also identified the existence of cross-border issues. • There were no observable differences in health assessments or HMPs based on whether the LHD was rural/remote/regional or urban. • There were large variations in rates of completion of health assessments and HMPs by LHD. The reasons for this were not identified. • A slight correlation between the number of assessments/HMPs and the rates of completion was observed, i.e. more assessments/HMPs equalled higher completion rates.

Evaluation sub-questions	Key findings

Have all children and young people within the target group received a primary assessment, followed by a comprehensive assessment based on triage and findings of the primary assessment? If not, why not?	According to case file audit data, while 90% or more children and young people who were referred for primary and comprehensive assessments received these assessments, the NSW Kids and Families data indicates that only around one third of these assessments occurred within the timeframes stipulated in the *Clinical Practice Guidelines*.
	• 2a primary health assessments:
	  ◦ Case file audit data indicated 90% of children and young people who were referred for a primary assessment then went on to receive a primary assessment. Reasons for some not receiving a primary assessment were not identified.
	  ◦ In 2012/13, most 2a primary assessments were completed more than 30 days after the interim order was issued (71%). Consultation participants suggested the main reason for this was the flow-on effect of delays in referrals made by Community Services. Most 2a assessments were completed within 30 days of the referral being received by the LHD (68% in 2012/13).
	• 2b comprehensive health assessments:
	  ◦ Case file audit data indicated 97% of children and young people who were referred for a comprehensive assessment then went on to receive a this assessment.
	  ◦ Consultation participants suggested the extent to which children and young people received comprehensive assessments differed between LHDs due to variations in resourcing and approaches.
	  ◦ In 2012/13, 61% of comprehensive assessments were completed more than 3 months after the interim order was issued. Consultation participants suggested the main reason for this was the relatively limited resources compared with the volume of referrals.

Related recommendations	
• 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding), 10 (Access to assessments), 13 (Engagement of carers)	

What, if any, differences have there been in the levels of support and access to the OOHC Health Pathway Program based on the age of children and young people? Why have these differences occurred?

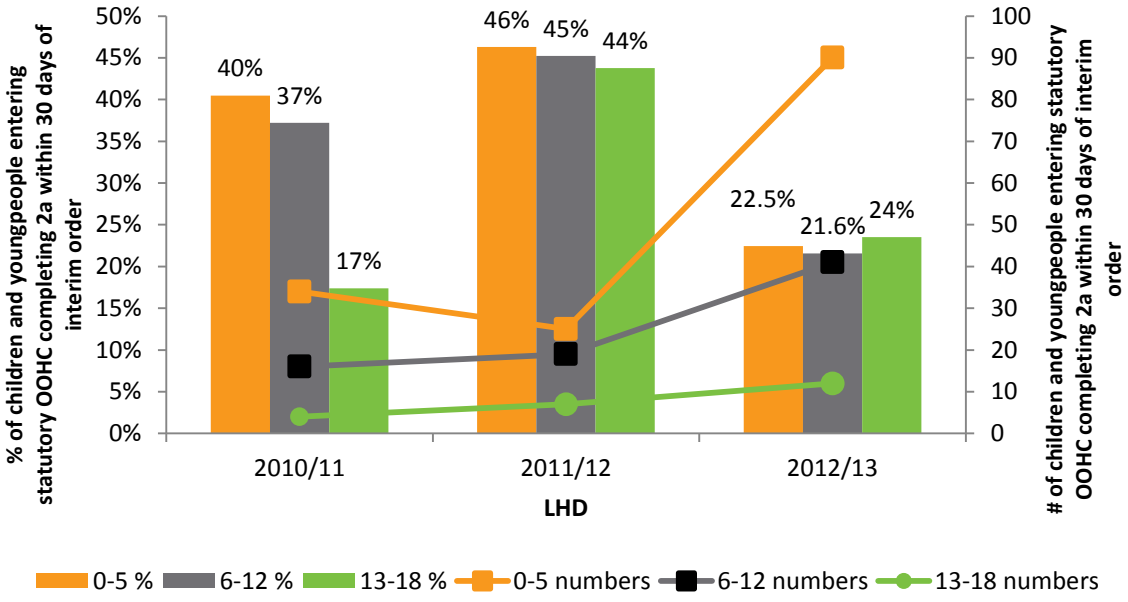
The most recently available data indicates there were no differences in access to primary health assessments by the age of the child or young person, children aged 6-12 years had greatest access to comprehensive assessments and HMPs were commenced for 93-95% of children and young people in OOHC. Access to each of these components of the OOHC Health Pathway Program by age is discussed in turn below.

2a primary health assessments by age group

During the 2011/2012 reporting period, additional, one-off funding was allocated to provide health assessments to all children aged between 0-5 already within OOHC (and who had not already received one within the last 12 months) in addition to those entering care[12].

Children aged 0-5 years had the highest rate of 2a primary assessments completed within 30 days of entering statutory OOHC[13] and young people aged 13-18 years had the lowest rate in 2010/11, as shown in Figure 9[14]. The rates for each age group then equalised from 2011/12 onwards, dropping considerably in 2012/13 due to incomplete data returns to the Community Services database[15].

Figure 9: 2a primary health assessments by age group



Source: NSW Department of Family and Community Services, KiDS database records

[12] Sourced from NSW Kids and Families: OOHC Health Pathway Program documentation

[13] The OOHC Health Pathway Program *Clinical Practice Guidelines* stipulate that a child or young person entering statutory OOHC should receive a primary health assessment (2a) within 30 days of the interim order being issued.

[14] These data were obtained from Community Services records, as NSW K&F does not record aggregate data broken by age categories. Community Services records are incomplete for 2a assessments (and 2b assessments and Health Management Plans), with only a subset of the children and young people in the OOHC Health Pathway Program being recorded in the Community Services KiDS database.

[15] The lower rate of completions for the 2012/13 financial year is due to incomplete data returns to the Community Services database for the most recent year of the OOHC Health Pathway Program, as shown by the high number of 'missing' entries.

Through consultations, IPCs and NSW Health OOHC Coordinators identified reasons that contributed to the higher rates of primary health assessments for children aged 0-5 years and lower rates for young people aged 13-18 years as follows:

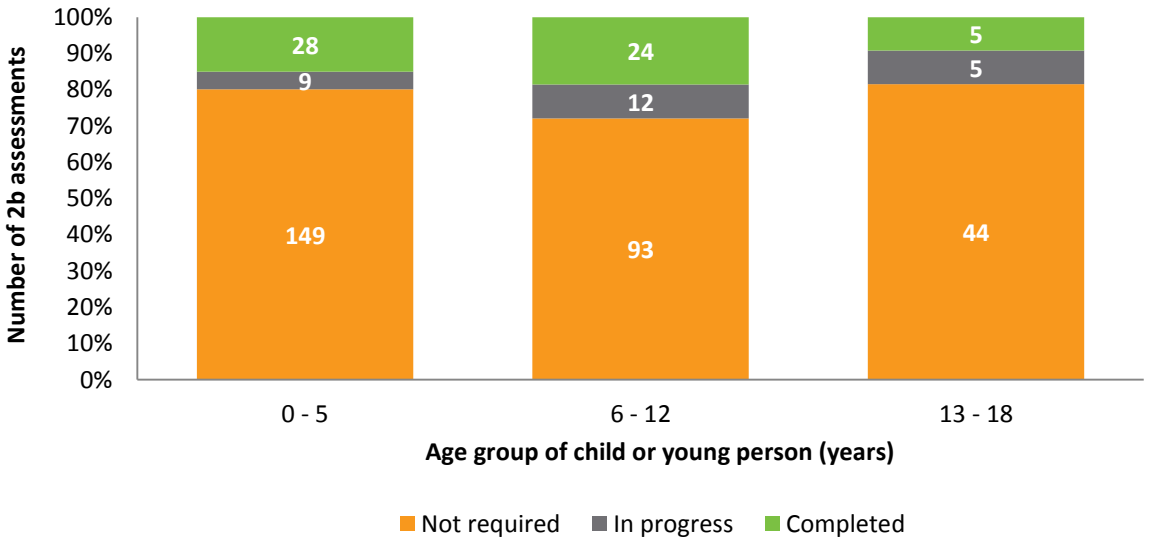
- 0-5 year olds – this age group accessed primary health assessments predominantly through child and family health nurses while the older age groups were unable to access these practitioners, instead relying heavily on access to GPs. Child and family health nurses were easier to access and better engaged with the OOHC Health Pathway Program than GPs.
- 13 – 18 year olds – unlike their younger counterparts, young people aged 14 years and above had to actively consent to participating in the OOHC Health Pathway Program and therefore could refuse to do so. Other reasons identified included young people in this age group tended to more frequently experience placement breakdowns and resultant placement changes, and were often in OOHC for a shorter period. The IPCs did note that, where youth health services were available, this did support greater access to the OOHC Health Pathway Program for those aged 13-18 years.

Notably, both the IPCs and NSW Health OOHC Coordinators highlighted through the consultations that children who entered OOHC at birth tended to experience long delays in accessing the OOHC Health Pathway Program partly due to delays in these children being able to access a Medicare number, a prerequisite for enrolment in the OOHC Health Pathway Program.

Comprehensive health assessments by age of the child or young person

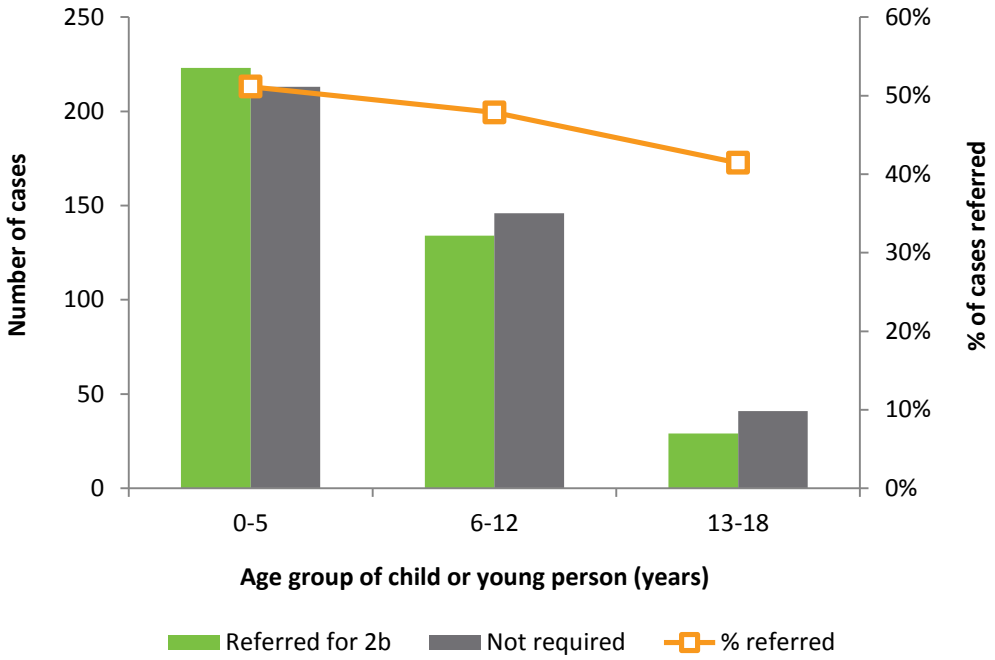
For those children and young people with recorded health assessment information, a majority were assessed as not requiring a comprehensive health assessment, as shown in Figure 10. Over the period 2010/11 to 2012/13, children aged 6-12 received the highest rate of comprehensive health assessments, followed by those aged 0-5 and 13-18. A more detailed view of 2b assessments was provided via the case file audit data, shown in Figure 11 below. In those LHDs that provided case file audit data, referral rates for 2b comprehensive assessments were similar for children aged 0-5 (51%) and 6-12 (48%) but significantly lower for those aged 13-18 (41%). The combination of data limitations and timing of consultations limited the opportunity for the evaluation to explore the reasons for these differences.

Figure 10: Percentage of 2b comprehensive health assessments by age category



***Source**: NSW Family and Community Services: Community Services, KiDS database 2010/11 to 2012/13*

Figure 11: Number and percentage of 2b assessments by age category in case file audit



***Source**: NSW Health, case file audit of Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

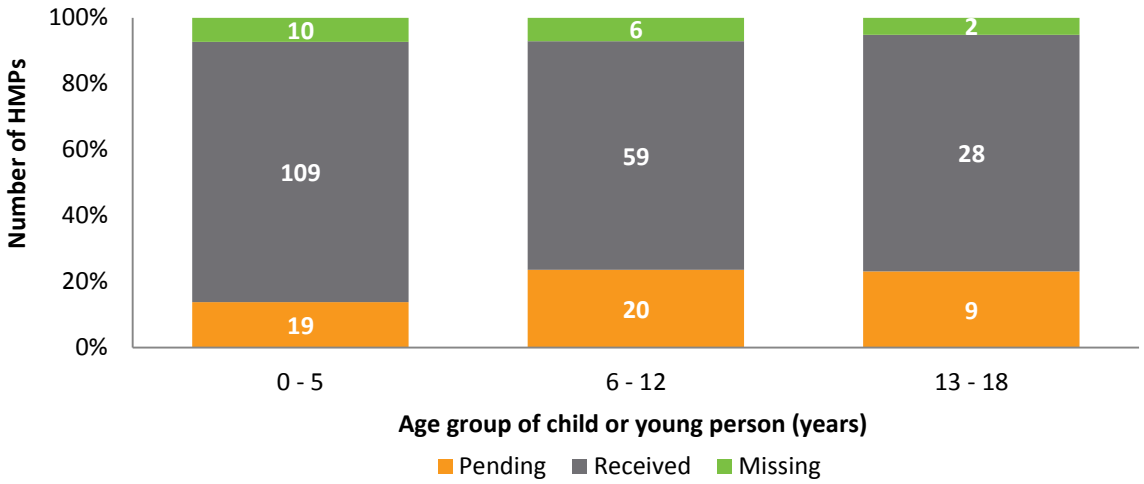
HMPs by age group

HMPs are developed from the 2a and, if applicable, 2b health assessments for each child and young person in OOHC. Development is stipulated to occur within three weeks of finalisation of assessment results (NSW Ministry of Health, 2013). An HMP is to be developed for every child who has received a health assessment. For more discussion of HMPs see Section 4.1.3.

Most children and young people in the OOHC Health Pathway Program received a HMP, as shown in Figure 12. For 2010/11 and 2011/12 (ie those years for which data was complete) more than 90% of children and young people in the OOHC Health Pathway Program had HMPs recorded as either pending or complete. Children aged 0-5 and young people aged 13-18 had the highest rates of completed HMPs. A case audit of children and young people in the OOHC Health Pathway Program in selected LHDs also found that most children and young people who had been assessed also received a HMP (Figure 13)[16]. No reasons for the particularly high rates of HMP completion or the differences between the age groups were identified through the data, consultations or surveys.

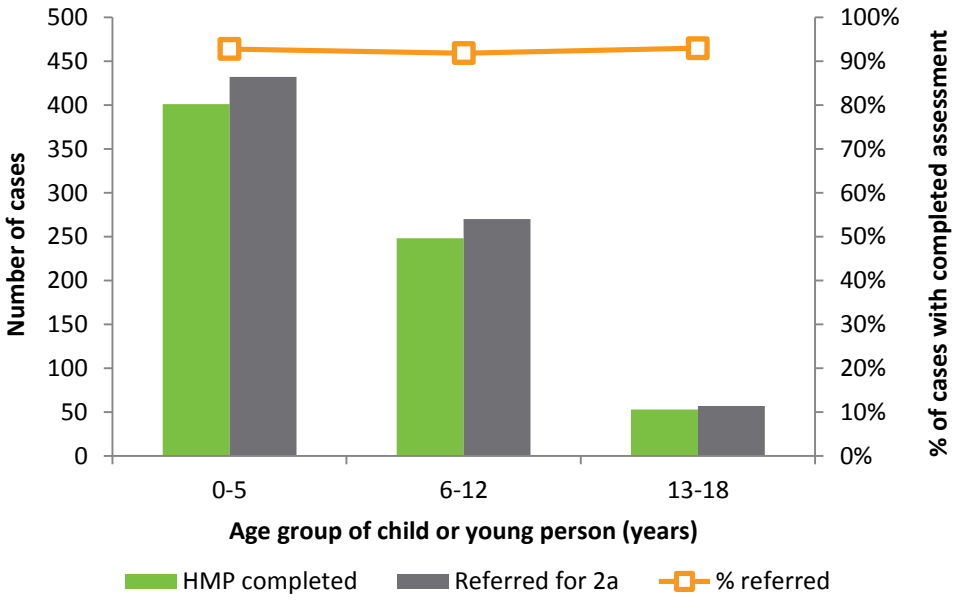
[16] There was no single source of data that contained the total number of HMPs completed for children and young people in the OOHC Health Pathway Program for a given year. NSW Kids and Families records the number of HMPs completed within 3 weeks of the 2a/2b assessment, but not the total number. Community Services records the total number of HMPs completed, but covers only a small subset of the OOHC Health Pathway Program population. Similarly, the case file audit identified whether a HMP had been completed, but was limited to 2012/2013 and the Hunter New England-, Mid North Coast, Northern NSW, and South Western Sydney LHDs.

Figure 12: HMPs, pending, received and missing, by age group



***Source**: NSW Family and Community Services: Community Services, KiDS database*

Figure 13: Number and percentage of HMPs by age category in case file audit



***Source**: NSW Health, case file audit of Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

What, if any, differences have there been in the rates of Aboriginal children/ young people and non-Aboriginal children/ young people receiving health assessments, HMPs and health reviews? Why have these differences occurred?

Compared to their non-Aboriginal counterparts, Aboriginal children and young people had similar rates of receiving primary health assessments, comprehensive assessments and HMPs except Aboriginal children and young people aged 6 years and above had lower rates for primary health assessments, those aged 13-18 years had lower rates for comprehensive assessments and those aged 0-5 years had higher rates of comprehensive assessments according to the available health data.

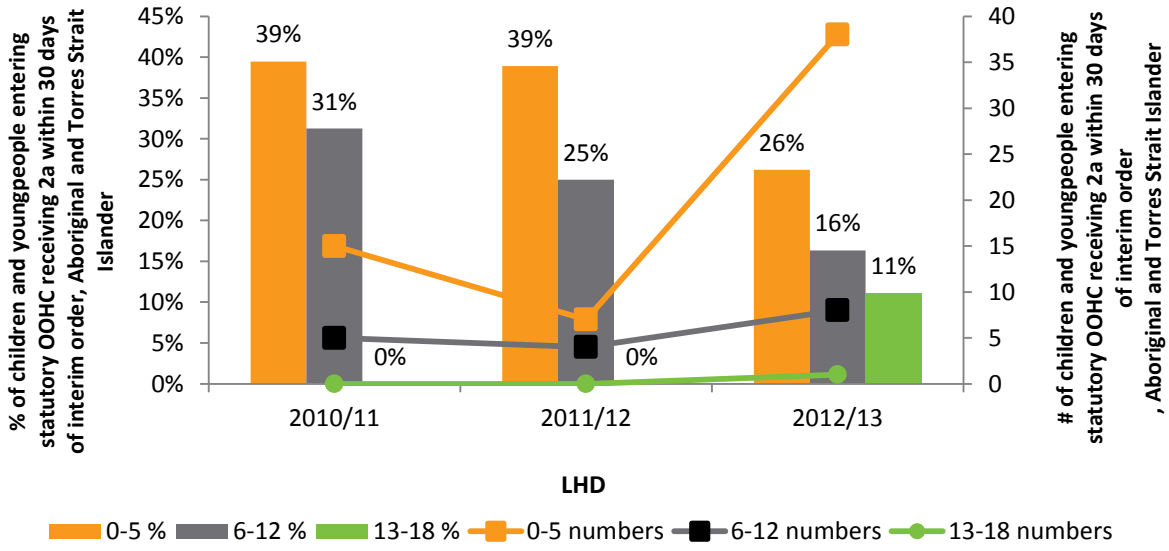
This is somewhat in contrast to the views expressed by NSW Health OOHC Coordinator consultation participants (who did not have access to the data at the time of consultation). They indicated that, across all LHDs, the rates of assessments, HMP development and also reviews for Aboriginal and Torres Strait Islander children and young people were likely to have been relatively low. The main reasons expressed for this were the weak engagement of both Aboriginal NGOs and the carers of these children and young people in combination with a policy of some health services to not offer further appointments to children/young people if they do not attend two appointments without prior notice. NGO OOHC Case Managers and Karitane's Connecting Carers NSW also indicated through consultations that the engagement of kinship carers could be significantly improved. The Health OOHC Coordinators suggested the establishment of Aboriginal Case Managers to support the OOHC Health Pathway Program could help address these issues.

Receipt of each of these components of the OOHC Health Pathway Program by Aboriginal and Torres Strait Islander children and young people is discussed in turn.

2a primary assessments for Aboriginal and Torres Strait Islander children and young people

Aboriginal and Torres Strait Islander children and young people make up approximately a third of all entries into statutory OOHC, but had below average rates of referral to the OOHC Health Pathway Program in 2010/11 and 2012/13 (see section 0). Figure 14 shows that referrals rates to 2a primary assessments within 30 days of the interim order were lower for Aboriginal and Torres Strait Islander children and young people than for the broader population enrolled in the OOHC Health Pathway Program.

Figure 14: Number and % of referrals to 2a within 30 days of interim order, Aboriginal and Torres Strait Islander, by age



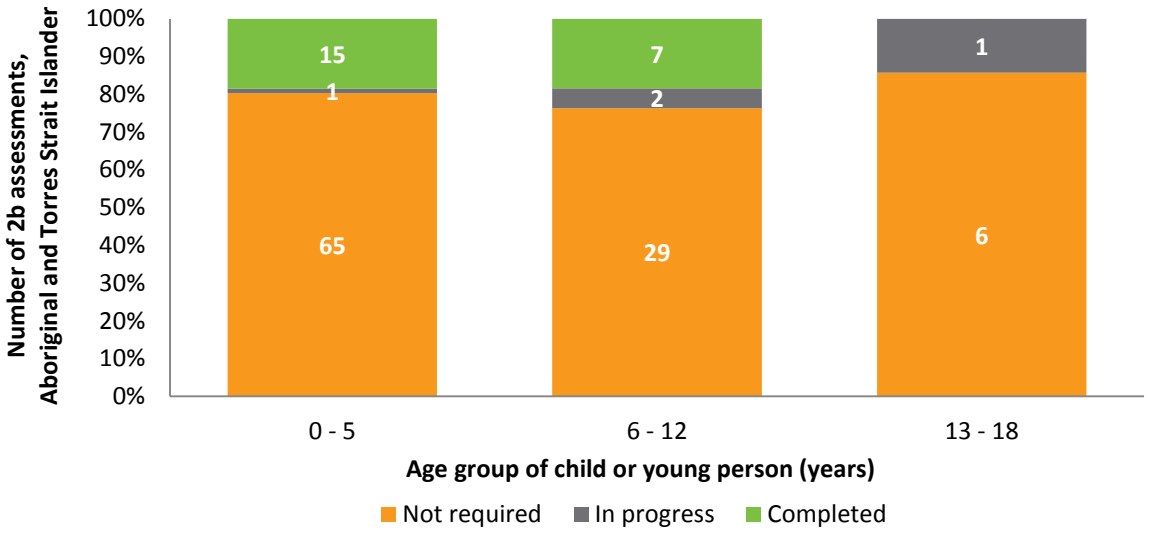
***Source**: NSW Family and Community Services: Community Services, KiDS database*

Like the overall OOHC Health Pathway Program population, Aboriginal and Torres Strait Islander children aged 0-5 received both the highest number and rate of 2a primary assessments of any of the age categories.

2b comprehensive assessments for Aboriginal and Torres Strait Islander children and young people

Few comprehensive assessments were recorded as being complete for Aboriginal and Torres Strait Islander children and young people in OOHC, shown in Figure 15. The 2b rates for Aboriginal children aged 0-5 (20%) and 6-12 (24%) was similar to those for non-Aboriginal children (20% and 28%, respectively), and slightly lower for young people aged 13-18 (14% for Aboriginal vs. 18% for non-Aboriginal). Children aged 6-12 had the highest rate of 2b comprehensive assessments recorded as completed or in progress. No 2b comprehensive assessments were recorded as being complete for Aboriginal young people aged 13-18.

Figure 15: Number of 2b comprehensive assessments for Aboriginal and Torres Strait Islander people in the OOHC Health Pathway Program

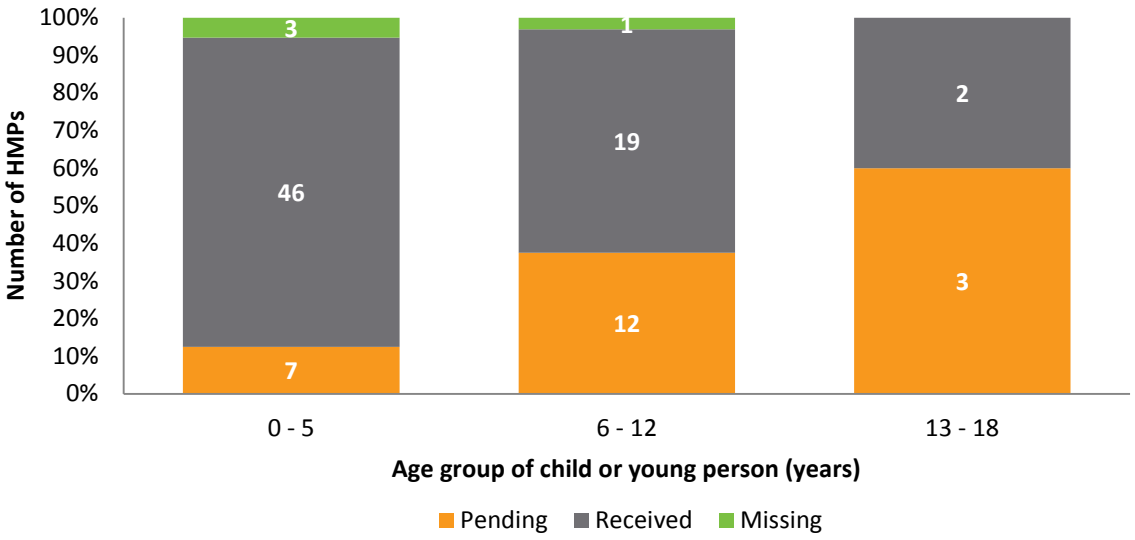


***Source**: NSW Family and Community Services: Community Services, KiDS database*

HMPs for Aboriginal and Torres Strait Islander children and young people

HMP completion rates for Aboriginal and Torres Strait Islander children and young people were broadly similar to their non-Aboriginal counterparts for each of the years 2010-2013, with the combined received and pending rates consistently above 90%. However, "received" rates for Aboriginal and Torres Strait Islander children and young people aged 6-12 (59%) and 13-18 (40%) were significantly lower than for the overall population (69% and 72%, respectively).

Figure 16: HMPs for Aboriginal and Torres Strait Islander people in the OOHC Health Pathway Program



***Source**: NSW Family and Community Services: Community Services, KiDS database*

What, if any, differences have there been in health assessment services based on the location of the children and young people, specifically difference between rural/remote and urban/regional locations? Why have these differences occurred?

There were no differences in the rates of receiving health assessments, HMPs and reviews based on the remoteness of the location of the children and young people according to the available health data.

This is in contrast to the views expressed during the IPC and clinician consultations. Participants indicated that, the more remote the child/young person, the more difficult the access to assessments and health services. Suggested reasons for this included the longer distances and travel times for carers, children/young people and clinicians to attend appointments, lack of transport to enable carers and the children/young people to attend appointments, and the often long waits for the relevant health practitioners to visit the rural/remote location.

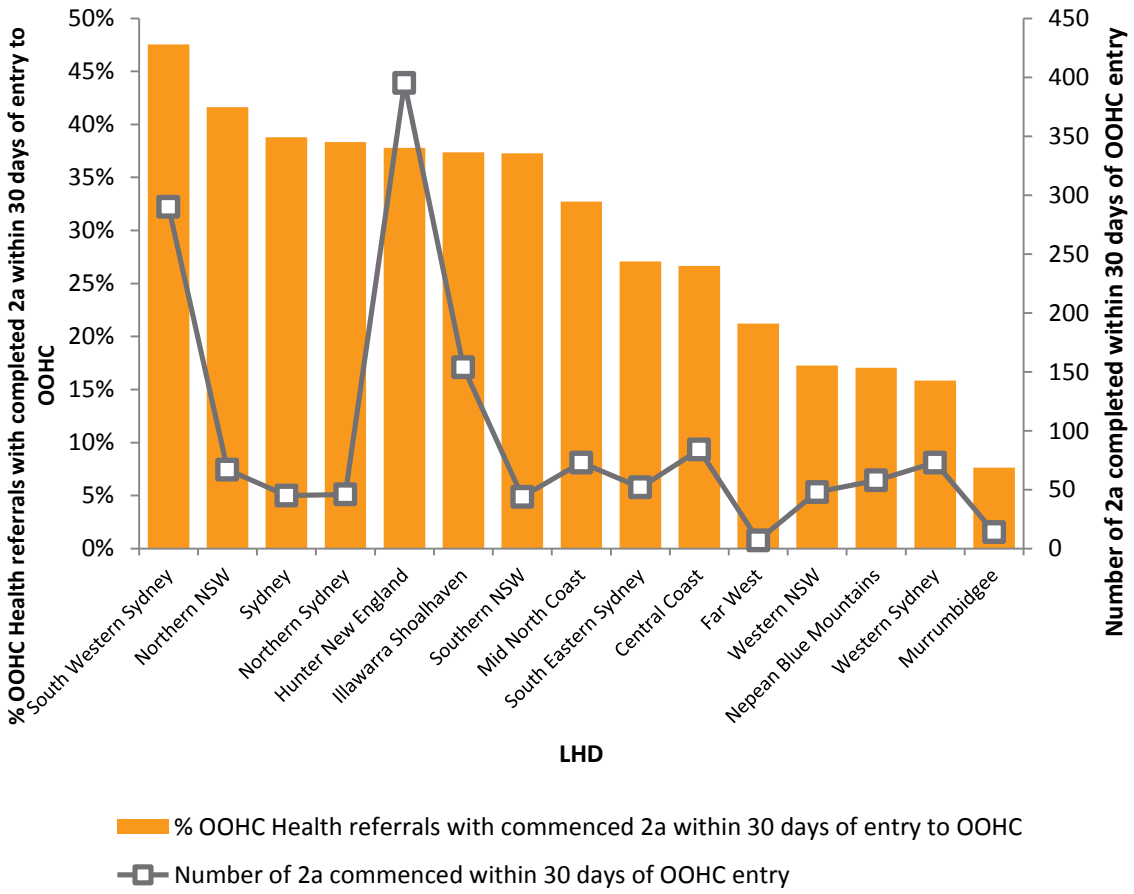
IPCs and NGO OOHC provider consultation participants also identified the existence of cross-border issues which have resulted in delayed access to health services. For example, some children/young people living in NSW close to the borders with Victoria and Queensland were unable to access nearby specialist services under the OOHC Health Pathway Program because they were located in a state other than NSW, instead being required to travel extensive distances to access services in Sydney.

Access to each of these components of the OOHC Health Pathway Program based on location is discussed in turn.

2a primary health assessments by LHD

There were large variations between LHDs in the number of 2a primary assessments that commenced within the specified timeframe of 30 days after entry into OOHC, as shown in Figure 17.

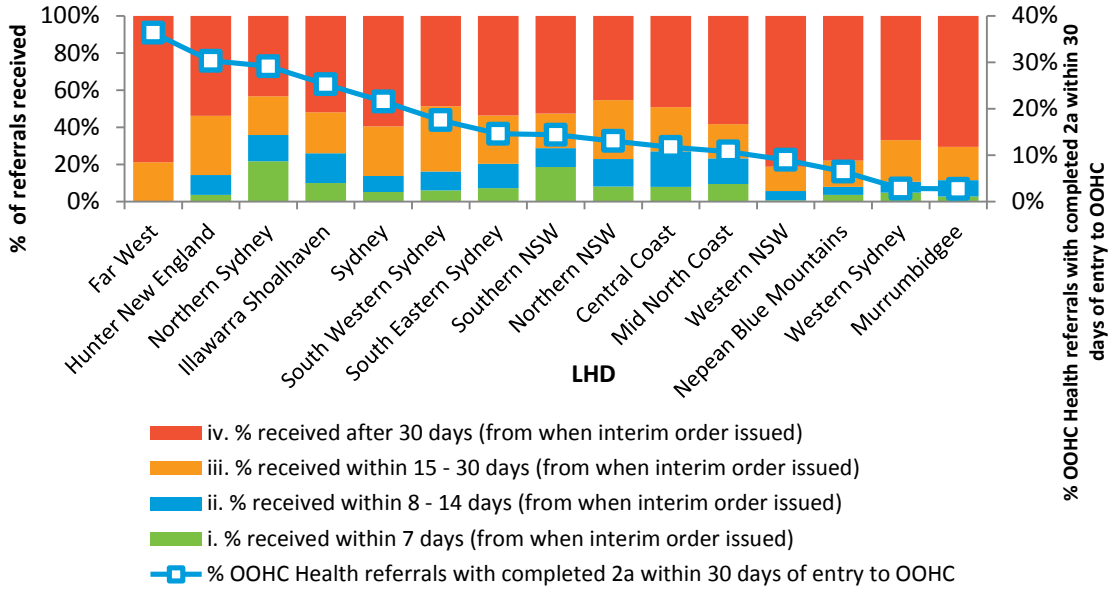
Figure 17: OOHC Health Pathway Program referrals and 2a assessments commenced within 30 days of interim order, by LHD



Source: *NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

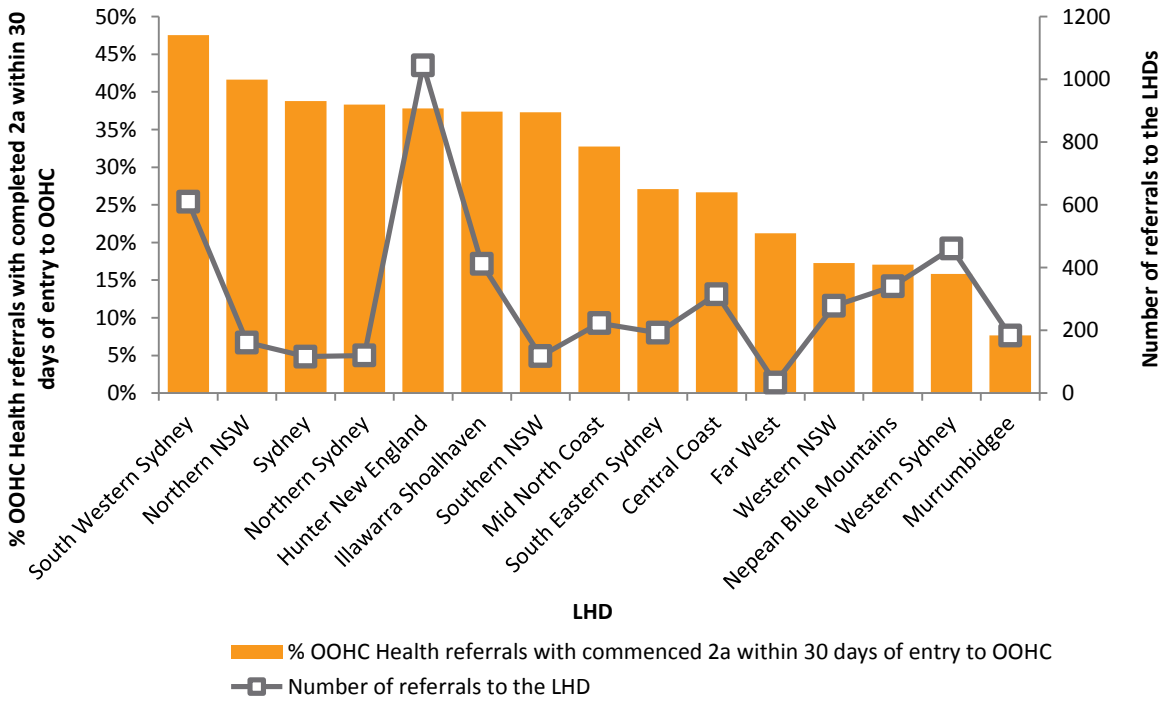
The reasons for these variations were not explicitly identified through the data, consultations or surveys. No significant urban/regional divide was observed in terms of assessment numbers or rates. However, there was a weak correlation between the timeliness of referrals from Community Services to LHDs and the percentage of 2a assessments completed within 30 days of the interim order (Figure 18).

Figure 18: Timeliness of OOHC Health Pathway Program referrals received by LHDs



Source: *NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

Figure 19: OOHC Health Pathway Program referrals with commenced 2a within 30 days of interim order compared to total number of referrals, by LHD



Source: *NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

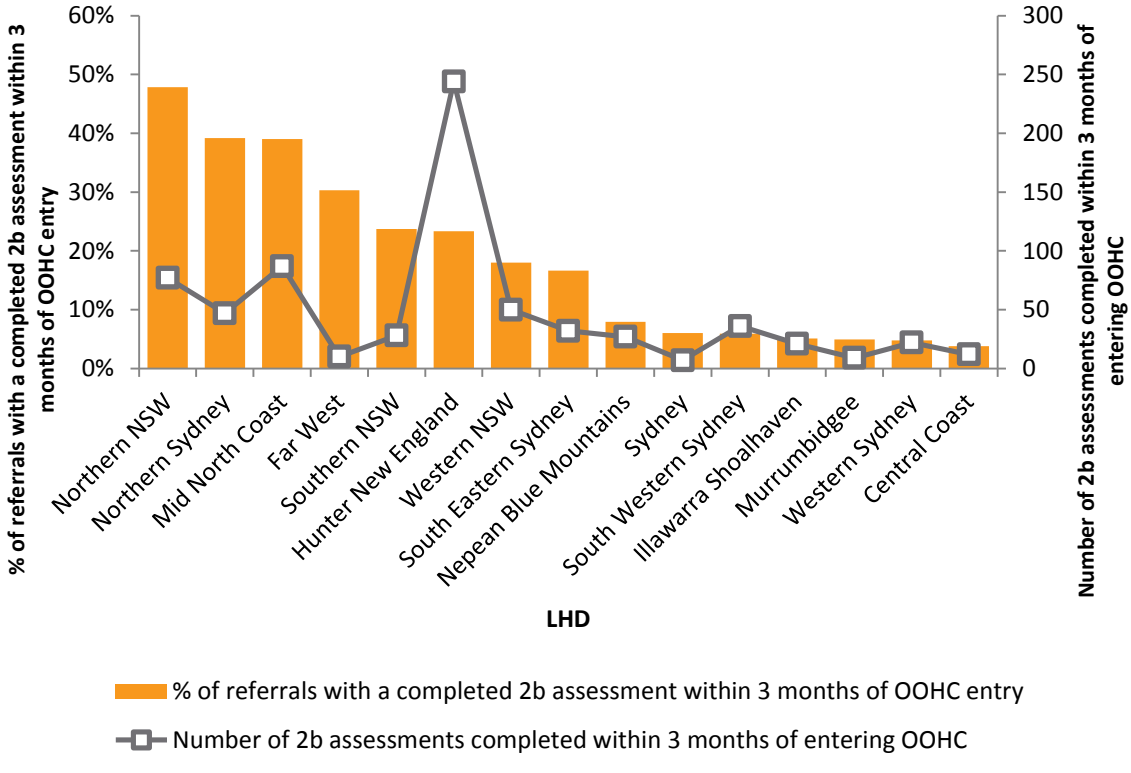
The highest number of 2a primary assessments was performed in the Hunter New England LHD (395), followed by South Western Sydney (290) and Illawarra Shoalhaven (154). The lowest number of 2a

primary assessments commenced was in the Far West LHD (7) and Murrumbidgee (14). Commencement rates were highest in South Western Sydney (48%) while the lowest rates were recorded in Murrumbidgee (8%), Western Sydney (16%) and Nepean Blue Mountains (17%).

2b comprehensive health assessments by LHD

Regional variations were also observed for 2b comprehensive assessments across the LHDs, the reasons for which were not identified through the data, consultations or surveys. Again, no link between urban/regional/rural status and the rate for 2b comprehensive assessments was observed. As for the 2a primary assessments, Hunter New England had the highest number of 2b comprehensive assessments (244), followed by Mid North Coast (87) and Northern NSW (77). The lowest numbers of 2b comprehensive assessments were performed in Sydney (7), Murrumbidgee (9) and Far West (10). The highest rates of 2b comprehensive assessments were recorded in Northern NSW (48%) and Northern Sydney (39%).

Figure 20: 2b comprehensive assessments by LHD

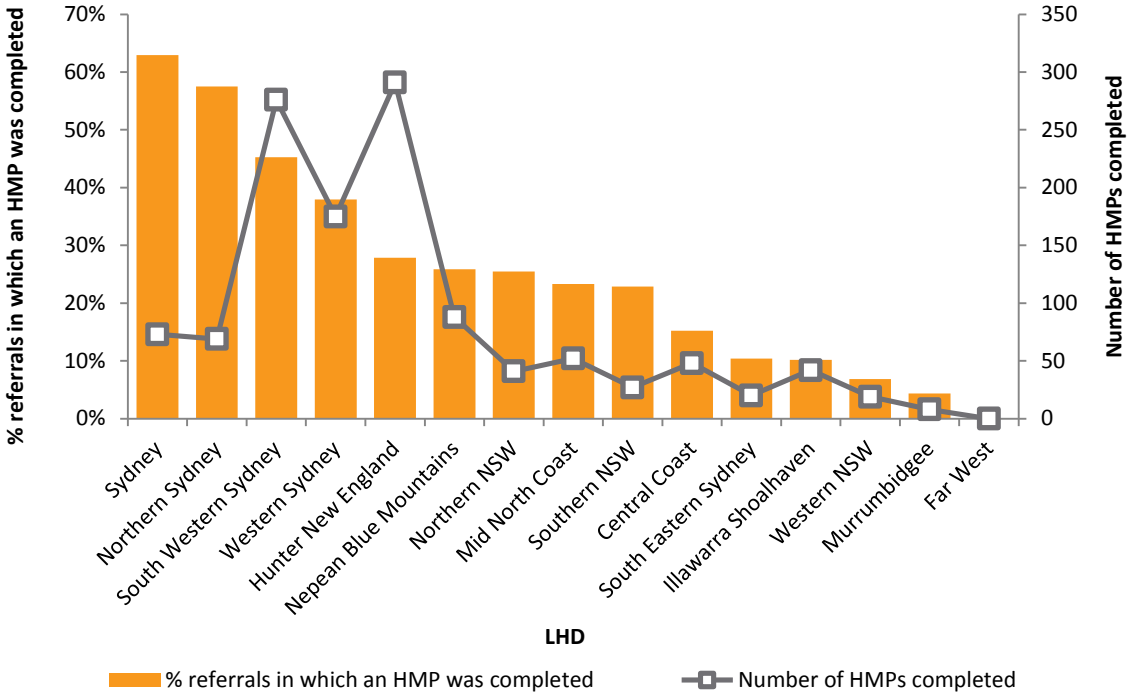


Source: *NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

HMPs by LHD

Urban LHDs had the highest rates of completing HMPs compared to rural and regional LHDs. These included Sydney (73 HMPs, representing 63% of referrals received), South Western Sydney (276, 45%) and Northern Sydney (69, 58%). Regional LHDs such as Murrumbidgee (8, 4%) and Far West (no recorded HMPs) had amongst the lowest number and rates of HMPs completed. Hunter New England had the highest number of HMPs recorded (291) as well as the 5th highest completion rate (28%). The reasons for these variations were not identified through the data, consultations or surveys.

Figure 21: HMPs by LHD



Source: *NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

Have all children and young people within the target group received a primary assessment, followed by a comprehensive assessment based on triage and findings of the primary assessment? If not, why not?

Completion of primary health assessments

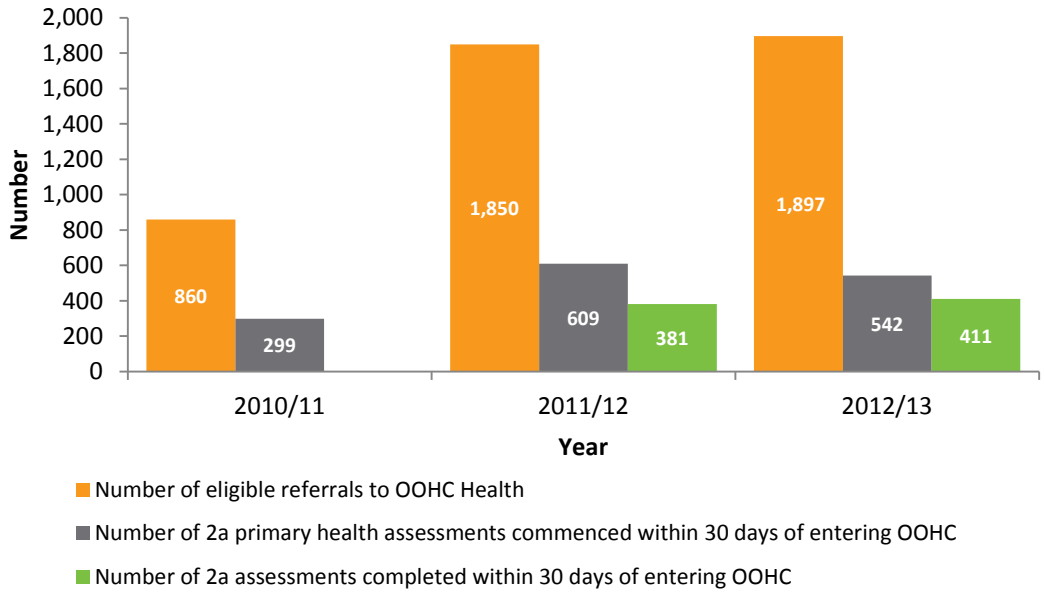
The vast majority (90%) of children and young people who were referred for a primary assessment (n=789) then went on to receive a primary assessment (n=710) according to the 2012/13 case file audit data obtained from four LHDs.[17] This information for all children and young people who entered OOHC was not available through the NSW Kids and Families or Community Services supplied datasets. Clinician consultations supported this finding from the case file audit data, indicating the majority of children and young people did receive primary health assessments. Consultation and survey participants did not identify specific reasons for some children and young people not receiving primary health assessments.

[17] The four LHDs were Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs.

Timeliness of primary health assessments

The OOHC Health Pathway Program guidelines stipulate that a child or young person entering statutory OOHC should receive a primary health assessment (2a) within 30 days of the interim order being issued. As seen in Figure 22, fewer than half of the children and young people referred to the OOHC Health Pathway Program received 2a primary health assessments within 30 days of the child or young person entering statutory OOHC. These rates decreased from 2010/11 to 2012/13. During 2010/11, 35% of 2a primary assessments commenced within 30 days of the child or young person entering OOHC. This proportion had dropped to 29% by 2012/13.[18]

Figure 22: Number of 2a primary assessments commenced and completed in 30 days of entering statutory OOHC

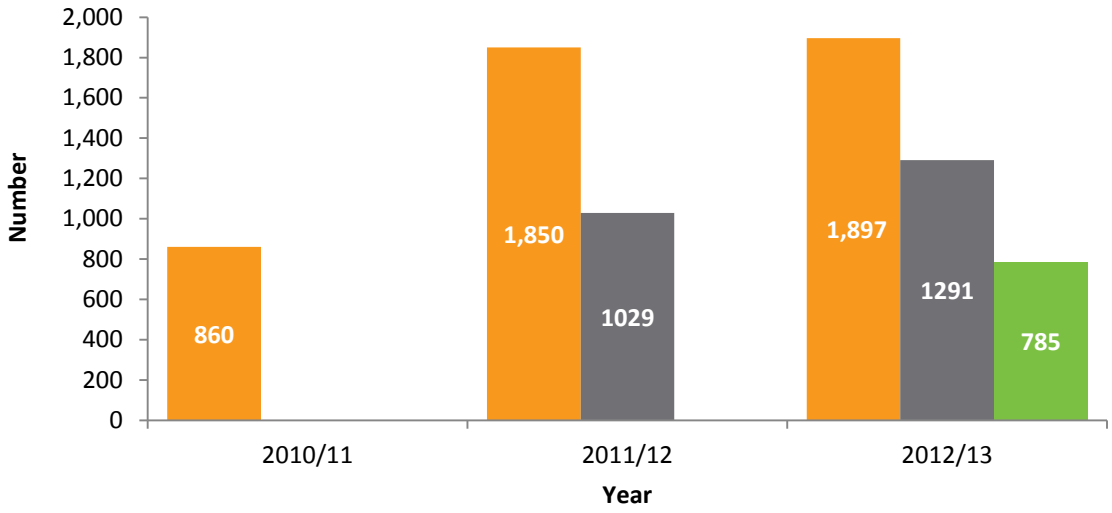


***Source**: NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

A range of consultation participants indicated that children and young people often did not receive a primary health assessment within the 30 days of an interim order being issued, and suggested one reason for this delay was the flow-on effect of delays in referrals made by Community Services to the OOHC Health Pathway Program. This is supported by evidence that shows a majority of children and young people receiving 2a primary assessments within 30 days of being referred to the OOHC Health Pathway Program, as shown in Figure 23. In 2011/12, 56% of children and young people referred to the OOHC Health Pathway Program received a 2a primary assessment within 30 days. This figure improved to 68% in 2012/13.

[18] Nous was unable to obtain data relating to the total number of 2a assessments commence and completed, e.g. for those completed after 30 days of entering OOHC or after referral to OOHC Health.

Figure 23: Number of 2a primary assessments commenced and completed in 30 days of referral to the OOHC Health Pathway Program



Number of eligible referrals to OOHC Health

Number of 2a primary health assessments commenced within 30 days of referral being received by Local Health District

Number of 2a assessments completed within 30 days of referral to LHD

***Source**: NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

Completion of 2b comprehensive assessments

According to the *Clinical Practice Guidelines*[19], a comprehensive health assessment may be conducted based on triage and the findings from the initial health assessment. 'Red Flags' detected as part of the 2a primary assessment that should lead to a referral to a 2b comprehensive assessment are outlined in these guidelines and include:

- physical health concerns/injuries
- developmental concerns, including relationship issues, academic or learning difficulties, and placement history concerns
- psychosocial or mental health issues, including medications, cultural concerns, and drug use
- general concerns regarding carer's wellbeing and capacity to meet the child's needs

Some LHDs (e.g. Mid-North Coast and Northern NSW) operated service models in which all children and young people receive both the primary health assessment and comprehensive health assessments from a paediatrician[20], while other LHDs (e.g. South-Eastern Sydney) referred children and young people to the 2b comprehensive assessment only after a GP referral from 2a as specified in the OOHC Health Pathway Program guidelines[21].

[19] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care

[20] Cormick, J. (2011) Out of Home Care Health Assessment Service Phase 1 Evaluation Report, prepared for NSW Health, December 2011

[21] NSW Health, Service Delivery Model Out of Home Care Health Pathways Program South Eastern Sydney LHDand Sydney Children's Hospital Network (Randwick)

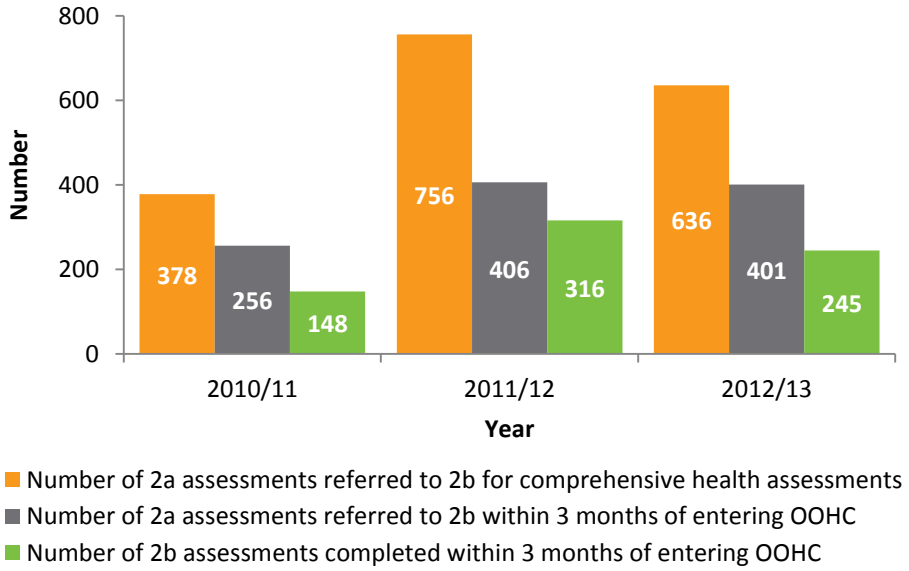
Similar to the primary health assessment data, the percentage of all children and young people who were referred for a comprehensive assessment who actually received one cannot be determined from the NSW Kids and Families, and Community Services supplied datasets. The case file audit from four LHDs indicated that 54% (n=386) of the 710 children and young people who were recorded as receiving a primary assessment were referred for a comprehensive assessment. Of these 386 children and young people, 97% (n=374) were recorded as actually receiving a comprehensive assessment.

The clinician, Health OOHC Coordinator and NGO OOHC Case Manager consultation participants suggested the extent to which children and young people received comprehensive assessments differed between LHDs due to variations in resourcing and approaches. For example, it was reported that all children and young people in one LHD were referred to and received a paediatrician conducted comprehensive assessment regardless of the results of the primary assessment. In a different LHD, a lack of available paediatricians meant that, for at least several months, relatively few children and young people who were referred for a comprehensive assessment actually received one.

Timeliness of 2b comprehensive assessments

Figure 24 shows that more than half of all children and young people who received 2a primary health assessments and were triaged to receive a 2b comprehensive health assessment were then referred to have a 2b comprehensive assessment within three months of their entry into statutory OOHC. Not all of these referrals then led to a 2b comprehensive assessment being completed within three months. Approximately one third of 2b comprehensive assessments were completed within three months of entry into statutory OOHC[22]. The main reason for this that was cited by consultation and survey participants, including clinicians and non-clinicians, was the limited resources available to conduct comprehensive assessments, particularly the psychosocial component, relative to the volume of children and young people referred for these assessments.

Figure 24: Number of 2b comprehensive assessments referred and completed within three months of entry into OOHC



***Source**: NSW Kids & Families, Quarterly Reporting Data 2010/11 to 2012/13*

[22] The total number of 2b assessments completed may be greater than shown here, as no data was recorded for this item. Only the number of 2b assessments referred and completed within 3 months of entry into OOHC were recorded by NSW Kids & Families.

4.1.3 A majority of health assessments lead to the development of a HMP

Evaluation sub-questions	Key findings
To what extent have health assessments resulted in the development of a HMP?	• Available data suggests most health assessments resulted in the development of a HMP, with case file audit data indicating 91% of assessments resulted in an HMP. • Case file data indicated 44% of HMPs were completed within the guideline of three weeks following the comprehensive assessment or primary assessment if a comprehensive assessment was not required.
To what extent have HMPs been communicated to the agency with case management?	• Limited evidence suggests that most HMPs were communicated from NSW Health/LHDs to Community Services (the case management agency), with less that 15% of HMPs recorded by NSW K&F also being recorded by Community Services in their KiDS database.
To what extent have the carer and child/young person received appropriate and timely intervention as a result of the HMPs?	• No information about the appropriateness of interventions resulting from HMPs was available. • Data obtained through a detailed review of nine cases suggested about half received their first intervention or further assessment within six months of entering OOHC. • The IPCs, through consultation, suggested that children and young people were more likely to have received appropriate and timely interventions if they had an HMP in place and they had stability in their placement and the case worker responsible for assisting them.
Related recommendations	
• 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding), 13 (Engagement of carers), 15 (Responsibility for developing HMP)	

To what extent have health assessments resulted in the development of a HMP?

All children and young people who receive a health assessment, either 2a or 2b, should also receive an HMP within three weeks of the assessment. The HMP identifies the outcomes of all health assessments conducted for the child or young person in OOHC and the appropriate health services for intervention and on-going care[23]. The carer is responsible for implementing the HMP with the support of the Health OOHC Coordinator and case manager under the OOHC Health Pathway Program guidelines[24], particularly with respect to referrals to specialist services.

The evidence suggests that most health assessments result in an HMP, and the available data for 2012/13 are summarised in Table 2[25]. NSW Kids & Families data indicated that more HMPs were completed in 2012/13 (696) than the number of 2a assessments (548), suggesting that the OOHC Health Pathway Program processes were completing HMPs for most children and young people entering the OOHC Health Pathway Program in that year as well as some cases from previous years. The case file audit data on children and young people enrolled in the OOHC Health Pathway Program supported this finding, showing that more than 91% of children and young people who received a health assessment also received a HMP.

[23] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care

[24] NSW Health (2011) A Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering Out Of Home Care

[25] No annual data was available for the total number of health plans completed for children and young people in OOHC for 2010/11 and 2011/12

Table 2: Number of HMPs, 2012/13

HMP metric	Number	Source
Number of 2a primary assessments with HMP, 2012/13 from selected LHDs	697	NSW Health, case file audit 2012/13 for Hunter New England, Mid North Coast, Northern NSW, South Western Sydney
Number of 2a primary assessments without HMP, 2012/13 from selected LHDs	61	
Number of HMPs completed within 3 weeks of assessment, 2012/13	511	NSW Kids & Families, OOHC Health reporting data 2012/13
Number of HMPs completed, 2012/13	696	
Number of 2a assessments, 2012/13	548	
Number of referrals to OOHC Health, 2012/13	1897	

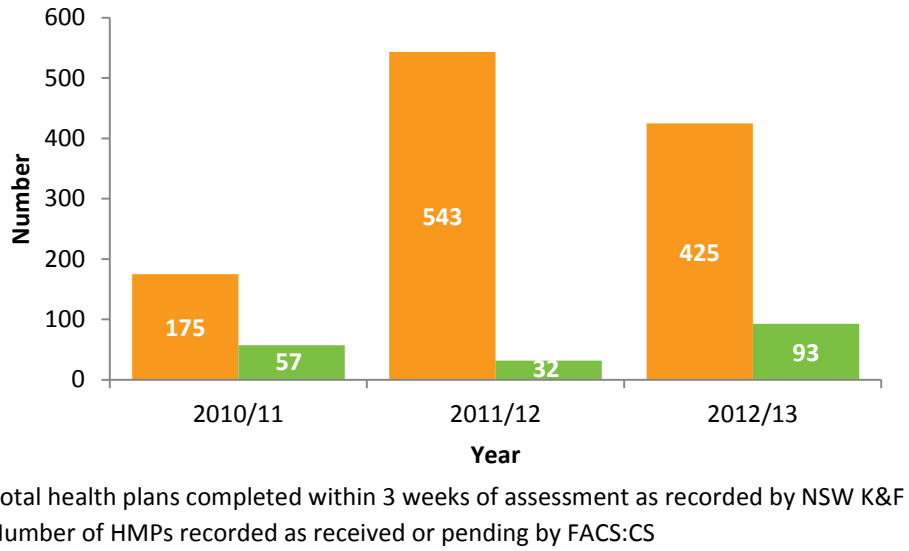
A significant proportion of HMPs are being completed within the specified 3 week timeframe from the 2a or 2b assessment. Unit data from the case file audit showed that 44% of HMPs were completed within three weeks of the 2b comprehensive assessment or within three weeks of the 2a primary assessment if a 2b comprehensive assessment was not required. An aggregate view provided by the NSW Kid & Families data showed that 73% of HMPs completed in 2012/13 were completed within 3 weeks of the assessment.[26]

To what extent have HMPs been communicated to the agency with case management?

Nous was unable to obtain data to directly determine whether all completed HMPs were communicated to Community Services. An indirect comparison is shown in Figure 25, in which the number of HMPs completed within three weeks of assessment (reported by NSW Kids and Families) was compared with the number of HMPs recorded as being received or pending by Community Services. These results indicate that not all completed HMPs were communicated to, or recorded by Community Services.

[26] It is unclear where this discrepancy stems from the available data, but may be due to different reporting practices or variations in performance across LHDs.

Figure 25: Number of HMPs recorded by NSW Kids and Families and Community Services



***Source**: NSW Family and Community Services: Community Services, KiDS database; NSW Kids & Families OOHC Health quarterly reporting data*

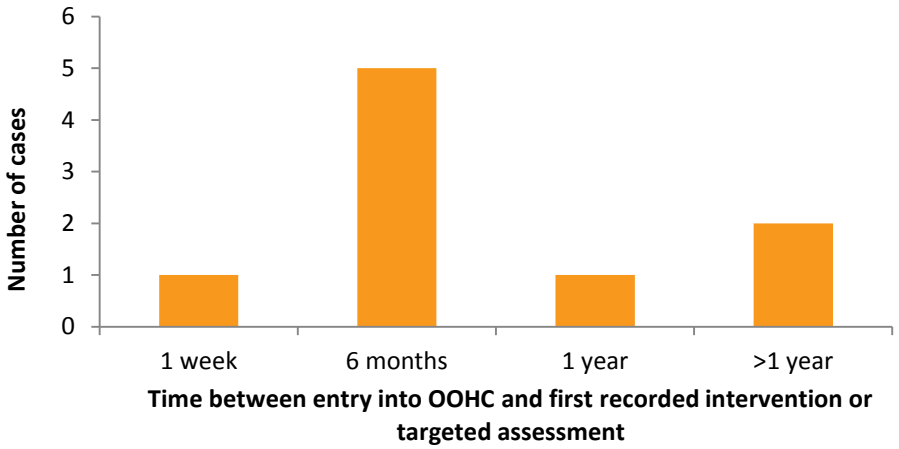
To what extent have the carer and child/young person received appropriate and timely intervention as a result of the HMPs?

No information about the appropriateness of interventions resulting from HMPs was available through the health data, case file audit data, consultations or surveys. Case file data was used to provide an indication of timeliness of interventions for children and young people resulting from HMPs because no data was recorded centrally by NSW Kids and Families or by the NSW Department of Family and Community Services. A limited number of cases (n=18) were audited in detail and, of these, nine cases had sufficiently complete information to assess the timeliness of interventions.

About half of the audited cases received an intervention or further assessment within six months of entering OOHC following the primary assessment and, if applicable, the comprehensive assessment (see Figure 26). There was no observable link between the type of intervention and the time required. These cases also showed that the sequence of steps in the OOHC Health Pathway as defined in the *Clinical Practice Guidelines* was not always followed in this chronological order. For example, in one case, the child was referred to child and family health services for immunisations and to oral health services on entry into OOHC prior to their formal primary assessment. In another case, the child was given a comprehensive assessment by a paediatrician on entry into OOHC prior to their referral to the OOHC Health Pathway Program.

During consultations, the IPCs suggested children and young people were more likely to have received appropriate and timely interventions if they had an HMP in place and they had stability in their placement and the case worker responsible for assisting them.

Figure 26: Time between entry into OOHC and first recorded intervention or further assessment[27]



***Source**: NSW Health detailed case audit, Hunter New England LHD*

4.1.4 There was little evidence to inform whether interventions were delivered in accordance with the OOHC Health Pathway Program guidelines

Evaluation sub-questions	Key findings
To what extent are the relevant interventions delivered in accordance with the plan?	◦ While no data was available to enable an assessment of whether the interventions and further assessments delivered were in accordance with the HMPs, some consultation participants suggested interventions were generally completed as recommended in HMPs and others highlighted challenges that prevented this from occurring. ◦ According to the case file audit data, the three most frequently occurring diagnoses for this population were dental issues, speech and language delay, and chronic conditions such as asthma. ◦ For children and young people over the age of 6 years, behavioural issues replaced speech and language delay as one of the top three most common diagnoses. ◦ There were no differences between the diagnoses of Aboriginal and Torres Strait Islander children and young people, and non- Aboriginal and Torres Strait Islander children and young people. ◦ According to the case file audit data, the most commonly delivered interventions or further assessments overall were dental followed by audiology, vision screening and immunisation. ◦ There was some variation in the most commonly delivered interventions or further assessments by age group. ◦ There were no differences between the interventions or further assessments delivered to Aboriginal and Torres Strait Islander children and young people, and non- Aboriginal and Torres Strait Islander children and young people.

[27] It is possible that, in some circumstances, the initial intervention may have been delayed in order to follow an appropriate clinical sequence (eg a child requiring a nutrition plan may have that intervention delayed until such time that a major dental intervention had been completed, resulting in a delayed 'first intervention'.).

Related recommendations

- 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding), 10 (Access to services), 13 (Engagement of carers), 15 (Service providers), 16 (Engagement principles), 17 (Data integration), 18 (Data collected)

To what extent are the relevant interventions delivered in accordance with the plan?

While no data was available to enable an assessment of whether the interventions or further assessments delivered were in accordance with the HMPs, consultation participants did provide some anecdotal evidence. The IPC consultation participants and clinician participants from three LHDs suggested interventions and further assessments were generally completed as recommended in HMPs while other clinicians highlighted challenges that prevented this from occurring at times. These challenges included:

- a lack of availability of some services (particular examples included psychosocial and speech pathology services)
- incidences of clinician resistance to treat this population, including due to a lack of clinician confidence in being able to provide treatment to appropriately and fully address needs related to trauma, and due to some clinical services with pre-existing intake criteria being unwilling to adapt these criteria to enable these children and young people to be appropriately prioritised.

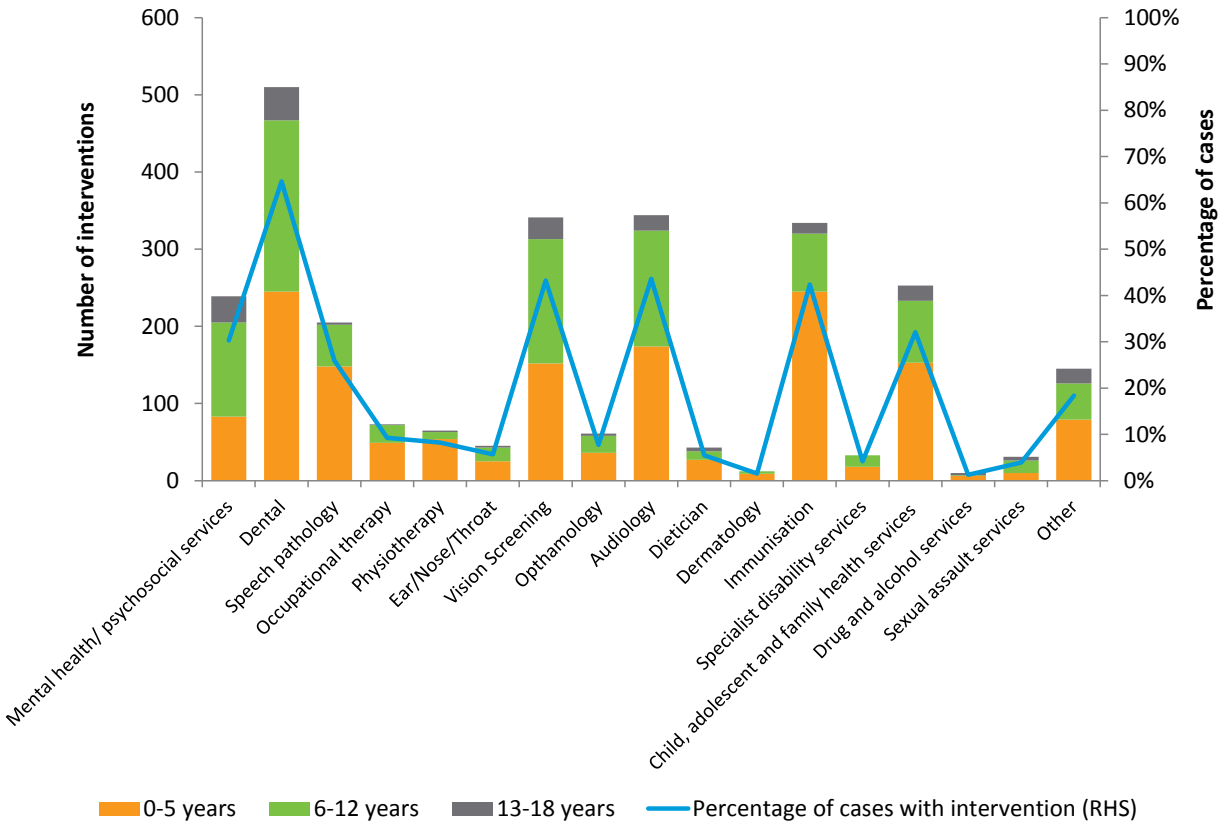
The case file audit provided a picture of the types of diagnoses and subsequent interventions and further assessments received by children and young people in the OOHC Health Pathway Program. Interventions and further assessments include a wide range of specialist services such as counselling, mental health support, sexual assault services, paediatric specialist care, and disability service providers. Health promotion and preventative health care are also considered to be an important generalist intervention delivered by the primary health care practitioner in the *Clinical Practice Guidelines*[28].

Overall, the three most frequently occurring diagnoses for children and young people who comprised the case file audit data were dental issues, speech and language delay, and chronic conditions such as asthma. This was the same for Aboriginal and Torres Strait Islander children and young people, and non-Aboriginal and Torres Strait Islander children and young people. By age group, these were also the three most common diagnoses for the 0 to 5 year olds. However, for those aged six years and over, behavioural issues replaced speech and language delay. Section 4.1.4 of the *Technical Supplement* contains further detail about the frequency of each diagnosis as well as the frequency of interventions.

In relation to interventions and further assessments, the case file audit data suggested the most commonly delivered interventions overall were dental, followed by audiology, vision screening and immunisation (as indicated by the blue line in Figure 27). Across all age groups, dental interventions were the most or second most common intervention and this aligns with the dental issues being one of the most common diagnosis across all age groups. For 0 to 5 year olds, the other two of the top three were immunisation and audiology interventions; for 6 to 12 year olds, they were vision screening and audiology; and for 13 to 18 year olds, mental health/psychosocial services and vision screening.

[28] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care

Figure 27: Interventions and further assessments overall and by age group[29]

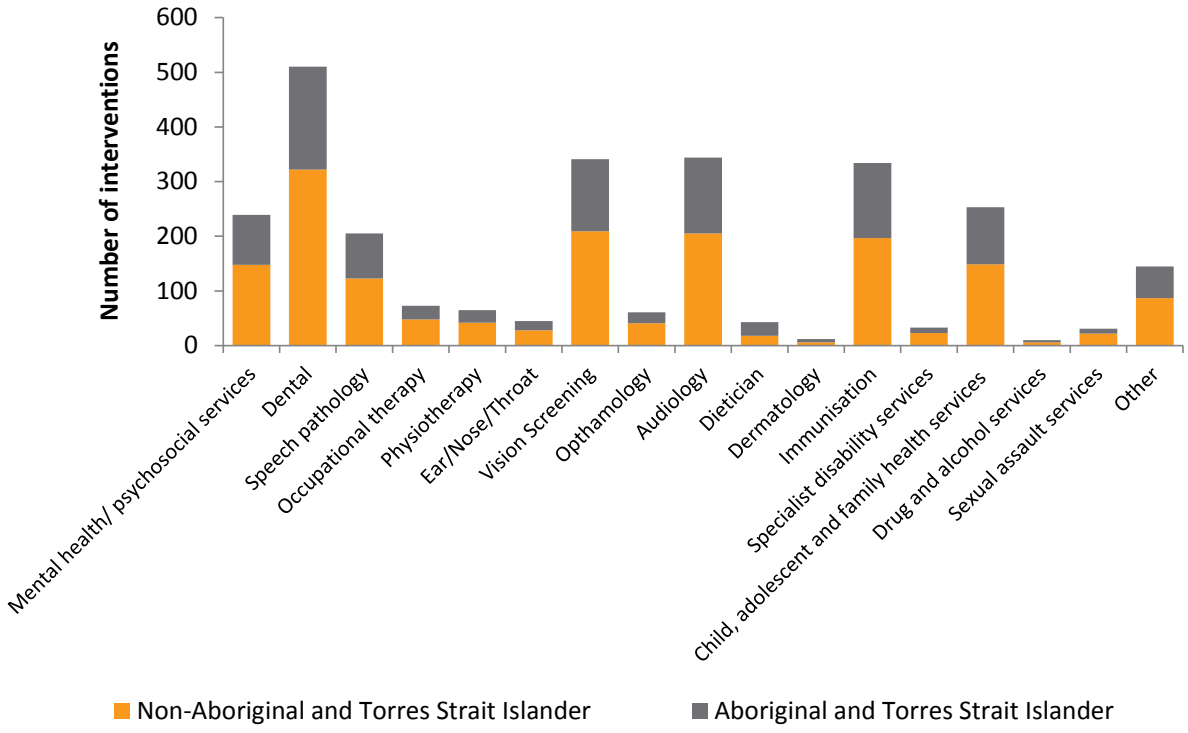


Source: *NSW Health, case file audit of Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

The interventions and further assessments delivered to children and young people in OOHC who were of Aboriginal and Torres Strait Islander background mirrored those received by the non-Aboriginal and Torres Strait Islander OOHC population according to the case file audit data (and shown in Figure 28).

[29] "Child, adolescent and family health service" was one of the categories used in the case file audit drawn from previous prevalence studies of interventions and further assessment conducted in NSW. This covers any type of family health clinic that is not otherwise covered in one of the other categories.

Figure 28: Interventions and further assessments by Aboriginal and Torres Strait Islander background



Source: *NSW Health, case file audit of Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

4.1.5 More than half of the completed HMPs were reviewed within the specified timeframes

Evaluation sub-questions	Key findings

Have all children and young people within the target group who have received an assessment and HMP then received a review of their HMP and health intervention as determined in the health care plan or within the target timeframe? If not, why not?	• Consultations with clinicians and Health OOHC Coordinators, supported by the limited available data, indicated that a substantial proportion of HMPs had not been reviewed.
	• Reasons for the low completion rates, as cited by clinicians and Health OOHC Coordinators in consultations, were:
	  ◦ limited resources
	  ◦ large caseloads
	  ◦ a large volume of new referrals
	  ◦ prioritisation of new referrals over reviews
	  ◦ a lack of clarity about the review process (ie responsibility, timing and content).

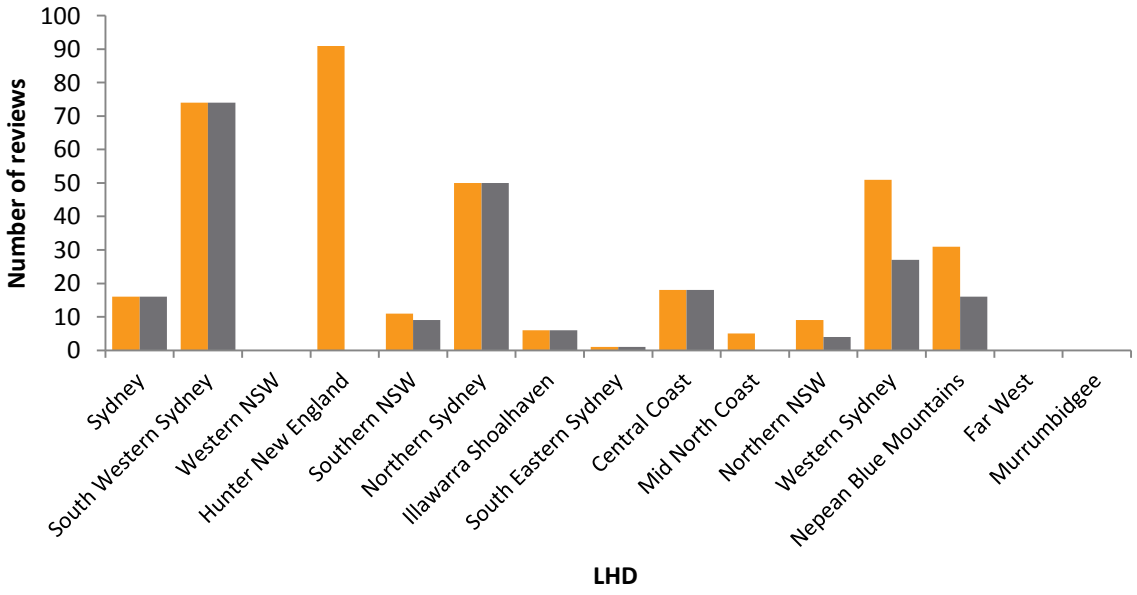
Related recommendations	
• 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding)	

Have all children and young people within the target group who have received an assessment and HMP then received a review of their HMP and health intervention as determined in the health care plan or within the target timeframe? If not, why not?

Reviews of HMPs are initiated by the Health OOHC Coordinator reminding the Community Services or NGO case manager and carer to schedule a consultation with the appropriate medical professionals. HMP reviews consist of a formal process to review the HMP of children and young people in the OOHC Health Pathway Program and ensure that they are receiving the health care services that they require[30]. The process is conducted by a primary health care practitioner who revises the HMP of the child or young person following a health assessment of any identified health, developmental or psychosocial and mental health problems recorded on their HMP. Under the *Clinical Practice Guidelines*, reviews are to be conducted every six months for children under 5 years and annually for children older than 5 years, or as clinically indicated.

There was limited data on whether health reviews are currently being conducted as part of the OOHC Health Pathway Program. No data on HMP reviews was recorded by Community Services. Data on this subject was collected by NSW Kids & Families for the 2012/13 reporting period, shown in Figure 29. On average these data indicated that 61% of HMP reviews were conducted within the specified timeframes (within 6 months for 0-5 year olds and within 12 months for older children and young people).

Figure 29: Number of completed HMP reviews by LHD, 2012/13[31]



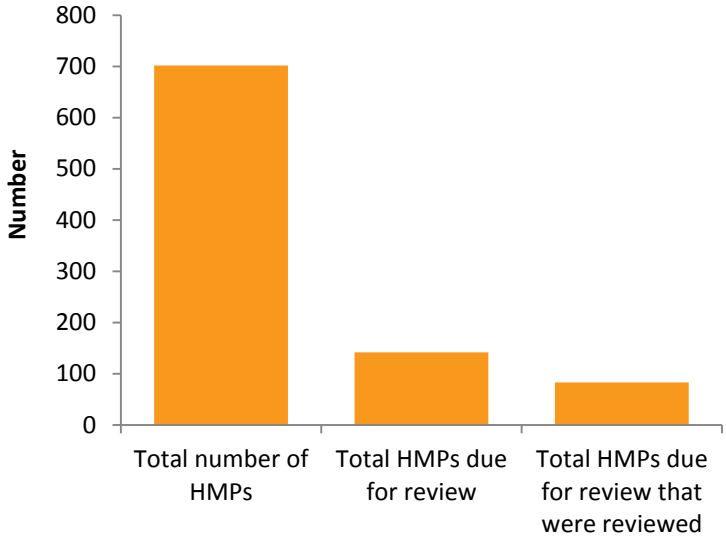
Source: *NSW Kids & Families, Quarterly Reporting Data for 2012/13*

[30] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care

[31] Data was not recorded for Far West LHD. Murrumbidgee and Western NSW LHDs recorded no HMP reviews. Hunter New England LHD was unable to calculate which of its HMP reviews were conducted within the specified timeframes.

The best available data for HMP reviews obtained in this evaluation was from the limited case file audit of selected LHDs, shown in Figure 30. More than half of HMPs due for review received an HMP review (58%). This finding is consistent with consultations with NSW Health OOHC Coordinators and clinicians who indicated that a substantial proportion of HMPs have not been reviewed (for example, more than half in one LHD).

Figure 30: Number of HMPs, HMPs due for review, and reviews in audited LHDs



***Source**: NSW Health, case file audit data for Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

The main reasons cited by these stakeholders for the lack of HMP reviews were limited resources, large caseloads, a large volume of new referrals, and prioritisation of new referrals to ensure children/young people entering OOHC to at least receive primary and comprehensive assessments and an initial HMP. Some stakeholders also reported that there was a lack of clarity about who was responsible for initiating and conducting a review, what the review itself should comprise, what documentation was to be recorded and who was to be notified that the review had been completed.

4.1.6 Economic benefit to the NSW Government from implementation of the OOHC Health Pathway Program

Evaluation sub-questions	Key findings

What is the economic benefit of the implementation of coordinated care and health screening, assessment, intervention and review for children and young people to the government?	• The OOHC Health Pathway Program was estimated to provide a net financial benefit to the NSW Government of $12.6m in terms of avoided health and non-health service costs for children and young people entering statutory OOHC from 2010/11 to 2012/13 (n = 5024) over the duration of their time in OOHC, assuming they remained in OOHC until the age of 18.
	  ◦ On average, the OOHC Health Pathway Program was estimated to deliver a net benefit of $10,000 per child in OOHC.
	  ◦ Health assessments and interventions provided the largest benefits, per person, for children aged 0-5 years followed by those aged 6-12

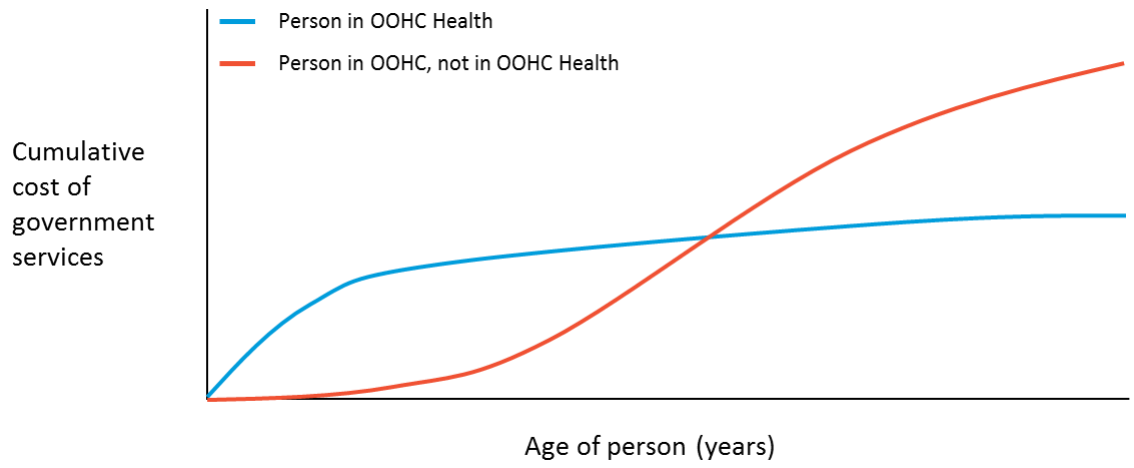
Evaluation sub-questions	Key findings
	and 13-18 years. ○ The largest aggregate benefit was $16,100 for a non-Aboriginal or Torres Strait Islander child aged 0-5 years with an audiology/ENT condition. ○ Research shows that health assessments have the potential to indirectly deliver up to $700,000 in avoided service costs per child in statutory OOHC, after the child has left OOHC. This benefit is due to improvements in health, educational and social outcomes over the lifetime of the person. The post-OOHC benefits are in addition to the figures calculated for this evaluation as they are not incurred by government during the child and young person's time in OOHC.
Related recommendations	
○ 11 (Funding for the OOHC Health Pathway Program)	

What is the economic benefit of the implementation of coordinated care and health screening, assessment, intervention and review for children and young people to the government?

Nous was engaged by NSW Kids and Families to conduct a limited economic appraisal (cost-benefit) of the OOHC Health Pathway Program as part of a wider formative evaluation of the program. A cost-benefit analysis rather than a full economic appraisal was undertaken due to data and scope limitations. The financial cost-benefit analysis provided an insight into the financial benefit of the OOHC Health Pathway Program to the NSW Government. It examined the service expenditure by the NSW Government to support children and young people during their time in OOHC.

The analysis looked at the health and non-health expenditure by the NSW Government in the situation where children and young people received interventions as a result of enrolment in the OOHC Health Pathway Program, as well as the expenditure to deliver services to these children and young people in the counter-factual situation where the OOHC Health Pathway Program was not implemented, described by Figure 31.

Figure 31 Conceptual illustration of lifetime trajectory approach to economic appraisal of the OOHC Health Pathway Program



Six case studies were used in the analysis, shown in Table 3. These case studies were chosen to represent a majority of children in OOHC in terms of age and type of medical condition. In each of the case studies, a trajectory of a child or young person's likely service interventions during their time in OOHC was completed. This was done both assuming that the case study received the OOHC Health Pathway Program interventions (an 'archetype') and also on the basis that the case study did not receive this intervention, and instead their condition remained undiagnosed (a 'counterfactual'). These service trajectories were informed by de-identified medical records from similar case types, service interventions associated with particular medical conditions and through consultation with medical experts.

Table 3: Frequency of case characteristics in the OOHC Health Pathway Program population for audited LHDs (n=789)

Case Type	Number of children and young people of indicated age band and ethnicity with health condition	Total number of children and young people of indicated age band and ethnicity	Proportion of children and young people of indicated age band and ethnicity with the health condition
Aboriginal or Torres Strait Islander child aged 0-5 with speech and language delay	53	170	31%
Non-Aboriginal or Torres Strait Islander child aged 0-5 with audiology/ENT condition	73	246	30%
Non-Aboriginal or Torres Strait Islander child aged 6-12 with dental caries	90	187	48%
Aboriginal or Torres Strait Islander child aged 6-12 with vision problems	25	99	25%
Non-Aboriginal or Torres Strait Islander child aged 13-18 with asthma	21	58	36%
Aboriginal or Torres Strait Islander child aged 13-18 with mental health issues	18	29	62%

***Source**: NSW Health, case file audit of Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

The interventions for both the archetype and counterfactual situations were costed using publically available information on service costs. The net financial benefit (or cost) was calculated as the difference between the two. The benefit (or cost) in each case was used in combination with the incidence of the case (i.e. how representative the case was) and the administrative expenditure on the OOHC Health Pathway Program to provide an estimate of the total benefit (or cost) to the NSW Government of implementing the program, summarised in Table 4.

Table 4: Cost-benefit of the OOHC Health Pathway Program

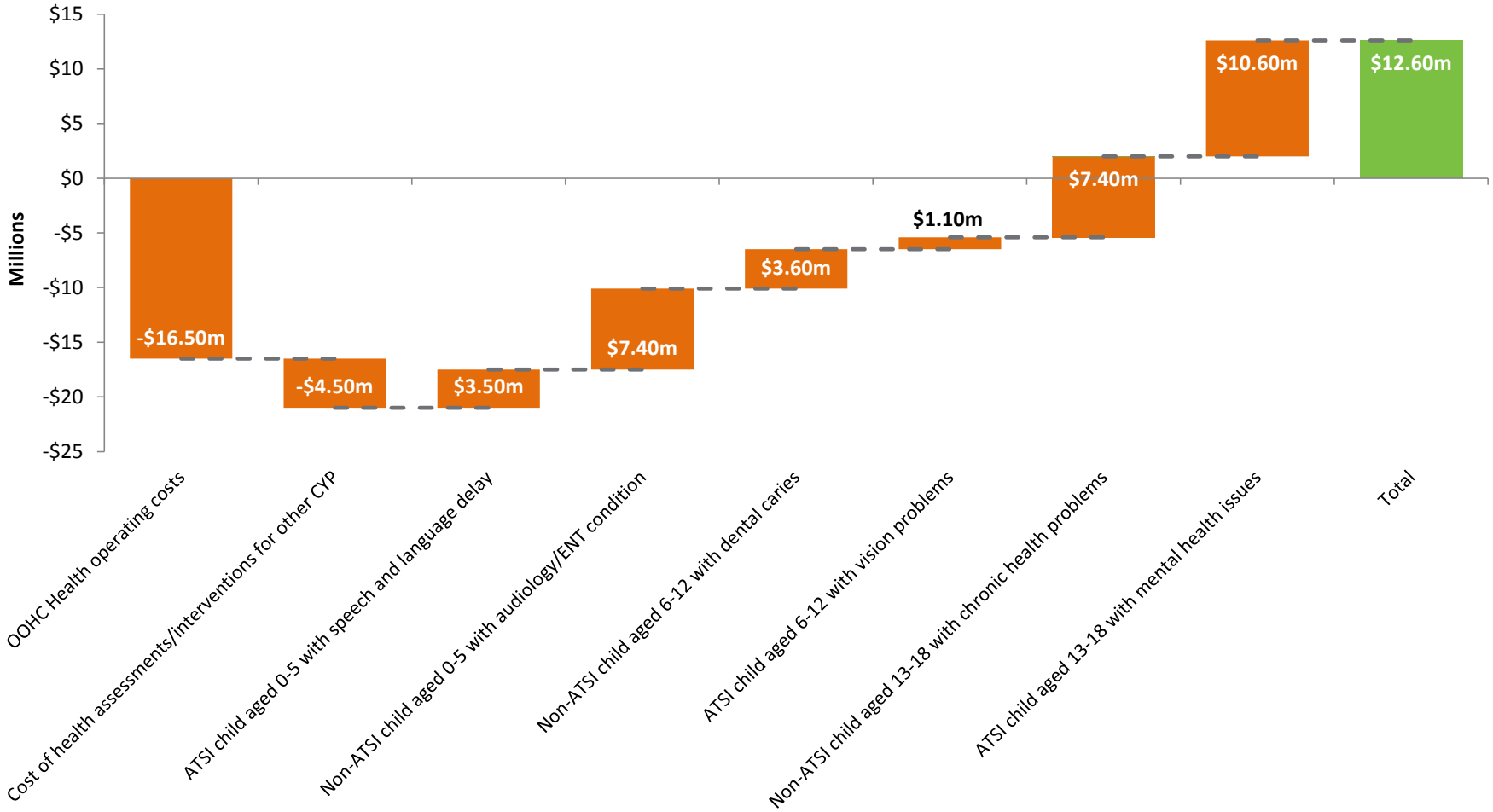
Case Type	OOHC Health cost per person	Counter-factual cost per person	OOHC Health cost	Counter-factual cost	Difference (benefit to NSW government)
Aboriginal or Torres Strait Islander child aged 0-5 with speech and language delay	$3,466	$16,014	$1,000,000	$4,400,000	$3,400,000
Non- Aboriginal or Torres Strait Islander child aged 0-5 with audiology/ENT condition	$2,221	$18,281	$1,000,000	$8,400,000	$7,400,000
Aboriginal or Torres Strait Islander child aged 6-12 with vision problems	$6,427	$13,406	$3,300,000	$6,900,000	$3,600,000
Non-Aboriginal or Torres Strait Islander child aged 6-12 with dental caries	$3,549	$11,741	$500,000	$1,600,000	$1,100,000
Aboriginal or Torres Strait Islander child aged 13-18 with mental health issues	$564	$6,765	$700,000	$8,000,000	$7,300,000
Non-Aboriginal or Torres Strait Islander child aged 13-18 with asthma	$3,489	$13,339	$3,800,000	$14,400,000	$10,600,000
Children and young people not in the above categories	$3,286	$13,258	$4,500,000	$0	-$4,500,000
OOHC Health overall costs	n/a	n/a	$16,500,000	$0	-$16,500,000
Total	**n/a**	**n/a**	**$31,200,000**	**$43,800,000**	**$12,600,000**

We estimate that the total benefit to the NSW Government of the OOHC Health Pathway Program is $12.6m in terms of avoided service costs for children and young people in OOHC. The largest cost savings were estimated to come from:

- Aboriginal or Torres Strait Islander young people aged 13-18 years with mental health issues, due to both large numbers of cases and high benefit per case
- non-Aboriginal or Torres Strait Islander young people with asthma due to the large number of cases
- non-Aboriginal or Torres Strait Islander children aged 0-5 years with audiology/ENT and associated developmental problems due to the high per person benefit.

A summary of the cost-benefit for each archetype considered is shown in Figure 32. Details of the analysis and tables of findings are shown in Section 4.1.6 of the *Technical Supplement*.

Figure 32: Cost-benefit of the OOHC Health Pathway Program, by cost-benefit category and case archetype



4.2 What service models (including linkages), protocols, processes, tools and resources have been used in supporting the OOHC Health Pathway Program, and how effective are they?

A range of service models, protocols, tools and resources have been used in supporting the OOHC Health Pathway Program. Some are highly effective and others less so.

The *Clinical Practice Guidelines*, released in October 2013, provide clear guidance on what is expected for the delivery of effective services. They will provide a vehicle for continued improvement in clinical practice and stronger engagement with clinicians and service providers.

Consistent with the devolved health model, the LHDs have adopted service delivery models that have been attuned to their local circumstances. LHDs have invested the additional OOHC funding to address service gaps e.g. employing a speech therapist.

This evaluation found that local service delivery models, protocols and processes were most effective in the delivery of health assessments and referral to services but less effective in the follow up component through the review of HMPs.

In this evaluation Nous found numerous examples of best practice service delivery. These are detailed in the report and include building relationships to continuously improve coordination, mechanisms to prioritise access to services and activities to improve clinician and other stakeholder engagement. In this report, Nous has illustrated the existing 'Core OOHC Health Pathway Service Delivery Model' and proposed a series of best practice initiatives that brings together initiatives already in operation and others that are based on a review of comparable national and international service delivery models.

OOHC Coordinators have provided a critical linkage point for service delivery in each LHD. Sustained effective implementation of the OOHC Health Pathway Program is dependent on these roles continuing and attracting and retaining the right staff.

The success of the OOHC Health Pathway Program is also dependent on effective engagement with clinicians. Overall Nous found that there was stronger engagement with clinicians in the public system compared with the private system. In addition, paediatricians and allied health practitioners consistently reported higher levels of engagement, with lower levels of engagement reported for GPs.

4.2.1 Service delivery models and protocols are defined, and have supported the implementation of health assessments and development of HMPs

Nous completed a review of the service model in operation in each of the LHDs in order to make an assessment of what has worked well to date and to provide guidance on what, specifically, LHDs might do to continuously improve implementation of the OOHC Health Pathway Program. This was informed by qualitative information obtained through interviews, focus groups and online surveys. There was insufficient quantitative information available to inform our assessment of the service models or parts thereof that were most effective. Further research is required to determine the effectiveness of individual service models.

Most LHDs were able to identify elements that were working well, offset by things that could be done better. For the most part, the elements that had been allocated additional resources or prioritised by staff were identified as working well.

Evaluation sub-questions	Key findings
Have the local service delivery models, protocols and processes been effective in supporting the implementation of the health assessments, development of HMPs, and review of the child or young person's HMP? If not, why not?	◦ All LHDs[32] have defined local service delivery models to implement the core components of the OOHC Health Pathway Program, but each LHD operates differently due to local circumstances. ◦ In both 2011/12 and 2012/13, more 2a/2b assessments were conducted than HMPs completed. This data, together with commentary obtained in consultations indicates that local service delivery models, protocols and processes are generally effective to implement timely health assessments but are less effective to support the timely completion of documented HMPs and reviews of the same. ◦ Stakeholders consulted were generally confident that interventions required were being completed. ◦ Several ongoing challenges to effectiveness were identified, including: resourcing constraints; difficulties accessing some health services (particularly in rural/remote areas); and limited understanding of the OOHC Health Pathway Program by some stakeholders (including their own role). ◦ Further research is required to complete an assessment of the effectiveness and cost-effectiveness of individual service models.
Following a comparison of the service delivery models, what aspects have worked well?	◦ LHDs have invested additional resources in specific services (eg employing a speech therapist) and realised an improvement in that area. ◦ Other key aspects of service delivery models, protocols and processes that have worked well include: building relationships to continuously improve coordination; mechanisms to prioritise access to services; and efforts to increase clinician and other stakeholder engagement and/or education. ◦ Successful implementation is dependent on attracting or retaining dedicated staff that demonstrate initiative in ongoing positions. ◦ Further research is required to complete an in depth comparison of the different service models in operation.

What service delivery models across LHDs were effective in supporting the implementation, coordination and provision of health assessments for children and young people in OOHC?	◦ A number of effective practices have been successfully replicated across the system, including:
	  ◦ The use of child and family health nurses to conduct primary assessments for children aged 0-5 years has been highly effective in providing appropriate and timely assessments.
	  ◦ Establishment of local OOHC clinical governance groups has supported decision making.
	  ◦ Provision of more and better information to carers has assisted them to better understand the system and their responsibilities and perform their role in supporting children and young people enrolled in the OOHC Health Pathway Program.
	  ◦ Culturally-appropriate assessment processes and staff that are sensitive to the specific needs of Aboriginal and Torres Strait Islander and CALD children and young people, contributed to better health outcomes for children and young people from these populations.
	◦ Most LHDs have also implemented effective 'local' initiatives.

[32] During the course of the evaluation, we received service delivery models from all LHDs except Far West. OOHC Health Pathway Program services in the Far West were provided through the Western NSW LHD until January 2013.

Evaluation sub-questions	Key findings

What components (if any) of these service delivery models can be applied or shared across LHDs?	• There are five aspects of the core OOHC Health Pathway Program service delivery model outlined in the *Clinical Practice Guidelines* that are critical to its success:
	  ◦ all medical information is obtained and a timely referral to the OOHC Health Pathway Program is achieved
	  ◦ effective coordination and ongoing communication between agencies
	  ◦ the HMP is documented and communicated to relevant parties
	  ◦ support is provided to carers to facilitate interventions
	  ◦ a timely review of the HMP is completed.
	• Informed by models in operation in other jurisdictions and overseas and by consultations with individual LHDs, the evaluation has identified a number of 'best practice initiatives' which could be pursued across all LHDs or in individual LHDs to continuously improve outcomes for children and young people in OOHC. These initiatives are aligned to the five steps of the Core OOHC Health Pathway Service Delivery Model.

Related recommendations	
• 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding), 10 (Access to services), 12 (Diversity), 13 (Engagement of carers), 14 (AMS engagement), 15 (Service providers), 16 (Engagement principles), 20 (Single point of contact), 23 (Further research)	

Have the local service delivery models, protocols and processes been effective in supporting the implementation of the health assessments, development of HMPs, and review of the child or young person's HMP? If not, why not?

LHDs have defined local service delivery models to implement the core components of the OOHC Health Pathway Program

LHDs follow the core elements of the OOHC Health Pathway Program as described in the *Clinical Practice Guidelines* and the original program documentation, i.e. children enrolled in the OOHC Health Pathway Program receive 2a and/or 2b health assessments followed by development of a HMP, medical interventions and health reviews. Each LHD operates a slightly different local service model depending on the demographics of the local OOHC population and available clinical and coordination resources.

Most LHDs use Child and Family Health Nurses to conduct primary health assessments for children aged 0-5, with physicians such as GPs and Paediatricians conducting these assessments in cases where the health of the child is comparatively poor. Aboriginal Medical Services are also used for Aboriginal and Torres Strait Islander children in the Illawarra Shoalhaven, Western NSW, Hunter New England and Mid-North Coast/Northern NSW LHDs.

By contrast, LHDs use a wide variety of clinicians to assess the health of children older than 5 years. A majority of LHDs rely primarily on GPs to perform this assessment with support from other clinicians. Western Sydney/Nepean Blue Mountains and Hunter New England are the only LHDs which primarily use nursing staff to assess children older than 5 years for the 2a primary health assessments.

LHDs also differ in their referral processes for children and young people in the OOHC Health Pathway Program from the 2a primary health assessment to the 2b comprehensive health assessment (see *Technical Supplement*). Most LHDs triage the 2b comprehensive assessment based on the outcomes of the 2a primary assessment, on referral from either the GP who completed the primary assessment (e.g.

Northern Sydney, Illawarra Shoalhaven and Hunter New England) or from the OOHC Team (e.g. Western Sydney/Nepean Blue Mountains and Southern NSW). Two LHDs have mandatory 2b comprehensive assessments for all children and young people entering OOHC regardless of the 2a outcomes (Western NSW and Mid North Coast/Northern NSW). Similarly, the South Eastern Sydney LHD refers most children and young people enrolled in the OOHC Health Pathway Program for a 2b comprehensive assessment regardless of the outcome of the 2a primary assessment.

Comprehensive health assessments are frequently performed by paediatricians under the service models being implemented in the LHDs (see *Technical Supplement*), though individual LHDs also make use of mental health services, psychologists, GPs, counselling services, and OOHC clinics to deliver parts of the 2b comprehensive assessment depending on local resources.

Four LHDs also provide 2b comprehensive assessments through Aboriginal Medical Services for Aboriginal and Torres Strait Islander children and young people (South Eastern Sydney, Western NSW, Hunter New England and Southern NSW LHDs) and the Mid North Coast /Northern NSW LHDs use staff and private paediatricians to deliver 2b comprehensive assessments to this group through outreach.

LHDs have been more successful in implementing some core components than others

The evaluation has found that the local service delivery models in operation across the LHDs have been successful in ensuring that children and young people in the OOHC Health Pathway Program receive primary and - where appropriate - comprehensive health assessments.

The evaluation has found that documented HMPs are not developed for all children and young people, and that most LHDs have found it difficult to complete a timely review of HMPs.

When surveyed, two-thirds of the six Health OOHC Coordinator respondents agreed or strongly agreed that local service delivery models, protocols and processes have been effective in supporting "*the implementation of health assessments*" and "*the delivery of interventions identified in Health Management Plans*". However, only one third agreed or strongly agreed that these same models, protocols and processes "*have been effective in supporting the review of Health Management Plans*".

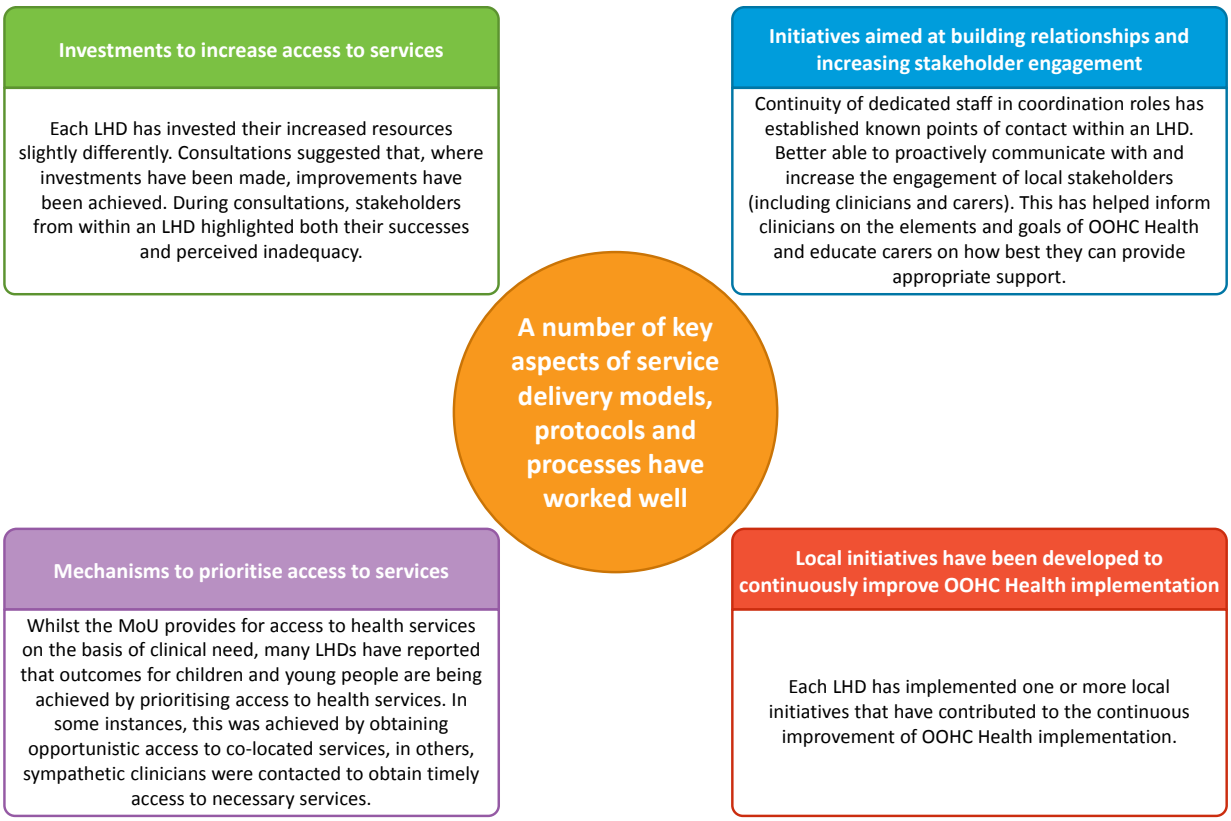
The key reason for these findings was identified in consultations with the NSW Health OOHC Coordinators who reported that, with limited resources, some elements of the OOHC Health Pathway Program have been prioritised over others (ie assessments and interventions over documented HMPs and reviews).

Following a comparison of the service delivery models, what aspects have worked well?

In surveys of Health OOHC Coordinators and health practitioners, judged "*Relationship building to continuously improve coordination*" and "*Local mechanisms to support access to services*" to be the aspects of the OOHC Service Model that have worked well.

The initiatives found to be common across many LHDs are outlined in Figure 33.

Figure 33: Aspects of service delivery models, protocols and processes that have worked well



As indicated in Figure 33, a number of local initiatives have been developed that have delivered local benefits and have supported the continuous improvement of the OOHC Health Pathway Program implementation in that LHD. Some examples include:

- co-location of the Health OOHC Coordinator with Community Services case managers
- employment of designated Aboriginal coordinators in LHDs with significant numbers of Aboriginal children and young people enrolled in OOHC
- development of an information brochure for carers to outline their role and responsibilities
- regular meetings between administration, coordination and clinical staff prior to assessments.

The common element to all of these aspects that have worked well is the attraction and retention of dedicated staff

Central to each of these aspects is a dedicated staff that has demonstrated initiative to identify and realise opportunity for continuous improvement. Each of the aspects that have been identified above are unlikely to have been as successful without the actions of these staff. The retention of these staff (and the attraction of others) to ongoing positions will be key to future implementation success. Effective succession planning should also be completed to ensure that some redundancy exists across roles to allow a replacement to step in during planned and un-planned leave and upon departure.

What service delivery models across LHDs were effective in supporting the implementation, coordination and provision of health assessments for children and young people in OOHC?

A number of effective practices have been successfully replicated across the system whilst other local initiatives have also contributed to success. Some prominent examples of each are outlined below.

Use of child and family health nurses to conduct primary assessments is very effective

Child and family health nurses have been widely used to conduct primary assessments for children aged 0-5 years and this has been highly effective to provide appropriate and timely assessments and represents a significant opportunity for future implementation.

Establishment of local OOHC clinical governance groups supports decision making

Governance groups consisting of key LHD staff, interagency partners and other stakeholders, including the heads of all local clinical departments that meet regularly have been an effective mechanism to review referrals, develop or review HMPs and monitor interventions.

Provision of more and better information to carers helps them perform their role

Through a range of mechanisms, LHD staff have assisted carers to better understand the system and their responsibilities and to perform their role in supporting children and young people in OOHC. In some circumstances, this has led to more comprehensive assessments being achieved and more timely identification of clinical needs.

Culturally-appropriate assessment processes and staff are essential

Stakeholder in a number of LHDs have reported that implementing systems, processes and procedures that are sensitive to the specific needs of Aboriginal and Torres Strait Islander and CALD children and young people has contributed to the health outcomes of these populations.

Other effective 'local' initiatives have been implemented

The following initiatives have been developed proactively through the initiatives of local coordinators or clinicians to as a reaction to local circumstances:

- use of 'Skype' video conferencing within an AMS to improve the timely access to clinical services
- a 'planning day' used to review the progress of the OOHC Health Pathway Program implementation and to establish working groups to progress system improvements
- arrangements with a private paediatrician to run a fortnightly OOHC clinic to complete comprehensive assessments and to bulk bill for this service
- building relationships with youth services to better engage young people that had previously been reluctant to attend appointments.

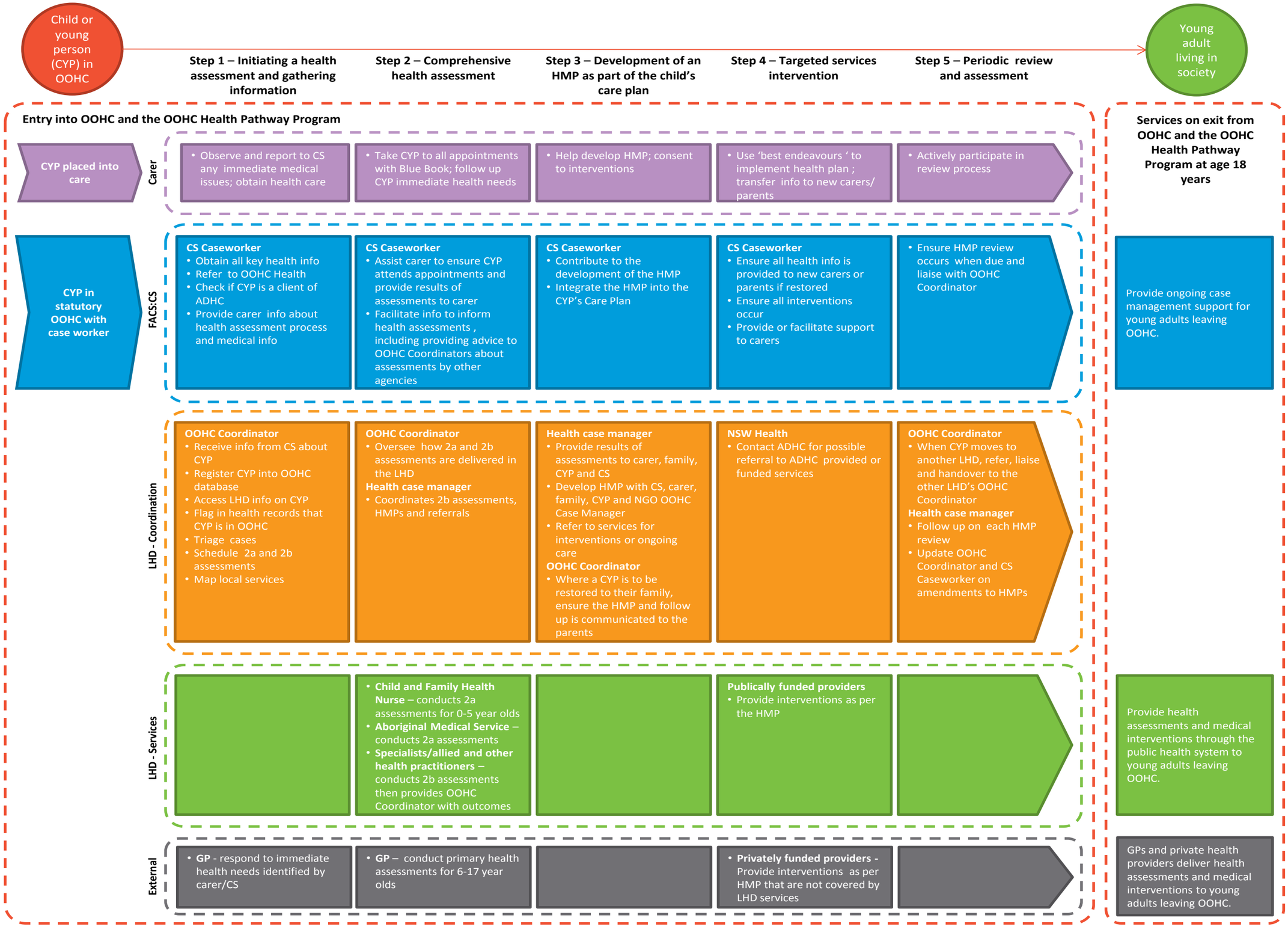
What components (if any) of these service delivery models can be applied or shared across LHDs?

The existing core OOHC Health Pathway Program service delivery model, as described in the *Clinical Practice Guidelines,* is summarised in Figure 34.

Of particular note in this model is that, wherever possible, and within existing resources, all relevant parties should ensure:

- all medical information is obtained and a timely referral to the OOHC Health Pathway Program is achieved (Step 1)
- effective coordination and ongoing communication between agencies (Step 2)
- the HMP is documented and communicated to relevant parties (Step 3)
- support is provided to carers to facilitate interventions (Step 4)
- a timely review of the HMP is completed (Step 5).

Figure 34: Existing core OOHC Health Pathway Program service delivery model



A number of best practice initiatives that complement the core OOHC Health Pathway Program model have been identified through both the consultations completed during this evaluation and an investigation of other Australian and overseas models. These initiatives are outlined in Table 5 and are aligned to the particular step or steps within the core model to which they could be best applied. Further detail about the models from other Australian jurisdictions and overseas that were explored is found in section 4.2.4 of this report and section 2 of the *Technical Supplement*.

The best practice initiatives in Table 5 include the introduction of a new role, the 'Primary Medical Contact'. The introduction of this role would have flow on effects on other key stakeholders in the OOHC Health Pathway Program, particularly the Health Case Manager and Health OOHC Coordinator roles. Figure 35 summarises the focus of each key stakeholder with the addition of the Primary Medical Contact.

Figure 35: Current roles of key stakeholders in the OOHC Health Pathway Program versus proposed roles with the implementation of best practice initiatives

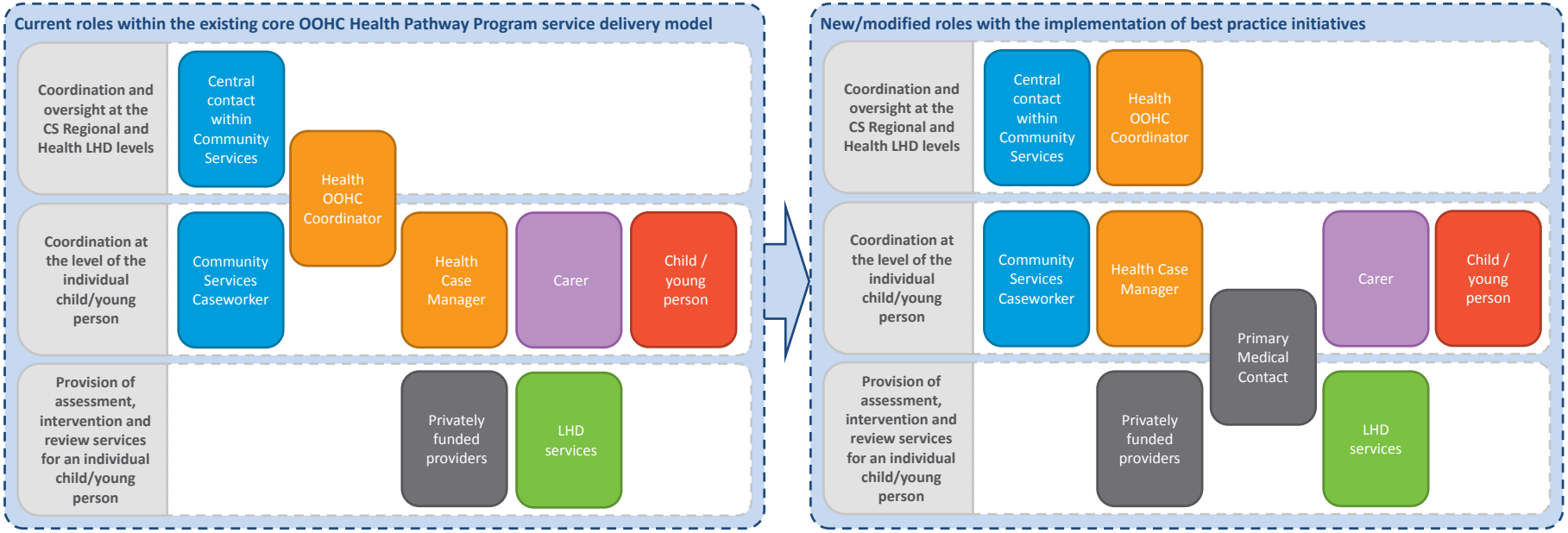
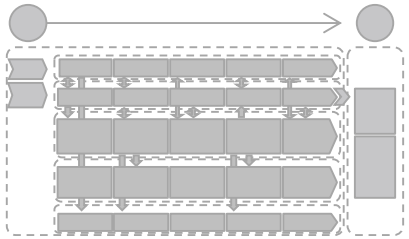
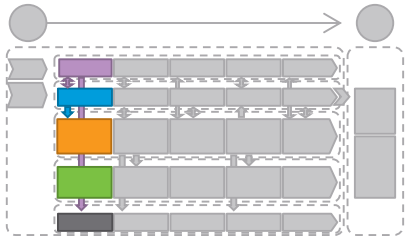


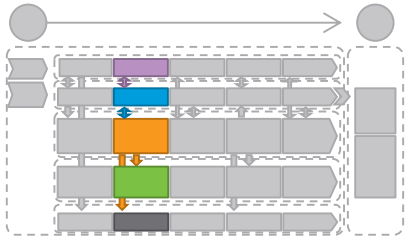
Table 5: Best practice initiatives

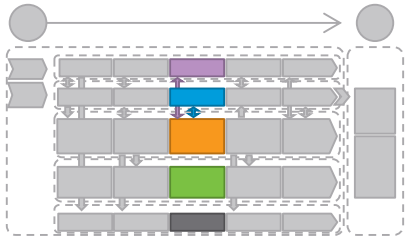
Core OOHC Health Pathway service delivery model step	Best practice initiative

General 	**Maintain continuity of staff in key roles**
	• Each LHD should develop and implement effective workforce planning strategies to improve continuity in the key coordinator roles and to minimise periods of vacancy. Particular actions include:
	  ◦ making key positions permanent or offering long term contracts
	  ◦ documenting and maintaining key contacts (including OOHC Health Pathway Program 'champions' among local agency contacts and service providers).
	  ◦ ensuring appropriate handovers are completed when staff turnover occurs.
	Improve data collection and transfer
	• All LHDs to adopt templates provided in the *Clinical Practice Guidelines*, complemented by documented processes and procedures to support implementation based on local requirements.
	• Development of checklists to support accurate and comprehensive data collection and transfer at key stages (e.g. following initial referral, for each individual OOHC Health Pathway Program element, and on change of placement).
	• Refine arrangements for electronic collection and reporting of agreed data sets.
	Develop and promulgate information resources to support stakeholder engagement and education
	• Development of 'content' that clearly identifies:
	  ◦ the reasons why the OOHC Health Pathway Program is important and the goals of the Program
	  ◦ the elements of the OOHC Health Pathway Program and what may be involved for the child or young person
	  ◦ the roles and responsibilities of key stakeholders (e.g. carers, Health OOHC coordinators, Health Case Managers, clinicians)
	  ◦ key points of contact (both central and local).
	• Translation of the agreed content into different media, including:
	  ◦ a centrally maintained website with links to associated resources (e.g. HealthDirect)
	  ◦ brochures (in hard and/or soft copy) targeted to key stakeholders (including carers, GPs and nurses, and paediatricians).
	• Development of engagement strategies for key stakeholders (supported with additional materials as required).
	Identify opportunities to link with other services to support the OOHC Health Pathway Program initiatives
	• Coordinate psychosocial screening within the education setting (e.g. engaging support of primary school teachers to complete assessments).
	Initiatives based on models operating overseas (see Section 4.2.4):
	• Training workshops targeted at GPs and GP practice nurses that cover the health needs of children and young people in OOHC, and the OOHC Health Pathway Program assessment guidelines.

Core OOHC Health Pathway service delivery model step	Best practice initiative

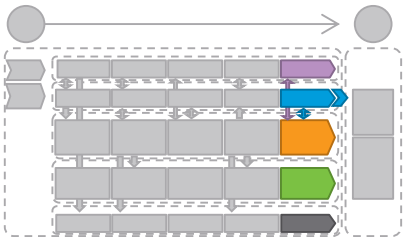
Step 1: Initiating a health assessment and gathering information
 
	Assign a Primary Medical Contact to each child and young person in the OOHC Health Pathway Program
	• In an extension to the provisions of the *Clinical Practice Guidelines*, each child enrolled in the OOHC Health Pathway Program should be allocated a Primary Medical Contact.
	  ◦ The Primary Medical Contact is the single health point of contact for the child/young person, carer, other clinicians involved in the care of the child/young person and the Health Case Manager in relation to clinical matters.
	  ◦ The Health Case Manager is the single health point of contact for the child/young person, carer, other clinicians involved in the care of the child/young person and the Health Case Manager in relation to administrative and logistic matters.
	  ◦ The Primary Medical Contact would typically be a GP but, in particularly complex cases, it may be more appropriate for this role to be undertaken by a specialist clinician such as a paediatrician.
	  ◦ The Primary Medical Contact should complete the 2a primary health assessment unless there is a more appropriate clinician to complete this assessment (e.g. a child and family health nurse for children aged 0-5 years with less complex issues).
	  ◦ Continuity of the person filling this role is important. However, if the child/young person moves location or if a more suitable clinician is found during the development of the HMP or subsequent reviews, the person filling the role should change. In these instances, formal and coordinated handover is critical to ensure continuity of care.
	• The allocation of a Primary Medical Contact would result in a number of adjustments to other roles in the OOHC Health Pathway Program as follows:
	  ◦ Health Case Manager – The role of the Health Case Manager should be modified so that it is responsible for all health-related coordination for each individual child/young person whom they are allocated. The role would work closely with and support the Primary Medical Contact, and continue to liaise with the other key stakeholders in the care of the child/young person – i.e. the carer and the child/young person as appropriate, the Health OOHC Coordinator, the Community Services or NGO Caseworker and, as required, clinicians. The role would be responsible for completing the HMP using input from the other stakeholders.
	  ◦ Health OOHC Coordinator – This role would shift from providing coordination at an individual child/young person level to providing coordination and oversight of the Program at the LHD level. The role would work most closely with the Community Services central regional point of contact and the Health Case Managers in the relevant LHD.
	Streamline processes for appropriate and timely referral for a comprehensive assessment
	• Upon receipt of the Health Referral Form, the Health OOHC Coordinator should consider whether a child may require a comprehensive assessment when identifying the suitable health practitioner to complete the 2a primary assessment and triage the allocation accordingly (e.g. referral to GP where a 2b comprehensive assessment is likely to be required).
	Engage carers earlier in the process and throughout
	• Health Case Manager to make contact with the carer to discuss the process and their role and responsibilities (identifying the resources available to them – see above).

Core OOHC Health Pathway service delivery model step	Best practice initiative
	Initiatives based on models operating overseas (see Section 4.2.4): • Allocation of a clear primary medical contact and primary care contact for each individual child/young person. • Programs that promote attachment between foster mothers and children/young people in OOHC.
Step 2: Comprehensive health assessment 	**Engage carers earlier in the process and throughout** • Primary Medical Contact to discuss outcomes of the primary assessment with carer and the child or young person as appropriate. **Establish comprehensive assessment clinics** • Build relationships with local clinicians to schedule the OOHC Health Pathway Program specific clinic times to facilitate timely comprehensive assessments and subsequent referrals. **Standardise documentation of the comprehensive assessment** • Adopt the template contained in the *Clinical Practice Guidelines*. • The Health Case Manager should receive documentation of the completed comprehensive assessment to support timely development of the HMP. **Establish multi-disciplinary clinical governance groups to support decision-making** • Leverage availability of local clinicians and coordinators to contribute to comprehensive assessments, guide development of HMPs and facilitate interventions through timely referrals. ***Initiatives based on models operating elsewhere*** (see Section 4.2.4): • Utilisation of formal multi-disciplinary teams.

Step 3: Development of an HMP as part of the child's care plan
 
	Standardise documentation of the HMP
	• Adopt the template contained in the *Clinical Practice Guidelines*.
	• Health Case Manager to complete the HMP in consultation with the Primary Medical Contact.
	• Prior to the HMP being finalised, the Health Case Manager should liaise with the Primary Medical Contact to determine whether it is appropriate that they continue in the Primary Medical Contact role:
	  ◦ If so, the Primary Medical Contact should take responsibility for the initial review unless a more appropriate substitute is identified and takes on this responsibility. In the latter case, the Primary Medical Contact should follow-up.
	  ◦ If not, the Primary Medical Contact should propose an alternative and confirm the new Primary Medical Contact (who would then take on the responsibilities identified above).
	• Move promptly to the electronic health record

Core OOHC Health Pathway service delivery model step	Best practice initiative
	Distribute the HMP to relevant stakeholders • Development of a checklist to ensure that the HMP is distributed to relevant stakeholders (including the carer, Health OOHC Coordinator, Community Services etc) by the Health Case Manager. ***Initiatives based on models operating elsewhere*** (see Section 4.2.4): • Utilisation of a central, electronic health record management system.

Step 4: Targeted services intervention
 
	Develop mechanisms to manage high volumes of referrals
	• NSW Health OOHC Coordinators should:
	  ◦ build stronger relationships with local clinicians to support timely referral and access to services.
	  ◦ proactively identify and document overflow arrangements, including:
	  ○ fostering partnerships with adjacent LHDs
	Identify and realise opportunities to continuously improve access to services
	• Co-locate assessment and intervention services known to be in high demand (including oral health, speech pathology and other allied health services) or negotiate access to these services through partnership with other LHDs, NGOs or private practices.
	• Build relationships with adjoining services to improve outcomes (eg Youth services).
	  ○ identifying not-for-profit or private sector services that may provide assistance.
	
	Initiatives based on models operating elsewhere (see Section 4.2.4)***:***
	• Co-location of health assessment and intervention services.

Step 5: Periodic review and assessment 	**Initial review** • Primary Medical Contact to take responsibility to complete the initial review and communicate the outcomes to relevant stakeholders. • Determine whether future reviews are warranted (and, if necessary, schedule the subsequent review). • Determine whether it is appropriate that they continue in the role (see above). **Subsequent reviews** • Repeat the proposed process for the initial review outlined above.

4.2.2 A range of tools and resources are in place to support the implementation of the OOHC Health Pathway Program

Evaluation sub-questions	Key findings

What resources and tools were used to support clinicians providing primary health assessments? How effective were they?	• According to service model documentation, a range of tools were used to complete primary health assessments with the most common being the ASQ, ASQ-SE and SDQ tools, and 2a Primary Health Screen Summary Template. No information was obtained in relation to their effectiveness.
	• Resources, other than assessment tools, effectively assisted in the completion of primary health assessments according to consultations and included:
	  ◦ advice from expert clinicians
	  ◦ coordination support from Health OOHC Coordinators
	  ◦ written information from pre-existing individual health resources (e.g. 'Blue Book'), a trauma symptom checklist and an interview guide for psychologists.
	• No specific comprehensive assessment tools were identified by half of the LHDs in their service model documentation while three LHDs identified a broad range of tools and the remaining two LHDs indicated they were guided by the 2b health screen template. No information was obtained in relation to their effectiveness.

What type of communication resources (in addition to the HMP) work best to support the implementation of the OOHC Health Pathway Program?	• Overall, around 40% of health practitioners agreed or strongly agreed they had received sufficient information/support regarding their roles in the OOHC Health Pathway Program according to survey results (n=137).
	• According to the survey, the extent to which the 137 health practitioner respondents had agreed or strongly agreed that they had received sufficient information/support regarding their role in the OOHC Health Pathway Program differed by:
	  ◦ Component of the health assessment process – health practitioners were more likely to indicate sufficiency in relation to the health assessment process (58%), with less than half agreeing or strongly agreeing there had been sufficiency in delivering interventions (42%), developing HMPs (32%) and undertaking periodic reviews (27%).
	  ◦ Type of health practitioner – paediatricians were most likely to have indicated sufficiency, followed by primary practitioners[33], then allied health practitioners and finally other health practitioners.[34]
	• The following types of communication resources worked best to support the implementation of the OOHC Health Pathway Program, as informed by consultation participants:
	  ◦ interagency and multidisciplinary meetings about individual cases
	  ◦ information at the process level in the form of factsheets, brochures and DVDs
	  ◦ formal and informal email communications between stakeholders

[33] For the purposes of this evaluation, 'primary practitioners' comprise GPs and child and family health nurses. All primary practitioner survey respondents who identified their profession were child and family health nurses (i.e. no primary practitioner respondents self-identified as GPs). A small proportion of respondents did not identify their profession.

[34] 'Other health practitioner' survey respondents (n=30) comprised nurses other than child and family health nurses (60% of 'other health practitioner respondents), managers (10%), health managers (6%), administrative staff (6%), dental therapists (3%) forensic clinicians (3%), hearing services staff (3%) and health practitioners not identified (9%).

Evaluation sub-questions	Key findings
	○ comprehensive and timely referrals and reports ○ joint training involving clinicians, NSW Health, Community Services, ADHC and DEC (e.g. about the OOHC Health Pathway Program and the impacts of trauma). ○ Through consultations, many stakeholders supported the development and form of the *Clinical Practice Guidelines*. ○ The early adoption of the electronic health record is anticipated to address a number of the challenges experienced and deliver benefits to this vulnerable population. ○ Further research is required to complete an in-depth comparison of the different service models in operation.
Related recommendations	
○ 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 3 (Continuity in roles), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding), 13 (Engagement of carers), 14 (AMS engagement), 16 (Engagement principles), 20 (Single point of contact) , 23 (Further research)	

What resources and tools were used to support clinicians providing primary health assessments? How effective were they?

Tools used to complete primary health assessments

According to service model documentation provided by each LHD, a range of assessment tools were used to complete primary health assessments (section 4.2.2 of the *Technical Supplement* contains a summary of tools by LHD). No information about the effectiveness of these tools was obtained from a review of the service model documentation or through the consultations and surveys.

The most commonly used tools were the ASQ[35], ASQ-SE[36] and SDQ[37] tools and a 2a Primary Health Screen Summary Template, all of which were included in the *Clinical Practice Guidelines* (sections 6 and 13).

A variety of other tools were also used for primary health assessments, examples of which are provided in Figure 36.

[35] Ages and Stages Questionnaire
[36] Ages and Stages Questionnaire – Social and Emotional
[37] Strengths and Difficulties Questionnaire

Figure 36: Example tools used to undertake primary health assessments

Standard tools identified in the Clinical Practice Guidelines	Standard tools not mentioned in the Clinical Practice Guidelines	Tools which were developed by a particular LHD
• HEADSS tool (13-18 year olds) - Northern Sydney LHD	• Aboriginal and Torres Strait Islander Child Health Assessment (0-14 year olds) – Hunter New England LHD • Aboriginal and Torres Strait Islander Health Assessment (15-18 year olds) – Hunter New England LHD	• WSLHD Youth Health Comprehensive Nursing and Medical Assessment Tool (13-18 year olds) – Western Sydney/Nepean Blue Mountains LHD • HNE LHD OOHC Primary Health Screening Template (all ages) – Hunter New England LHD

Resources used to complete primary health assessments

In addition to the abovementioned tools, LHDs also used a number of other resources to assist them to complete primary health assessments.

In Hunter New England, based on service model documentation, clinicians used the General Practitioner Management Plan Patient Summaries for 6 to 18 year olds. The effectiveness of this resource as an input into primary health assessments was not determined.

Several other resources, all of which were deemed to effectively contribute to the completion of primary health assessments, were identified by the IWG and clinicians during consultations. These included:

- clinical advice – access to clinicians who were experienced and knowledgeable in child protection
- coordination – access to an Health OOHC Coordinator who was able to answer clinician queries and obtain additional health information required by clinicians to undertake their assessments effectively
- written information in the form of
  - pre-existing resources (e.g. the 'Blue Book') from which clinicians could extract relevant health, growth and developmental history
  - a trauma symptom checklist for psychologists
  - an interview guide for psychologists.

Tools used to complete comprehensive assessments

Compared to primary health assessment tools and based on service model documentation provided by each LHD, tools to assist with comprehensive assessments were less well documented and fewer specific assessment tools were utilised. Section 4.2.2 of the *Technical Supplement* contains a summary of the comprehensive assessment tools identified by each LHD. No information about the effectiveness of these tools was obtained from a review of the service model documentation or through the consultations and surveys.

Six LHDs did not identify any specific tools (Northern Sydney, Western Sydney/Nepean Blue Mountains, Western NSW, Mid North Coast/Northern NSW, Murrumbidgee and Central Coast LHDs) to support completion of comprehensive assessments.

In contrast, three LHDs (South Eastern Sydney/Sydney Children's Hospital Network, Hunter New England and South Western Sydney/Sydney LHDs) identified a breadth of tools to assist with completion of comprehensive assessments. These included some that were also used to complete primary health assessments (e.g. ASQ, ASQ-SE and SDQ tools) as well as tools designed to measure:

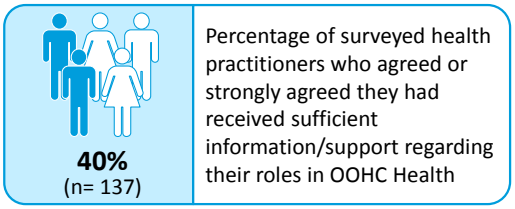
- carer stress – Parental Stress Index Short Form
- psychosocial and mental health – Assessment Checklist for Children (4-11 years) and Assessment Checklist for Adolescents (12-17 years); Achenbach Child Behaviour Checklist (CBCL),CBCL – Teacher Report Form, and CBCL – Youth Self Report Form; the Connors and Griffiths tools
- development – Wechsler Preschool and Primary Scale of Intelligence, Wechsler Intelligence Scale for Children, Australian Developmental Screening Tool (ADST), Peabody Picture Vocabulary Test and Bayley tools.

The Illawarra Shoalhaven and Southern NSW LHDs used a 2b health screen template but did not identify additional assessment tools.

What type of communication resources (in addition to the HMP) work best to support the implementation of the OOHC Health Pathway Program?

Sufficiency of information/support regarding respondent roles

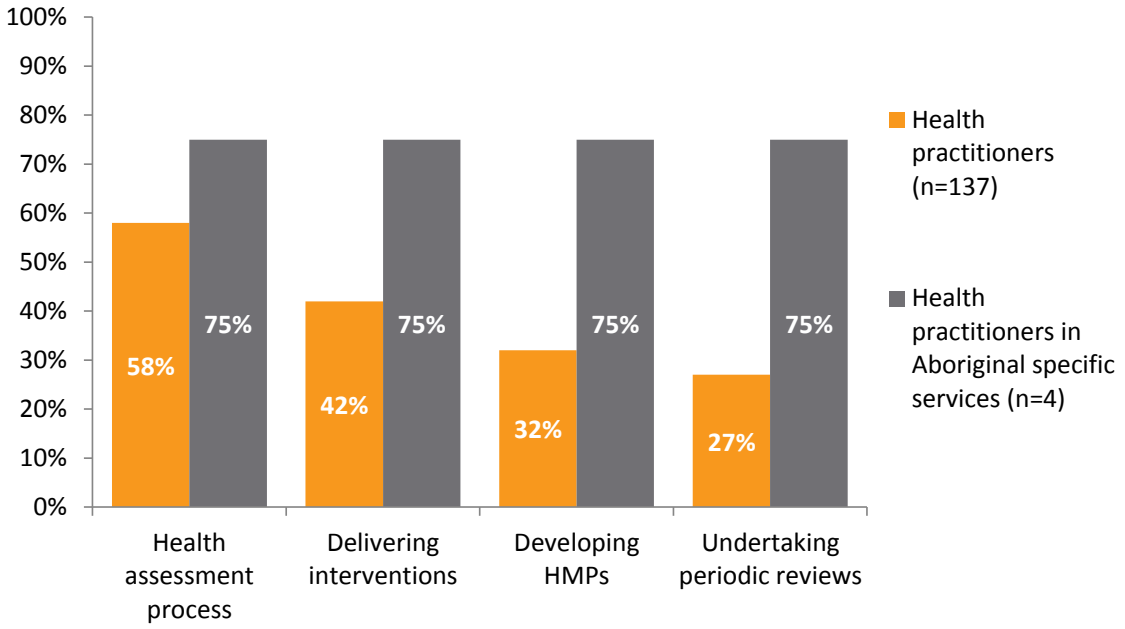
Overall, around 40% of health practitioners indicated sufficiency of information/support as illustrated in the box to the right. Within this, there were differences in the extent to which survey respondents indicated sufficiency according to the specific component of the OOHC Health Pathway Program and the type of health practitioner who responded. Each of these is discussed in turn.



Variation in sufficiency of information/support by component of the OOHC Health Pathway Program

According to survey responses, the extent to which 137 health practitioner respondents felt they had received sufficient information/support regarding their role in the OOHC Health Pathway Program varied by component of the health assessment process as demonstrated in Figure 37. While only a small sample size of four, health practitioners in Aboriginal specific services offered a contrasting view with three of the four respondents agreeing or strongly agreeing they had received sufficient information/support across all components of the OOHC Health Pathway Program.

Figure 37: Extent to which health practitioners in Aboriginal specific services and health practitioners outside Aboriginal specific services agreed or strongly agreed they had received sufficient information/support regarding their role in each component of OOHC Health



Source: Surveys of health practitioners and health practitioners working within an AMS or other Aboriginal specific service

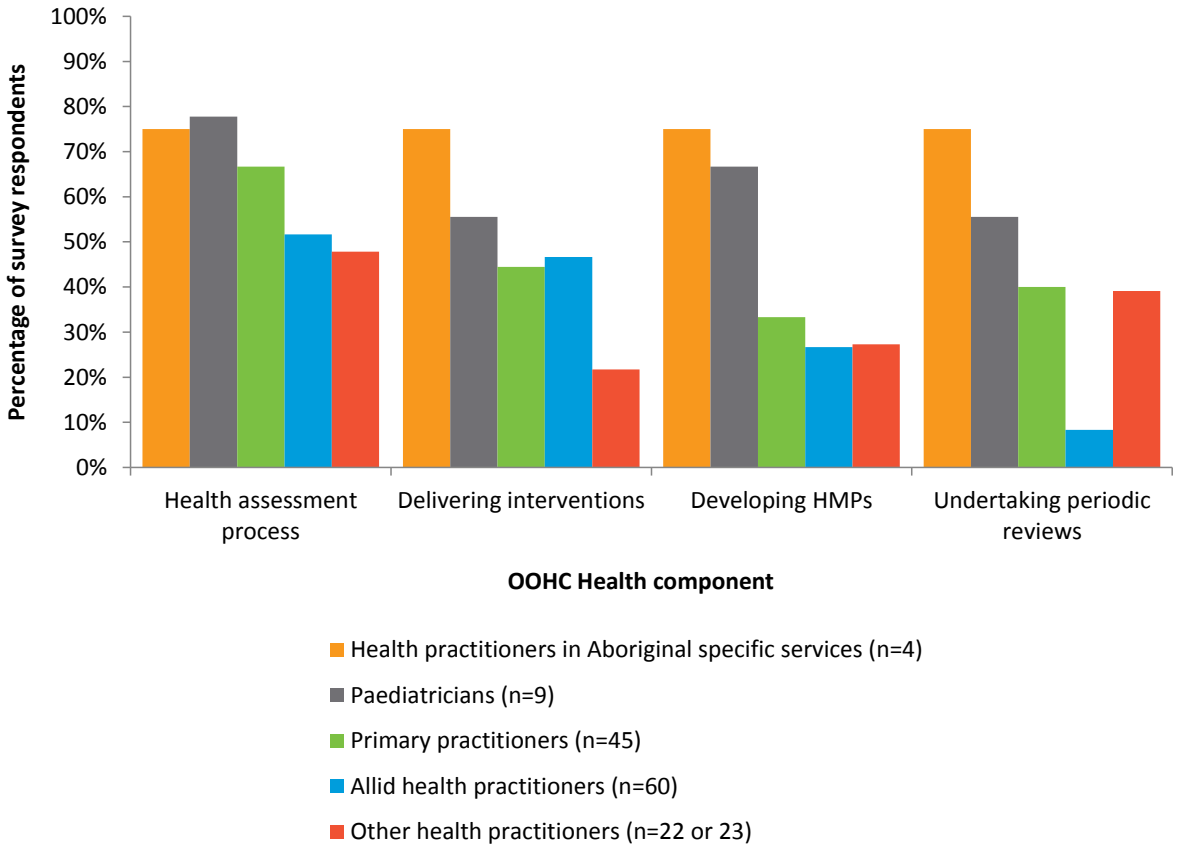
Variation in sufficiency of information/support by clinician type

Survey responses indicated that paediatricians were the most likely of the four types of health professions surveyed to agree or strongly agree they had received sufficient information/support regarding their role in each of the four main components of the OOHC Health Pathway Program, as indicated in Figure 38. Depending on the component, between 56% and 78% of the paediatrician respondents indicated sufficiency.

The primary practitioner survey respondents, the vast majority of which were child and family health nurses[38], were the next most likely to indicate sufficiency followed by the allied health practitioner respondents. Other health practitioner survey respondents (comprising mainly nurses other than child and family health nurses, and managers) were the least likely to agree or strongly agree they had received sufficient information/support regarding their role across each of the four main components of the OOHC Health Pathway Program, with between 22% and 48% indicating sufficiency.

[38] For the purposes of this evaluation, 'primary practitioners' comprise GPs and child and family health nurses. All primary practitioner survey respondents who identified their profession were child and family health nurses (i.e. no primary practitioner respondents self-identified as GPs). A small proportion of respondents did not identify their profession.

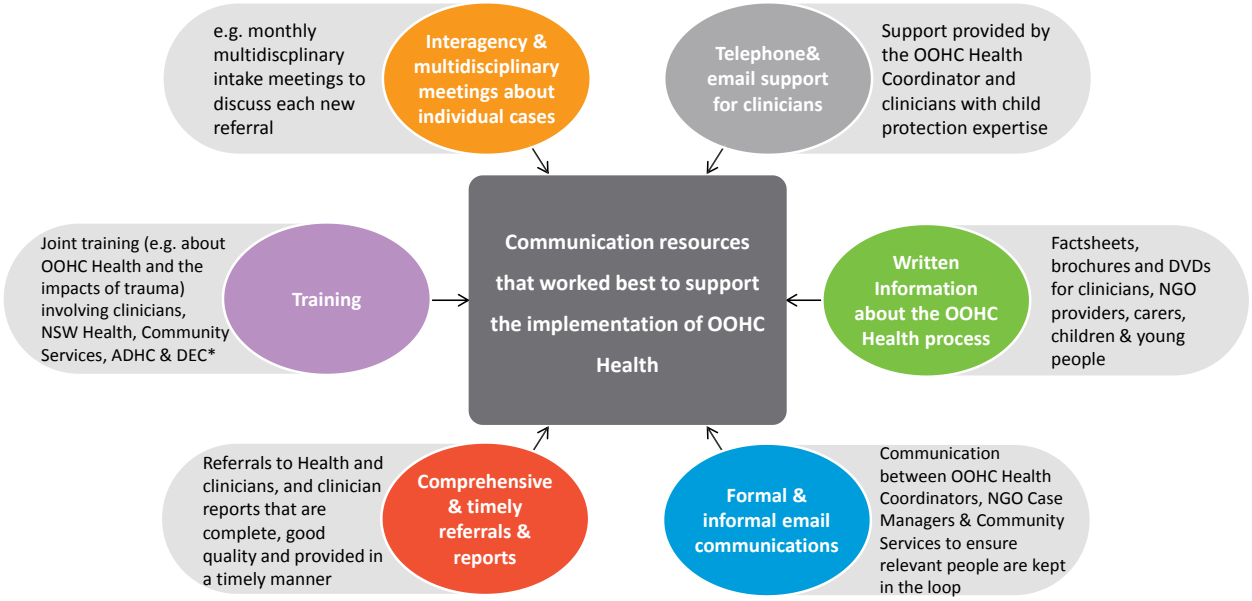
Figure 38: Extent to which health practitioners and Aboriginal specific health practitioners agreed or strongly agreed they had received sufficient information/support regarding their role in each component of the OOHC Health Pathway Program



Types of communication resources that worked best to support the OOHC Health Pathway Program

A variety of communication resources and mechanisms that effectively supported the implementation of the health assessment process were identified during consultations with both clinical and non-clinical stakeholders. The most effective of these are summarised in Figure 39.

Figure 39: Types of communication resources that best supported OOHC Health



* ADHC – Ageing, Disability and Home Care (Department of Family and Community Services, NSW)
DEC – NSW Department of Education and Communities

Clinical Practice Guidelines

Many stakeholders, including both clinical and non-clinical stakeholders, expressed a desire through the consultations to be able to access clinical practice guidelines that provide detailed information about the health assessment process being implemented under the OOHC Health Pathway Program. Subsequent to these consultations, a comprehensive set of *Clinical Practice Guidelines*[39] were published in October 2013.

[39] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care

4.2.3 Clinicians generally deliver primary and comprehensive assessments according to the OOHC Health Pathway Program principles

Evaluation sub-questions	Key findings

How successful has the engagement been of practitioners, both public and private, in conducting primary health care assessments? What are the factors that promote or hinder this process?	• Clinicians in the public system, as opposed to those providing services within AMSs, were better engaged in undertaking primary health assessments than those in the private system according to consultations.
	• Less than half (44%) of health practitioner survey respondents overall (n=124) and a similar proportion of primary practitioners (45%, n=40) agreed or strongly agreed that the engagement of the Health OOHC Coordinators with both public and private health was successful in supporting the conduct of primary health assessments.
	• Factors that promoted engagement included the ten key dependencies to ensure effective clinician engagement identified in section 4.3.4 plus:
	  ◦ successful engagement of carers
	  ◦ co-location of health assessment and intervention services.
	• Factors that hindered engagement were:
	  ◦ incomplete referrals
	  ◦ a lack of direct engagement by NSW Health with GPs
	  ◦ paucity of GP understanding about child development milestones, the impacts of trauma and the importance of primary assessments as a component of the broader OOHC Health Pathway.

What proportion of medical assessments are undertaken by GPs, Nurses, and Aboriginal Medical Services?	• 2a primary assessments were primarily undertaken by Child and Family Health Services (41%) and GPs (18%). • From the available data, of the completed 2b comprehensive assessments, the majority (51%) were completed by health practitioners other than GPs, Child and Family Health nurses and AMS practitioners although the nature of these practitioners was not clear. Almost one third were completed by GPs (31%), 9% by allied health practitioners, 8% by Child and Family Health Nurses and 1% by AMSs.

How successful has the engagement of paediatricians and allied health professionals been in conducting the comprehensive assessments? What factors promote or hinder this engagement?	• Paediatricians and allied health practitioners were, in general, successfully engaged in conducting comprehensive assessments according to clinician consultations.
	• Two main factors promoted engagement in conducting comprehensive assessments:
	  ◦ a strong understanding of the impacts of trauma
	  ◦ receipt by the assessing clinician of all relevant information about the individual before the assessment appointment.
	• Two key factors hindered engagement in conducting comprehensive assessments:
	  ◦ limited resources
	  ◦ paediatricians have experienced challenges in accessing Medicare payment in cases where the referral was made by a practitioner that was not a GP.

Evaluation sub-questions	Key findings
To what extent has a relationship between the primary health provider/ professional and the carer of the child/ young person been fostered, similar to a relationship between a biological parent and their primary health care professional (e.g. their GP)?	• The extent to which a relationship has been fostered between the primary health professional and carer that is similar to that between the primary health professional and biological parent was mixed - 56% of the 122 health practitioner survey respondents indicated such a relationship had been fostered. • Consultations highlighted that these relationships are crucial and identified the need to overcome the challenges to developing such relationships which include: placement breakdowns; incomplete carer knowledge about the child/young person's background; weak carer engagement; involvement of both the carer/s and biological parent/s in the care of the individual; and the involvement of multiple 'carers' in the extended families of children/young people from an Aboriginal or Torres Strait Islander background.
Related recommendations	
• 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 3 (Continuity in roles), 4 (Best practice service delivery), 5 (Best practice coordination), 6 (Awareness and understanding), 13 (Engagement of carers), 14 (AMS engagement), 16 (Engagement principles), 20 (Single point of contact)	

How successful has the engagement been of practitioners, both public and private, in conducting primary health care assessments? What are the factors that promote or hinder this process?

Engagement of clinicians in the public versus the private system

With respect to the OOHC Health Pathway Program, clinicians in the public health system predominantly comprise *child and family health nurses*, allied health practitioners, other health practitioners, paediatricians and *health practitioners in Aboriginal Medical Services and other Aboriginal specific services*. Those in the private system mainly comprise *GPs* and paediatricians. The clinicians indicated in italics are those that are most commonly involved in completing primary health assessments under the OOHC Health Pathway Program (as identified from service model documentation, a summary of which is presented in section 4.2.1.1 of the *Technical Supplement*).

Consultation participants indicated that, overall, clinicians in the public system were better engaged than those in the private system to complete primary health assessments. Within the public system, child and family health nurses were effectively engaged in providing these assessments to their target population of 0-5 year olds, and represent a significant opportunity for assessment of other age groups. Consultations also identified that, in the private system, GPs were less effectively engaged and this had manifested in a reluctance to complete reports from primary assessments and/or reports written that contained minimal information. In some LHDs, this was reported to have resulted in all children going on to receive comprehensive assessments following primary assessments. Consultations highlighted difficulties had been experienced in engaging health practitioners in Aboriginal specific services.

Reasons for these differences in levels of engagement are outlined in the following sections about factors that promote and hinder engagement.

Factors that promoted clinician engagement in conducting primary assessments

The ten key dependencies for effective clinician engagement with NSW Health that are described in section 4.3.4 are applicable here because they also promote clinician engagement in undertaking primary assessments. Two additional factors were identified during clinician consultations and were also highlighted by representatives from the consulted AMSs:

- **Effectively engaged carers** – these helped ensure children and young people attended appointments, background health and other information was brought along and any actions arising from the primary assessments were more likely to be undertaken.
- **Co-location of health assessment and intervention services** – this enabled easier and faster access to appropriate services.

Factors that hindered clinician engagement in conducting primary assessments

Consultations with clinicians and AMS representatives identified three main factors that acted as barriers to engagement in completing primary assessments, the last two of which relate specifically to GPs:

- incomplete referrals that were missing vital information, such as a Medicare number, current medications and immunisation history, required to enable a proper primary assessment to be completed
- a lack of direct engagement with GPs by NSW Health to provide them with information about the OOHC Health Pathway Program and garner their support for the health assessment process
- gaps in GP understanding about normal child development milestones, impacts of trauma and the importance of primary health assessments as a component of the broader OOHC Health Pathway process.

Effectiveness of the Health OOHC Coordinators in engaging with public and private clinicians

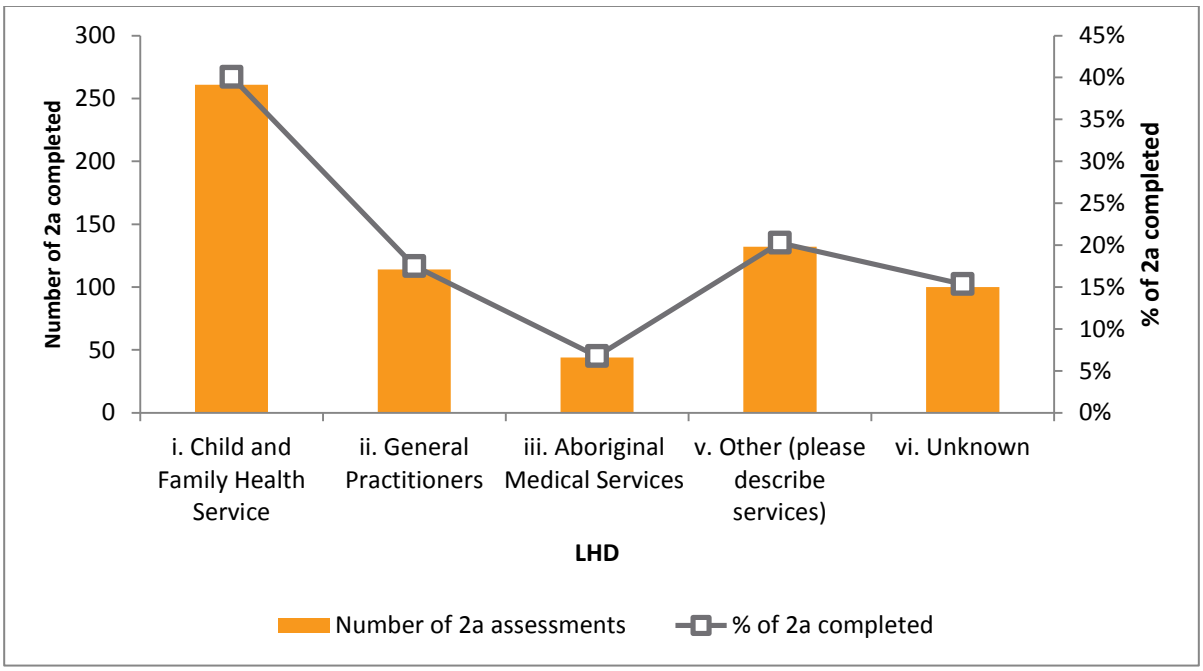
Of the 124 health practitioner survey respondents, 44% agreed or strongly agreed that the engagement of the Health OOHC Coordinators with both public and private health was successful in supporting the conduct of primary health assessments. In particular, this overall view was supported by the sub-group of health practitioners who were predominantly responsible for undertaking primary health assessments, the primary practitioners. 45% of the 40 primary practitioner survey respondents agreed or strongly agreed engagement was effective.

What proportion of medical assessments are undertaken by GPs, Nurses, and Aboriginal Medical Services?

The proportion of 2a primary assessments that were undertaken by GPs, Child and Family Health Services or Aboriginal Medical Services is shown in Figure 40[40]. The majority of 2a primary assessments were completed by Child and Family Health Services (40%), with GPs also performing a significant proportion of primary assessments (18%). Different LHDs used different types of practitioners to conduct evaluations. For example, Hunter New England and Illawarra Shoalhaven used GPs extensively, whereas Nepean Blue Mountains used Child and Family Health services for this role (see *Technical Supplement* for details).

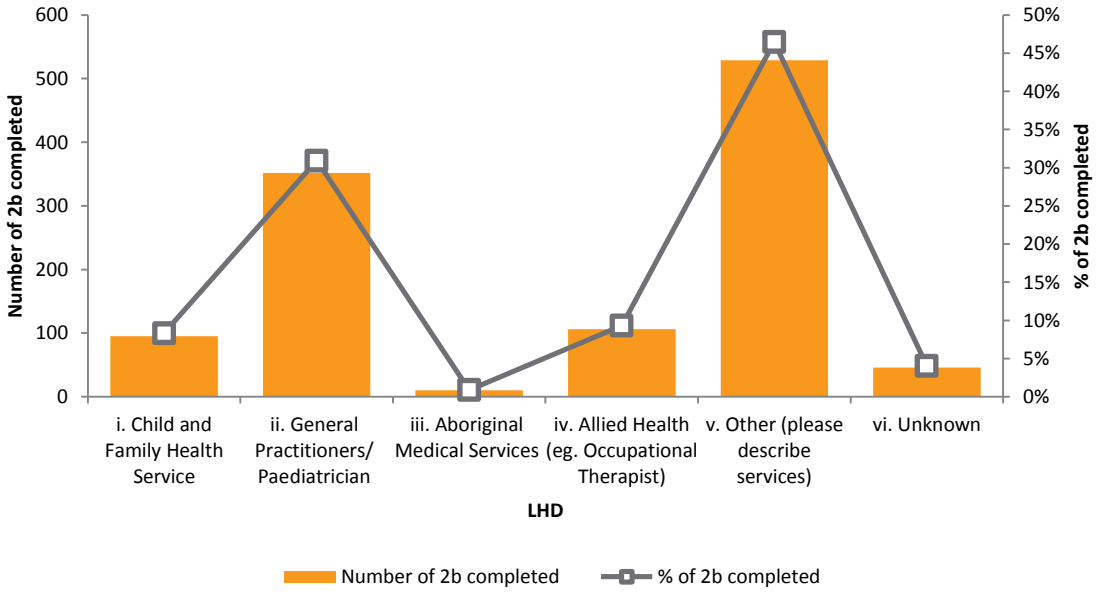
[40] While the percentages of 2a primary health assessments were recorded by NSW Kids & Families, these data commonly had values greater than 100% for each sub-category, indicating that the underlying data was erroneous.

Figure 40: Number and percentage of 2a comprehensive assessments completed by practitioner type



According to the available NSW Kids and Families data on 2b comprehensive assessments (demonstrated in Figure 41), the majority (51%) of these assessments were completed by health practitioners other than GPs or those in Child and Family Health Services and Aboriginal Medical Services. It is unclear from the data what type of health practitioners these included and no relevant information was obtained through other data collection activities. Almost one third of all the 2b comprehensive assessments were completed by GPs or paediatricians (31%), with 9% completed by allied health, 8% by Child and Family Health nurses and only 1% by health practitioners in Aboriginal Medical Services.

Figure 41: Number and percentage of 2b comprehensive assessments completed by practitioner type



Source: NSW Kids & Families, Quarterly reporting data, 2010/11-2012/13

How successful has the engagement of paediatricians and allied health professionals been in conducting the comprehensive assessments? What factors promote or hinder this engagement?

Engagement of paediatricians and allied health professionals in conducting comprehensive assessments

Paediatricians and allied health practitioners were, in general, successfully engaged in conducting comprehensive assessments according to clinician consultations. This was supported by the survey findings outlined in Section 4.3.4 that indicated the majority of clinicians were viewed to be effectively engaged with the OOHC Health Pathway Program more broadly.

Factors that promoted engagement in conducting comprehensive assessments

Two main factors that promoted the engagement of paediatricians and allied health practitioners in completing comprehensive assessments were identified through clinician consultations:

- a strong understanding of the impacts of trauma, including abuse and neglect, on children and young people in OOHC
- receipt by the assessing clinician of all necessary information about the child/young person prior to the assessment appointment – in some LHDs, paediatricians had regular meetings with a social worker or Health Case Manager to review referrals and identify any information gaps to allow the social worker or Health Case Manager time to fill any gaps prior to the assessment.

Factors that hindered engagement in conducting comprehensive assessments

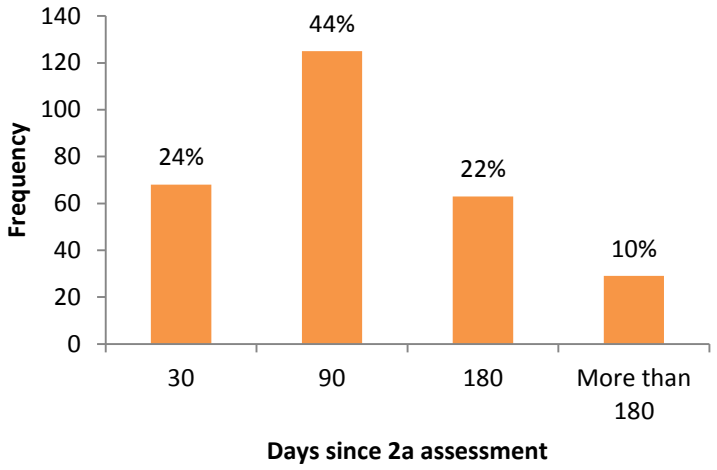
Clinician consultations identified two key factors that hindered engagement with comprehensive assessments. These were:

- Availability of appropriately skilled clinicians which, in some cases, resulted in aspects of comprehensive assessments not being completed (e.g. the psychosocial assessment)
- for paediatricians specifically, the absence of GP referrals for comprehensive assessments resulted in challenges with paediatricians being paid through Medicare.

These factors contributed to the delay in receiving a 2b comprehensive assessment that was experienced by many children and young people in OOHC who were triaged to receive a comprehensive assessment based on their 2a primary health assessment. The *Clinical Practice Guidelines*[41] stipulate a 2b comprehensive assessment should be performed within 90 days of entering care if clinically indicated during the 2a primary assessment. However, according to the available data from four LHDs (see Figure 42), the median time for the completion of a 2b comprehensive assessment following a 2a primary assessment was 90 days in 2012/13, with almost one third being completed more than 90 days after the 2a primary assessment. Given that a 2a primary assessment is generally commenced after 30 days from the interim order, this indicates the majority of children and young people received a 2b comprehensive assessment well outside the stipulated 90 days after entering OOHC.

[41] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care

Figure 42: Days elapsed between 2a primary assessment and 2b comprehensive assessment



***Source**: NSW Health, case file audit of Hunter New England, Mid North Coast, Northern NSW and South Western Sydney LHDs, 2012/13*

AMS representatives highlighted through consultations that the timing of the 2b comprehensive assessment was often too early to identify symptoms of trauma which have not yet manifested. This results in later challenges in ensuring timely access to appropriate mental health and other services. Therefore this group suggested trauma and mental health assessments should form part of ongoing reviews and follow-up assessments.

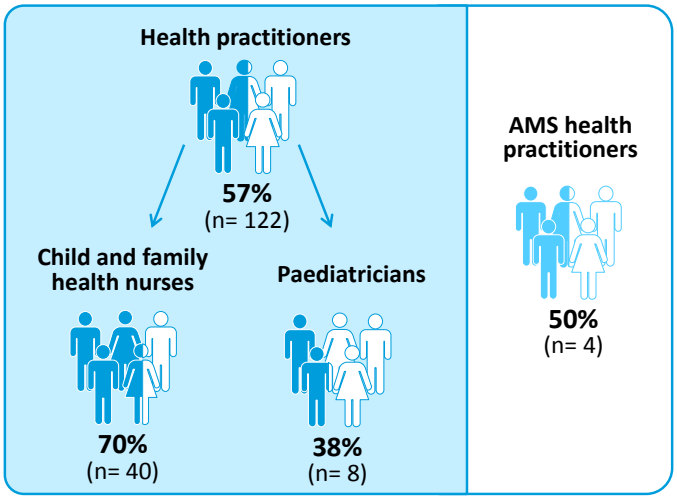
To what extent has a relationship between the primary health provider/ professional and the carer of the child/ young person been fostered, similar to a relationship between a biological parent and their primary health care professional (e.g. their GP)?

Extent to which relationships have been fostered

The extent to which a relationship between the primary health professional and carer that is similar to that between the primary health professional and biological parent has been fostered was not clear. Both consultations and surveys of clinicians and AMS representatives offered a mixed picture.

As illustrated in Figure 43, just over half of the health practitioner and half of the four AMS health practitioner survey respondents agreed or strongly agreed that such a relationship had been fostered. Child and family health nurses were most likely and paediatricians least likely to have perceived that relationships between primary health providers and carers were fostered in ways similar to those between primary health providers and biological parents.

Figure 43: Percentage of survey respondents who agreed or strongly agreed that a relationship between the primary health provider/professional and the carer of the child/young person was fostered, similar to relationship between a biological parent and their primary health care professional



Challenges to developing a similar relationship with carers as biological parents

In situations where the relationship between the clinician and carer was not as strong as a typical relationship between the clinician and a biological parent, clinician consultations indicated three common reasons for the difference:

- placement breakdowns
- weak carer engagement
- lack of carer awareness of all relevant details of the child/young person's background – in these circumstances, clinicians found it more difficult to build a relationship with a carer when they had a lesser understanding of the child/young person's history and were unable to provide the necessary information to the clinician.

Clinicians suggested these relationships were crucial and could be improved through mechanisms to increase carer engagement and to enable better recording and transfer of information about a child/young person's health history between all those who are involved in providing care.

Clinicians highlighted that it was particularly difficult to develop a relationship with carers that was as strong as with the biological parents when both a carer/s and biological parent/s were involved in a child or young person's care at the same time (e.g. while the child/young person was being restored to the care of the biological parents).

The importance of extended family for Aboriginal or Torres Strait Islander children and young people, and the consequent multiple number of people with a caring role who need to be engaged and supported was noted by AMS representatives during consultations.

4.2.4 Effective linkages with other systems and services were operating

Evaluation sub-questions	Key findings
Does the OOHC Health Pathway Program link effectively with other systems and services supporting vulnerable children and young people? If not, why not?	• While the OOHC Health Pathway Program did link effectively with a range of services and systems, some linkages were in the process of being established and/or strengthened, and some linkages were associated with significant challenges according to consultations. • Effective core linkages included with Community Services, DEC, ADHC and NGO OOHC providers. Other effective linkages identified through consultations were with Juvenile Justice NSW, charities, Medicare Locals, Aboriginal and Torres Strait Islander elder groups, and refugee health services.

What recommendations or links, if any, can be made from other current models of care in Australia and overseas that could assist in the effectiveness of the OOHC Health Pathway Program?	• According to a comprehensive literature review, the OOHC Health Pathway Program assessment process is consistent with the actions of all other Australian states and territories which are continuing to establish programs aligned to the aims of the *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care* and comprises some elements in common with these other programs.
	• OOHC Health also has some elements in common with international models of practice, including in the UK and USA (e.g. a requirement for all children and young people entering OOHC to have a health assessment within the first 30 days).
	• Six aspects of other Australian and international models of care may enhance the effectiveness of the OOHC Health Pathway Program:
	  ◦ allocation of a clear primary medical contact and primary care contact for each individual child/young person
	  ◦ utilisation of a central, electronic health record management system
	  ◦ utilisation of formal multidisciplinary teams
	  ◦ co-location of health assessment and intervention services
	  ◦ training workshops about the health needs of children and young people in OOHC and the OOHC Health Pathway Program assessment guidelines targeted at GPs and GP practice nurses
	  ◦ programs that promote attachment between foster mothers and children/young people in OOHC (e.g. Redbank House's Alternate Care Clinic Reparative Parenting Program).

Related recommendations	
• 4 (Best practice service delivery), 5 (Best practice coordination), 17 (Data integration), 19 (Implementation of the eHR)	

Does the OOHC Health Pathway Program link effectively with other systems and services supporting vulnerable children and young people? If not, why not?

OOHC Health did effectively link with a range of government agencies, NGOs and private providers in addition to the core NSW Health services (e.g. Health OOHC Coordinators, paediatricians, GPs, allied health practitioners and AMSs) discussed in detail throughout this report. Several stakeholders noted in consultations that many linkages were either still in the process of being established or were being strengthened. Interagency meetings were highlighted as a valuable mechanism for fostering strong linkages.

The linkages can be grouped into core linkages that were particularly important to the success of the OOHC Health Pathway Program, as indicated in Table 6, and other linkages. Table 6 lists the effective core linkages identified by stakeholders during consultations and provides specific examples and implementation challenges for each.

Non-core linkages that were effective included with Juvenile Justice NSW, charities such as The Smith Family and Cerebral Palsy Alliance, Medicare Locals, Aboriginal and Torres Strait Islander elder groups, and refugee health services.

Table 6: Core services and systems OOHC Health effectively linked with and challenges experienced within those linkages

Effective OOHC Health linkages	Examples of linkages	Challenges within the linkages
Community Services	• From commencement of OOHC Health, fortnightly meetings between Community Services and NSW Health central office representatives. • Formation of regional implementation groups comprising representatives from NSW Health, Community Services, DEC and ADHC.	• Delays in the time taken for Community Services to make referrals to NSW Health (with less than 20% of referrals completed within the stipulated 14-day timeframe, as discussed in section 0). • Poor communication flow from Community Services to Health OOHC Coordinators about relevant changes in a child/young person's situation (e.g. change of placement).
Department of Education and Communities NSW (DEC)	• Inclusion of DEC OOHC Coordinators in quarterly AMS meetings at a local/regional level. • Establishment of a joint NSW Health/ DEC psychosocial screening program within schools for children and young people in OOHC.	• None identified
Ageing, Disability and Home Care[42] (ADHC)	• NSW Health and ADHC jointly established a formal process for NSW Health to directly refer children/ young people in OOHC to receive ADHC services .	• ADHC was often unable to provide therapy services for eligible children/ young people in a timely manner.
NGO OOHC providers	• None identified.	• The recent establishment of the roles has affected: • NGO OOHC Case Managers understanding of the OOHC Health Pathway Program, particularly HMPs and reviews. • Information flows between Health OOHC Coordinators to NGO OOHC Case Managers are still developing.

[42] NSW Department of Family and Community Services

What recommendations or links, if any, can be made from other current models of care in Australia and overseas that could assist in the effectiveness of the OOHC Health Pathway Program?

Links to other current models of care

To determine which aspects of other current Australian and international models of care could strengthen the effectiveness of the OOHC Health Pathway Program, Nous undertook a literature review which built on previous reviews completed in 2010 during the development of the *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care* (Nous Group, 2010) and in 2013 for the development of the *Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care* (NSW Ministry of Health, 2013). The full literature review is found in Section 2 of the *Technical Supplement*. Some models of care for inclusion in the literature review were suggested by NSW Kids and Families and the IWG during consultations.

Implementation of the OOHC Health Pathway Program in NSW is consistent with the actions of all other Australian states and territories which are continuing to establish programs aligned to the aims of the *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care* (Child Health and Wellbeing Subcommittee of the Australian Population Health Development Pincipal Committee, 2011). While the specifics of these programs vary and they are at different stages of maturity, the OOHC Health Pathway Program has components in common with some of these other programs (e.g. initial health assessments and comprehensive assessments under the Western Australian Better Care Better Services model).

Similarly, the OOHC Health Pathway Program shares elements with international models of practice including in the UK and USA although the specific composition of these elements does vary. For example, policies in the UK, USA and Australia all state a requirement for children and young people entering OOHC to receive a health assessment within the first 30 days. The implementation of this policy requirement has differed. In NSW, the OOHC Health Pathway Program stipulates a primary health assessment is to be completed within the first 30 days and followed up by a comprehensive assessment within the first 90 days if clinically indicated (NSW Ministry of Health, 2013). In the UK, a single health assessment is to be completed within that timeframe as per the 2013 *Working Together to Safeguard Children* model. In the USA, some areas require an initial health assessment within the first 24 hours while others indicate within 5 days, both of which are to be followed up with a comprehensive assessment within the 30 day period (Greiner & Thackeray, 2013) (California Department of Health Care Services, 2012). As well as varying timeframes, each model utilises different clinicians to perform the health assessments (e.g. GPs, nurse practitioners) and different assessment locations (e.g. hospital-based services, community health settings).

Recommendations from other models of care

There have been a limited number of evaluations of the effectiveness of models of care to assess the health of children and young people in OOHC. Through our review of the literature Nous has identified six aspects of other Australian and overseas models appear to work well and may be drawn on to enhance the effectiveness of the OOHC Health Pathway Program. These aspects are as follows and are described further below:

- allocation of a clear primary medical contact and primary care contact for each individual child/young person
- utilisation of a central, electronic health record management system
- utilisation of formal multidisciplinary teams
- co-location of health assessment and intervention services

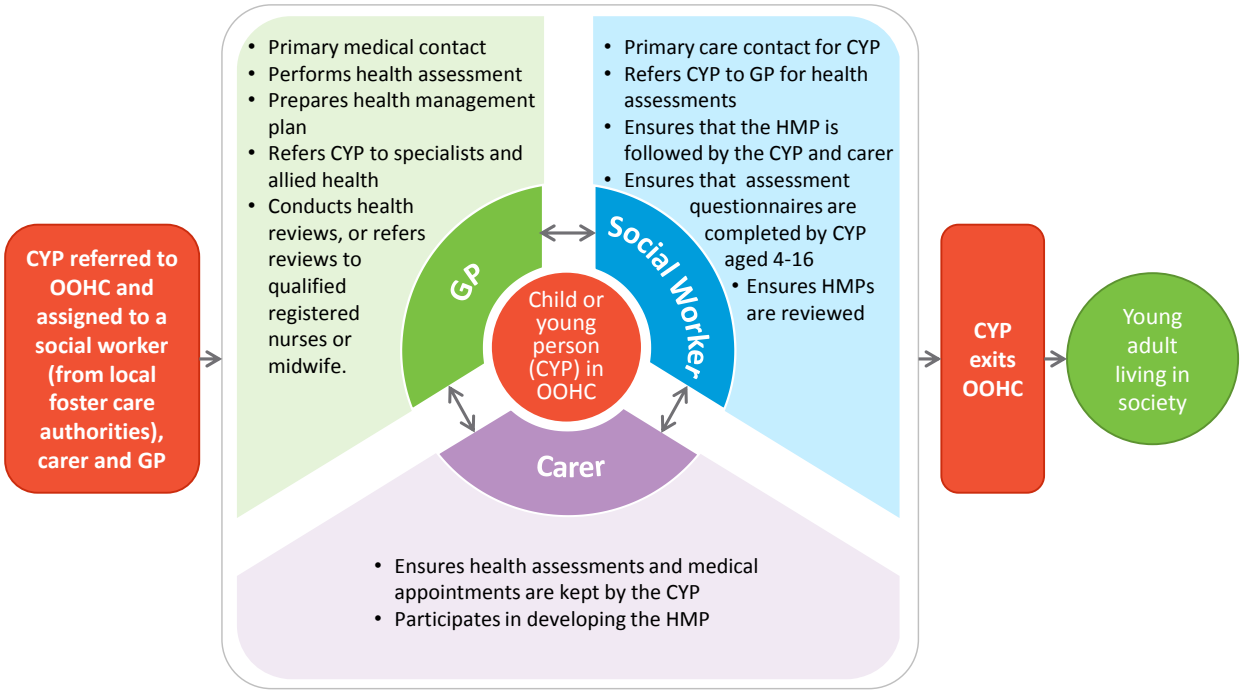
- training workshops about the health needs of children and young people in OOHC and health assessment guidelines targeted at GPs and GP practice nurses
- programs that promote attachment between foster mothers and children and young people in OOHC.

Clear primary medical contact and primary care contact

The UK has a national model of OOHC that legally requires children to undertake a holistic health assessment on entry under Working Together to Safeguard Children implemented on 15 April 2013. Under this model (summarised in Figure 44: Key health-related components of the UK national model of OOHC), each child or young person entering OOHC receives a health assessment from a registered medical practitioner, typically a GP, who acts as the primary medical contact for the duration of the child's time in OOHC. A health plan is created within the first four weeks of OOHC, and reviews of the plan are carried out by the GP, a qualified registered nurse or midwife depending on availability. Medical records are held by the GP, the social worker, and the carer. Social workers from the local foster care authorities are required to ensure that health assessments are carried out, that a health plan is created, and that health plans are implemented.

While the health system in the UK differs considerably from that of Australia, the concept of each child/young person in OOHC having a primary medical contact and a primary care contact is relevant and would help to ensure greater continuity of care.

Figure 44: Key health-related components of the UK national model of OOHC



Central, electronic health record management system

Multiple jurisdictions use a centralised electronic health record management system to manage medical records for children and young people in OOHC. These include Victoria's Looking After Children system, Western Australia's Department for Child Protection electronic health passport (Foster Care Association of Western Australia, 2010), Queensland's Child Health Passport, and state-level health passports in several states of the USA (Mekonnen, et al., 2009). Through the consultations held as part of this evaluation of the OOHC Health Pathway Program, participants highlighted that systems such as these

would help reduce gaps in background health information about children and young people in OOHC, and ensure better coordination and communication of health information. As identified by Vimpani et al., these systems help maintain continuity of care for children and young people OOHC who experience multiple placements (Vimpani, et al., 2011).

Currently in NSW, the paper-based 'Blue Book' Child Personal Health Record is the most extensively used health record management system used by individuals with GPs and clinics maintaining medical records according to their own systems. As at July 2013, Australia's National eHealth Record system did not yet support the inclusion of adequate child health, growth and development information to enable it to replace the 'Blue Book' (NSW Kids and Families, 2013). The use of the National eHealth Record as a centralised electronic system to manage the health records of children and young people in OOHC in NSW remains a potential in the future and should be pursued as soon as practical.

Multidisciplinary teams

The effective use of multidisciplinary teams to provide care to this population was cited by consultation participants in this evaluation as an example of what has worked well in some LHDs. Two Australian models of care, one of which provides services to vulnerable families (Spilstead Model) and one of which provides services to a subset of children/young people in OOHC (Evolve Interagency Services), provide examples of the effective use of multidisciplinary teams.

The Spilstead Model was developed and is used by the Dalwood Children's Services in northern Sydney. The model is a collaborative effort between the Northern Sydney LHD and Spilstead Charitable Trusts and supports vulnerable families who experience challenges in caring for their children. The model is based on neuro-developmental research and utilises evidence-based types of early intervention, including a multidisciplinary team to provide services. An evaluation of the model conducted by service staff in 2009 reported very positive results for both children and parents, including in the areas of child wellbeing and developmental areas (Gwynne, et al., 2009) (Gwynne, et al., 2012).

Evolve Interagency Services operates throughout Queensland to provide therapeutic and behaviour support services for children and young people with severe and complex psychological and behavioural problems who are in OOHC and on child protection orders. The model is a partnership between the three Queensland Government departments that deliver child protection services. Once a child/young person has been referred to the program, an interagency panel assigns them a primary service provider based on their needs and they then receive an initial or comprehensive assessment. The provider's multidisciplinary team then works with the child/young person, their carer, family, child safety officers, school guidance officers and other relevant stakeholders to develop, coordinate, deliver and review care (Queensland Government, 2013) (Department of Communities, 2013).

Co-location of health assessment and intervention services

Both the Spilstead Model (outlined above) and the medical home model used to provide health services to children and young people in OOHC in the USA successfully utilise co-located services in a 'one-stop shop' approach. Consultation participants in this evaluation identified the value of this approach and recognised that some LHDs had specialised OOHC Health Pathway clinics.

There are three main types of health care models used in the USA to cater for this population – medical homes, consultation clinics and community based consultations. The medical home model involves dedicated, permanent health clinics for children who are anticipated to be in OOHC for an extended period of time. These clinics are often co-located with other services that support children and young people who have experienced trauma. They act as 'one-stop shops' for health care and provide continuity of care through acting as the primary health care provider (Greiner & Thackeray, 2013).

Training workshops for GPs and GP practice nurses

Victoria successfully piloted one-day training workshops for GPs/GP practice nurses as part of their 2010 health assessment pilot for OOHC that covered the health needs for children and young people in this population in addition to assessment guidelines (General Practice Victoria, 2010). All participants rated the training highly while acknowledging there were some elements (e.g. medico-legal implications) that required further refinement. Participants of consultations (and respondents to the surveys) completed in this evaluation repeatedly identified the need for clinician education and training, particularly for GPs, about the needs of this population and the OOHC Health Pathway process.

Programs that promote attachment between foster mothers and children/young people in OOHC

Programs that promote attachment between foster mothers and children/young people in OOHC have been shown to improve health outcomes through increasing early detection of health issues and managing ongoing medical care (Bick & Dozier, 2013). Participants in consultations completed in this evaluation identified that some LHDs, such as the Northern Sydney and Western Sydney LHDs, have implemented reparative parenting programs (funded by NSW Kids and Families from *Keep Them Safe* funds) which have effectively contributed to promoting these attachments. The Western Sydney LHD Reparative Parenting Program is delivered through the Alternate Care Clinic, Redbank House (see section 2.4.2 of the *Technical Supplement* for further information).

4.3 What governance and engagement structures have been set up for the Program, and how effective are they?

The multi-level program governance structures established for the OOHC Health Pathway Program have provided a strong foundation for effective delivery of the program. These structures have established partnerships between NSW Kids and Families, Community Services, LHDs and the SCHN. At the local level, LHDs have established and are operating local management and governance arrangements including local implementation interagency working groups and multi-disciplinary care teams.

As outlined earlier, the Health OOHC Coordinators have been an important element of delivery of the OOHC Health Pathway Program. They have been supported by an OOHC Clinical Advisor located in the SCHN, appointed to 30 June 2014. There were a range of views on the effectiveness of the OOHC Clinical Advisor role. Twenty-two percent of the surveyed health practitioners were aware of the role, with allied health practitioners among those most likely to be aware. The clinicians who were aware of the position indicated the role had been effective in providing them with advice and support. With the release of the *Clinical Practice Guidelines* late last year, maintaining a clinical advisory role will be important, at least for the next 12 months.

During this evaluation Community Services ceased central funding for their Interagency Pathway Coordinators. From 1 July 2013, Community Services put in place alternative arrangements with each Community Services Region allocating a central contact point for the OOHC Health Pathway Program. Maintenance of these central contact points and ensuring they work effectively is a critical success factor for the future implementation of the the OOHC Health Pathway Program.

4.3.1 OOHC Health governance and advisory structures are established and operating effectively

Evaluation sub-questions	Key findings
How effective are the local management and governance structures supporting the role of the NSW Health OOHC Coordinator?	• Most LHDs had established and were operating local management and governance structures, including local implementation working groups (consisting of relevant managers and interagency representatives) and multi-disciplinary care teams.

Evaluation sub-questions	Key findings
	• Many LHDs had also developed local initiatives to support implementation, including stakeholder and staff engagement mechanisms. • The combination of these structures and initiatives, and ongoing support from NSW Kids and Families, has maintained adequate governance for the implementation of the OOHC Health Pathway Program. Whilst there are things that can be done to improve the effectiveness of governance arrangements, these will be implemented in parallel with other necessary improvements. Some improvements will be realised as understanding of the program increases.

What are the key dependencies in the processes and working relationship between the NSW Health OOHC Coordinator and the Community Services Interagency Pathway Coordinator to ensure the success of the OOHC Health Pathway Program?	• Most NSW Health OOHC Coordinators had effective relationships with their respective Community Services IPCs (86% of the seven survey respondents agreed or strongly agreed this was the case).
	• Based on consultations, the processes and working relationship between NSW Health OOHC Coordinator and Community Services IPC were more likely to succeed if the following five characteristics were present:
	  ◦ a collaborative approach involving open, timely and quality communication
	  ◦ regular formal meetings supported by informal day-to-day communication
	  ◦ the coordinators were a central point of contact for each other, particularly the IPC (or single point of contact in Community Services) for the Health coordinator)
	  ◦ continuity in coordinator roles
	  ◦ agreed systems/processes to request and share information, and raise and address issues.

What impact will the cessation of the funding for Interagency Pathway Coordinators have on the OOHC Health Pathway Program?	• Three Community Services Regions have continued to fund the IPC role past 30 June 2013 out of their Regional budgets (Metro Central, Metro West and Metro South West).
	• The key IPC functional areas that are likely to be impacted by the cessation of their role are monitoring, data collection, training and networking.
	• Community Services implemented an exit strategy and a Regional transition process prior to the cessation of KTS funding which aimed to integrate the work of the IPCs into other Regional practices and processes. The exact way in which integration was to occur at the Regional level was to be determined by each Region based on local circumstances.
	• Six potential impacts were identified from cessation of funding of the IPC role:
	  ◦ reduced and delayed enrolments in the OOHC Health Pathway Program and poorer quality health referrals
	  ◦ greater difficulty tracking changes in the circumstances, especially placement details, of individuals
	  ◦ weaker Community Services data collection
	  ◦ increased administrative load on other stakeholders, particularly the Health OOHC Coordinators
	  ◦ breakdown of key working relationships that had been established between the IPCs and local NSW Health staff
	  ◦ new Community Services caseworkers will not be adequately trained and supported in the OOHC Health Pathway Program.
	• Nous did not evaluate the extent to which these potential impacts eventuated.

Related recommendations

- 2 (Service delivery models), 3 (Continuity in roles),4 (Best practice service delivery), 5 (Best practice coordination), 16 (Engagement principles), 20 (Single point of contact), 21 (Effectiveness of systems and processes)

How effective are the local management and governance structures supporting the role of the NSW Health OOHC Coordinator?

NSW Kids and Families has provided high level support to LHDs by focussing on state-level issues and, where possible encouraging LHDs to strengthen networks with local Community Service representatives to ensure a collaborative approach to resolving issues.

Maintaining continuity of the OOHC Coordinator in their role was identified in consultations (including stakeholder interviews, focus groups and online survey) as being the key factor to improving the management and governance of the implementation of the OOHC Health Pathway Program. Stability in these roles facilitated:

- timely completion of assessments and other elements of the OOHC Health Pathway Program
- more and better communication within and between agencies
- enhanced relationships with key stakeholders (including clinicians and carers)
- improved clinical decision-making.

The combination of the structures and initiatives outlined below, together with ongoing support from NSW Kids and Families have provided adequate governance for the implementation of the OOHC Health Pathway Program. Whilst there are things that can be done to improve the effectiveness of governance arrangements, these will be implemented in parallel with other necessary improvements. Further improvements will be realised as understanding of the program increases.

LHDs have established local governance structures to support implementation of the OOHC Health Pathway Program

Stakeholders indicated through the consultations that governance structures were operating effectively. The following governance structures were common to most LHDs:

- Local Implementation Working Group to support management and resourcing decision making
- multi-disciplinary care teams to support clinical decision making via case conferences.

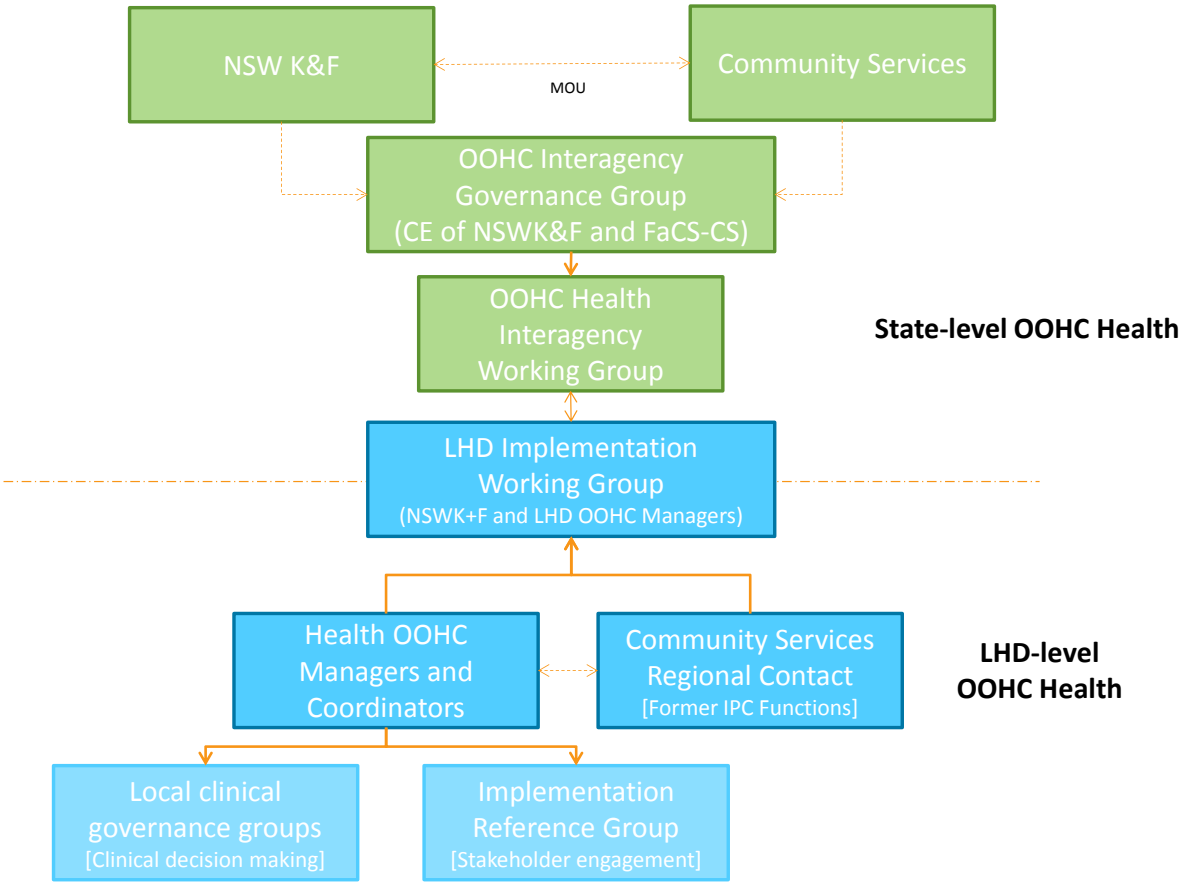
A number of factors and/or local initiatives have increased the effectiveness of local management and governance structures.

A number of local initiatives have been implemented to support overall implementation, including:

- Staff engagement mechanisms (including the establishment of an 'Implementation Reference Group' of key stakeholders - including clinicians that complete assessments) to drive better role clarity, and to document processes and procedures.
- Stakeholder engagement mechanisms to provide information, clarify roles and responsibilities, support escalation of issues and complaint resolution.
- Co-location of the OOHC Coordinator with either the child health or child protection functions to strengthen relationships and to increase information transfer and improve care coordination.

Following investigation of the service models in operation and the initiatives implemented in some LHDs, the evaluation has informed the proposed core governance model illustrated in Figure 45.

Figure 45: Proposed core governance model



What are the key dependencies in the processes and working relationship between the NSW Health OOHC Coordinator and the Community Services Interagency Pathway Coordinator to ensure the success of the OOHC Health Pathway Program?

All Health OOHC Coordinators indicated they had effective relationships with the Community Services Interagency Pathway Coordinators in their respective areas (as illustrated in the box to the right). A number of key dependencies to ensure these relationships worked effectively were identified through consultations, primarily with the Health OOHC Coordinators and IPCs, but also with the IWG and Community Services OOHC PPS team.

100%
(n= 6)

Percentage of surveyed OOHC Health Coordinators who agreed or strongly agreed they had an effective relationship with the Community Services IPC in their respective area

Key dependencies

The processes and working relationship between the NSW Health OOHC Coordinator and Community Services IPC were more likely to succeed if the following five characteristics were present:

- *A collaborative approach involving open, timely and quality communication* – this ensured the efficient flow of information, effective collection of data and a greater likelihood that individual children and young people were referred, assessed, treated and reviewed.
- *Regular (e.g. monthly) formal meetings supported by informal day-to-day communication*.
- *The coordinators were a central point of contact for each other, particularly the IPC for the Health coordinator* – a central point of contact who had the time to dedicate to the OOHC Health Pathway Program, was able to navigate within their own agency, and had the knowledge and authority to resolve issues or ability to escalate issues as required was able to facilitate more timely care for children and young people.
- *Continuity in coordinator roles* – this enabled the coordinators to build strong relationships with each other, with other stakeholders in their respective LHDs and with stakeholders across the broader system.
- *Agreed systems/processes* – this ensured agreement about and a shared understanding of the mechanisms to request and share information, and raise and address issues.

The presence of these same characteristics in the processes and working relationships between the NSW Health OOHC Coordinators and the Community Services representatives in each Region who have taken over the functions of the IPCs following cessation of the IPC role will enhance the likelihood of their success.

What impact will the cessation of the funding for Interagency Pathway Coordinators have on the OOHC Health Pathway Program?

The IPC role and its funding

The Community Services IPC role was intended to "establish and maintain collaborative working relationship and shared responsibility with other Regional government agencies and key stakeholders on the implementation of KTS initiatives" (Community Services, NSW Department of Family and Community Services, n.d.). These initiatives included the OOHC Health Pathway Program in addition to three other initiatives related to children and young people in OOHC – development of Individual Education Plans for each child/young person; implementation of revised MOUs between Community Services (and NGOs with case management responsibility) and Health, DEC and ADHC; and implementation of Community Services (and NGOs with case management responsibility) Agreements with the Catholic Education Commission and Association of Independent Schools NSW.

While the IPCs had responsibilities across the following four functional areas in relation to these initiatives, monitoring, data collection, training and networking, the exact way in which the role was implemented in each Region varied depending on local circumstances (Community Services, NSW Department of Family and Community Services, n.d.).

The IPC positions were funded under Keep Them Safe, commencing in September 2010 and ceasing on 30 June 2013. Some Community Services Regions decided to continue to fund the IPC role out of the Regional budget (including the Metro Central, Metro West and Metro South West Regions).

Transition arrangements

Community Services instituted an exit strategy and a three month Regional transition process to enable the work undertaken by the Regional IPCs to be integrated into Regional practices and processes prior to 30 June 2013 (Community Services, NSW Department of Family and Community Services, n.d.). The exact way in which this integration was to occur was to be determined at the Regional level then documented for approval by the Regional Director.

The key components of the transition process were fourfold:

- Each Region was to nominate a contact within the Child and Family Referral Unit to continue working with NSW Health and DEC, including liaising with the Health and Education OOHC Coordinators.
- IPCs were to provide training to Child Protection staff about the Interagency Pathways, including the revised Regional processes that would come into effect once the IPCs finished in their role.
- The KiDS database was to be modified to enable central collection of data.
- IPCs were to provide written step-by-step instructions about the operation of the Health (and Education) Pathways after 30 June 2013 for use by Community Services casework staff.

Community Services central OOHC Service Improvement team provided some support to the Regions during the transition (e.g. developed a standardised training package about the Interagency Pathways to be used by the IPCs as a basis for their training to Child Protection staff) and intended to work with NSW Health and DEC post 30 June 2013 to monitor progress within the Regions.

Likely short term impacts of cessation of funding for the IPC role

The cessation of the *Keep Them Safe* funding for the IPC role was expected to have a number of potential impacts, mainly in those Regions that have not continued to fund the role through the Regional budgets. Table 7 outlines the six main potential impacts identified through a combination of consultations with the IPCs incumbent in May 2013, Community Services PPS team, Health OOHC Coordinators, and NSW Kids and Families, and information obtained from Community Services' *Exit strategy for Interagency Pathway Coordinators and transition plan for Regions: Tab A*' (Community Services, NSW Department of Family and Community Services, n.d.).

Table 7: Anticipated potential impacts of cessation of funding for the IPC role

Likely impact	Source	
Reduced and delayed enrolments in the OOHC Health Pathway Program and poorer quality health referrals – two of the core IPC functions were to check the completeness of referrals to the OOHC Health Pathway Program and to send referrals on to the appropriate Health OOHC Coordinator.		
Greater difficulty tracking changes in the circumstances, especially placement details, of individuals – the IPC was responsible for obtaining this information and conveying it to the Health OOHC Coordinator.		

Likely impact	Source	
Weaker Community Services data collection – IPCs were collecting data manually. Data collection is a critical task, with data contributing to national and state reporting on the OOHC Health Pathway Program and progress against the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care. Post 30 June 2013, the new arrangements rely on Community Services caseworkers to input the necessary data into the KiDS database.		
Increased administrative load on other stakeholders, particularly the Health OOCH Coordinators – the functions of the IPC role remain critical to the success of the OOHC Health Pathway Program and, in those Regions not maintaining the IPC role, these functions were to be spread across other stakeholders and added to their pre-existing responsibilities. Consultations participants indicated the Health OOHC Coordinators were especially likely to experience a higher administrative load because it was expected they will have to follow up on incomplete referrals with multiple NGO providers and will spend more time having to navigate through Community Services when questions/issues arise.		
Breakdown of key working relationships that had been established between the IPCs and local NSW Health staff – this was anticipated to result in reduced local issue resolution which would result in a greater likelihood of Community Services escalating issues to NSW Health.		
New Community Services caseworkers will not be adequately trained and supported – IPCs were responsible for training caseworkers in their Regions and providing additional mentoring and support to those who required it.		

Nous did not evaluate the extent to which these potential impacts have eventuated.

4.3.2 OOHC Health performance is reported to the governance group at regular intervals

Evaluation sub-questions	Key findings
Does the governance group receive regular updates on performance of the OOHC Health Pathway Program? If not, why not?	• The Implementation Working Group, as the overall governance group of the OOHC Health Pathway Program, reported during their consultation that they did receive regular updates on performance at their quarterly meetings.
Related recommendations	
• 3 (Continuity in roles), 17 (Data integration), 18 (Data collected), 20 (Single point of contact), 21 (Effectiveness of systems and processes)	

Does the governance group receive regular updates on performance of the OOHC Health Pathway Program? If not, why not?

The Implementation Working Group (IWG), as the overall governance group for the OOHC Health Pathway Program, reported through their consultation that they did receive regular quarterly updates on performance.

The IWG comprises representatives from the NSW Kids and Families Senior Team, NSW Health OOHC Managers, and the relevant managers of the Sydney Children's Hospital Network, Hunter New England LHD and Alternative Care Clinic at Redbank House (A complete list of members of the IWG is found in the stakeholder engagement plan in section 3.2 of the *Technical Supplement*). The NSW Health OOHC Managers provided updates to the rest of the IWG about the performance of the OOHC Health Pathway Program in each LHD, including against relevant key performance indicators, at the scheduled quarterly meetings.

In addition to monitoring the performance of the OOHC Health Pathway Program across the state, the IWG reported these meetings also provided a state-wide perspective of the health assessment process as well as a forum in which emerging issues were identified and resolved or escalated, and information and ideas for improvement were shared.

4.3.3 Health OOHC Coordinators and an OOHC Advisor are in place to support implementation

Evaluation sub-questions	Key findings
How effective is the role of the NSW Health OOHC Coordinator in the LHD in supporting the implementation of health assessments?	◦ The perceived effectiveness of the Health OOHC Coordinator role varied by stakeholder group with non-clinical stakeholders (Health OOHC Coordinators themselves, NGO OOHC Case Managers and the IWG) indicating through consultations and surveys that the role was highly effective, and just over half the health practitioner survey respondents (n=124) indicating effectiveness. Of the health practitioners, paediatricians were most likely (75%) and primary practitioners least likely (48%) to agree or strongly agree the role was effective. ◦ The perceived effectiveness of the Health OOHC Coordinator role varied by component of the OOHC Health Pathway Program according to health practitioners, with the 124 survey respondents most likely to indicate effectiveness regarding comprehensive assessments (55%) and least likely in relation to periodic reviews (24%).
What are examples of NSW Health OOHC Coordinator role best practice that can be shared throughout the network?	◦ Examples of Health OOHC Coordinator role good practice that other LHDs could benefit from were identified through consultations with these Coordinators and included: ◦ establishment of Health Case Manager roles ◦ ensuring all necessary information was collated for clinicians prior to appointments ◦ development of a standardised email template for communication between the Health OOHC Coordinator and NGO OOHC Case Managers ◦ providing clinicians with training opportunities about trauma ◦ developing and documenting approaches to GP and carer engagement.

Evaluation sub-questions	Key findings

What, if any, barriers that prevent the effectiveness of the NSW Health OOHC Coordinators exist?	• The Health OOHC Coordinators themselves, and other consultation participants, identified six main factors that have hampered the effectiveness of their role:
	  ◦ the substantial workloads of these roles
	  ◦ insufficient administrative and health case management support
	  ◦ inexperience in the OOHC sector
	  ◦ turnover of people in the roles and roles left unfilled for a period of time
	  ◦ weak stakeholder understanding of the Health OOHC Coordinator role and associated responsibilities
	  ◦ the lack of a state-wide database for data collection.

To what extent did the OOHC Advisor in the Sydney Children's Hospital Network fulfil the intended role of the position?	• Views about the extent to which the OOHC Advisor fulfilled the intended role varied, due mainly to differing perceptions of the intended state-wide purpose and functions of the role.

How effective is the role of the OOHC Advisor in the Sydney Children's Hospital Network in providing advice and support to clinicians providing health assessments to children and young people in OOHC?	• Perceptions of the effectiveness of the OOHC Advisor in providing advice and support to clinicians involved in the OOHC Health Pathway Program were varied.
	• Twenty-two percent of surveyed health practitioners (n=120) were aware of the OOHC Advisor position, with allied health practitioners among those most likely to be aware. Of the clinicians who were aware of the position, they indicated the role had been effective in providing them with advice and support.
	• Through surveys, clinicians identified a range of supports the OOHC Advisor had provided, including advice about the OOHC Health Pathway Program process, advice about individual cases, referrals to paediatric services, information about previous assessments completed, information provided through a quarterly newsletter and various education activities.
	• Through surveys, clinicians who had not previously sought support from the OOHC Advisor identified seven areas of support they could anticipate seeking in future:
	  ◦ information about the OOHC Advisor role and the support it can offer
	  ◦ information about the OOHC system, the OOHC Health Pathway Program and the needs of the target population
	  ◦ regular updates about the OOHC Health Pathway Program and changes
	  ◦ clinical advice about individual cases
	  ◦ advice about locally available specialist services
	  ◦ guidance on the needs of carers and how best to engage with them
	  ◦ access to linkages with other agencies.

Related recommendations	
• 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 3 (Continuity in roles), 6 (Awareness and understanding), 12 (Diversity), 13 (Engagement of carers), 14 (AMS engagement), 16 (Engagement principles), 20 (Single point of contact), 21 (Effectiveness of systems and processes), 22 (Extended funding for OOHC Advisor role)	

How effective is the role of the NSW Health OOHC Coordinator in the LHD in supporting the implementation of health assessments?

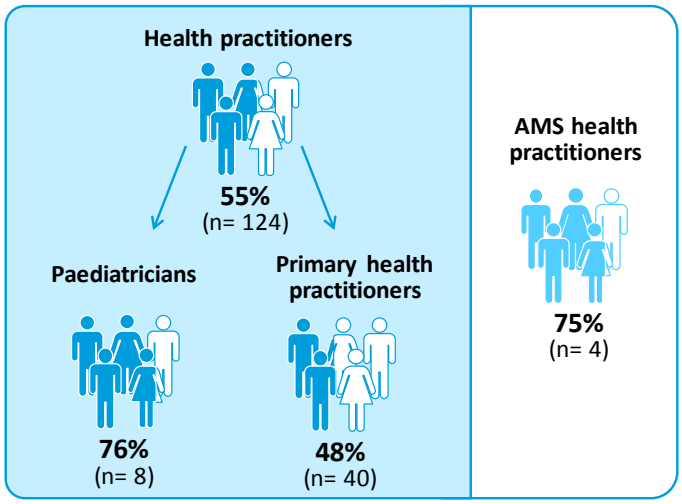
Stakeholders perceived the effectiveness of the NSW Health OOHC Coordinator role in supporting the OOHC Health Pathway Program differently depending on their own role and the particular component being considered.

Variation in perceived effectiveness by stakeholder group

Non-clinical stakeholders, including the Health OOHC Coordinators themselves, NGO OOHC Case Managers and the IWG, reported through consultations that the Health OOHC Coordinator role was highly effective. This was supported by 100% of the six Health OOHC Coordinator survey respondents agreeing or strongly agreeing their role has been effective in supporting the implementation of the health assessment process.

In contrast, health practitioners indicated a lower level of effectiveness through the surveys. Just over half (55%) of the 124 health practitioner respondents agreed or strongly agreed the Health OOHC Coordinator role effectively supported the implementation of the OOHC Health Pathway Program. Of these respondents, paediatricians were most likely and primary practitioners least likely to indicate effectiveness (as illustrated in Figure 46). Of the four AMS survey respondents, 75% indicated the role was effective.

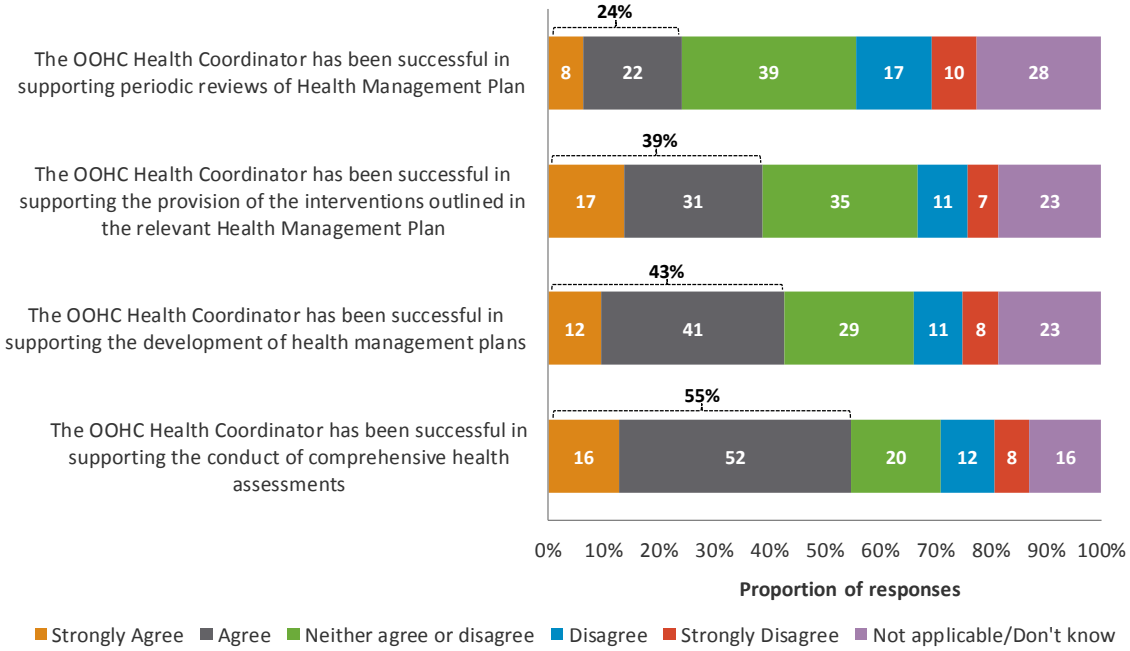
Figure 46: Percentage of survey respondents who agreed or strongly agreed the NSW Health OOHC Coordinator role in the LHDs is effective in supporting the implementation of health assessments



Variation in perceived effectiveness by component of the OOHC Health Pathway Program

The survey responses of health practitioners, summarised in Figure 47, also indicated they were more likely to view the Health OOHC Coordinator role as effective at supporting implementation of comprehensive assessments (55%), followed by development of HMPs, provision of interventions and then periodic reviews.

Figure 47: Extent to which health practitioner respondents agreed with the each statement about the success of the Health OOHC Coordinator in supporting the components of OOHC Health (n=124)



Source: Health practitioner survey

What are examples of NSW Health OOHC Coordinator role best practice that can be shared throughout the network?

Through the consultation with the NSW Health OOHC Coordinators, six examples of Health OOHC Coordinator role good practice that other LHDs could benefit from were identified. These were:

- *Establishment of Health Case Manager roles* – Health OOHC Coordinators in some LHDs established a Health Case Manager role to support the Coordinator role by acting as a key conduit between stakeholders (including clinicians, NSW Health, Community Services, NGO providers and carers) and a first point of contact for clinicians. The role also assisted with administrative tasks such as collecting background health information, facilitating access to appointments, developing HMPs and arranging reviews.
- *Ensuring all necessary information was collated for clinicians prior to appointments* – this reduced the administrative burden on the clinicians, thereby enhancing the engagement of those clinicians under the OOHC Health Pathway Program.
- *Development of a standardised email template for communication between the Health OOHC Coordinator and NGO OOHC Case Managers* – this helped to ensure clarity and consistency of information exchanges between the two parties.
- *Providing clinicians with training opportunities about trauma* – the need for greater education about the impacts of trauma on children and young people was consistently identified throughout consultations and surveys with both clinical and non-clinical staff and is supported by findings from the 2011 'Education needs of health professionals working with children and young people in OOHC questionnaire' conducted by the OOHC Advisor and completed by 564 health professionals (Fulton, 2011). In at least one LHD, the Health OOHC Coordinator acted to address this need by providing relevant training opportunities.

- *Developing and documenting approaches to engaging with GPs and carers* – in recognition of the need to improve the engagement of GPs and carers under the OOHC Health Pathway Program, the Health OOHC Coordinator in the Central Coast LHD developed formalised GP and carer engagement models for use within their LHD.

What, if any, barriers that prevent the effectiveness of the NSW Health OOHC Coordinators exist?

Consultation participants, particularly the Health OOHC Coordinators themselves, identified six main factors that have hampered the effectiveness of their role in supporting the OOHC Health Pathway Program. These included:

- *The substantial workloads of these roles* – the relatively high volume of new referrals combined with the number of children and young people already enrolled in the OOHC Health Pathway Program has created a significant workload for one full time equivalent Health OOHC Coordinator in each LHD. The Coordinators expressed their concern that the magnitude of their workload will only continue to increase as more children and young people are enrolled in the OOHC Health Pathway Program than exit it, and with the cessation of the IPC role.
- *Insufficient administrative and health case management support* – the administrative and health case management work that the Health OOHC Coordinators have had to undertake have resulted in less time available for them to fulfil a more strategic role. Note that some LHDs have established Health Case Manager roles and provided administrative support to assist the Coordinators.
- *inexperience in the OOHC sector* – NSW Kids and Families consultation participants highlighted that a lack of previous experience in the OOHC sector and an associated lack of knowledge of the system hindered the effectiveness of the Health OOC Coordinator role
- *Turnover of people in the roles and roles left unfilled for a period of time* – movement of people in and out of these roles results in a lack of continuity, weakening of relationships and loss of accumulated knowledge. In at least one LHD, the role of Health OOHC Coordinator was vacant for a period, resulting in many of the responsibilities of the role not being fulfilled and a lack of handover to the person who later took on the position.
- *Weak stakeholder understanding of the Health OOHC Coordinator role and associated responsibilities* – Health OOHC Coordinators identified that the OOHC Health Pathway Program stakeholders, particularly clinicians, had a poor understanding of the program overall, including the specific role and associated responsibilities of the Coordinator. Clinicians themselves supported this through their consultations and survey responses. This has led, at times, to incorrect and unrealistic expectations of the role.
- *The lack of a state-wide database for data collection* – this hampered accurate data collection as well as effective information sharing and reporting.

To what extent did the OOHC Advisor in the Sydney Children's Hospital Network fulfil the intended role of the position?

Views about the extent to which the OOHC Advisor fulfilled the intended role vary, due mainly to differing perceptions of the intended state-wide purpose and functions of the role. This suggests a need to clarify and agree the roles and responsibilities of the position to support a shared understanding and enable a collaborative working relationship.

According to NSW Kids and Families, the OOHC Advisor role is a one full time equivalent position funded to 30 June 2014. The role provides two key functions:

- a state-wide clinical advisory role (0.5 FTE)
- a local role for Sydney Children's Hospital Network providing operational support for when a children or young person enters the hospital system (0.5 FTE).

The role was vacant for six months during 2013 when the incumbent Advisor was on maternity leave.

The OOHC Advisor role was originally based at The Children's Hospital at Westmead and later moved to the Child Protection Unit at Randwick's Sydney Children's Hospital following the establishment of the Sydney Children's Hospital's Network (SCHN). The role is funded under *Keep Them Safe* and managed by the SCHN but effectively reports to both the SCHN and NSW Kids and Families.

According to the position description, the focus of the role was to:

- act as a "state-wide clinical leader", providing advice and clinical support to the Health OOHC Coordinators and clinicians, and building capacity to address the complex health needs of this population
- build strong relationships with a range of internal and external stakeholders including within SCHN, NSW Health, Health OOHC Coordinators, local service providers, NGOs and key government agencies
- "promote a culture within NSW Health which provides advocacy for the rights of children and young people in OOHC to care and protection and which facilitates partnerships across the human services sector and with foster and kinship carers".

NSW Kids and Families noted that the role has, by necessity, evolved from that described in the original position as the program has matured and recruitment stabilised.

The OOHC Advisor and the SCHN OOHC Advisor managers, indicated that the OOHC Advisor role has three main functions which are consistent with the role's state-wide position description:

- state-wide coordination of the Health OOHC Coordinators, including providing resources to them
- provision of clinical support to clinicians who provide health care to children and young people in OOHC
- provision of direct support to clinicians in tertiary practice at SCHN to help facilitate the implementation of the OOHC Health Pathway Program and to assist children and young people who are transferred between SCHN and their local LHD for management.

Based on these three functions, the OOHC Advisor and the position's manager indicated the role has been fulfilled as intended. They also identified two main challenges to being able to appropriately fulfil the role: the volume of work expected to be completed within one full time equivalent position and the establishment of strong working relationships with the Health OOHC Coordinators.

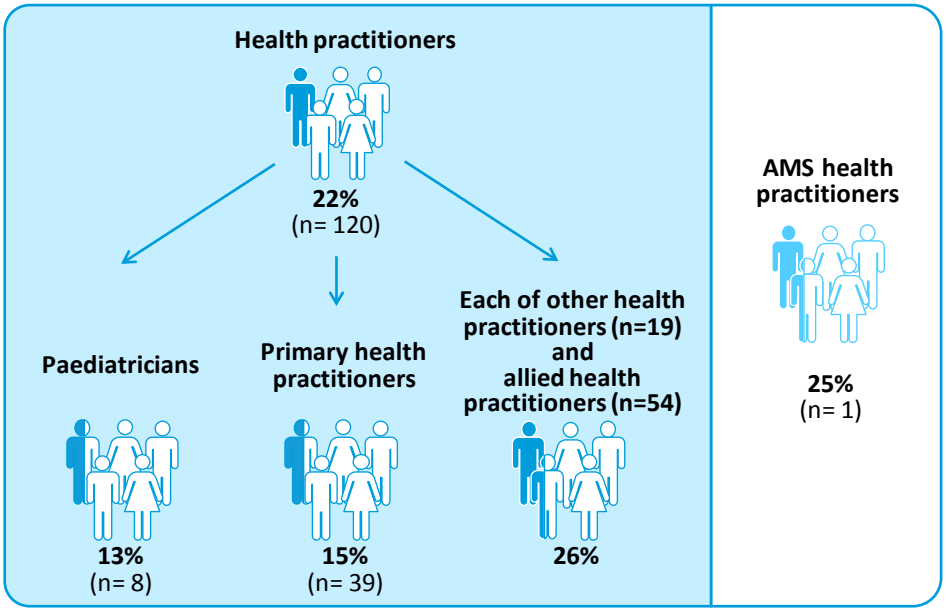
How effective is the role of the OOHC Advisor in the Sydney Children's Hospital Network in providing advice and support to clinicians providing health assessments to children and young people in OOHC?

Perceived effectiveness and awareness of the OOHC Advisor role

Perceptions of the effectiveness of the OOHC Advisor in providing advice and support to clinicians involved in the OOHC Health Pathway Program were varied.

Of the clinicians surveyed, those who were aware of the OOHC Advisor role indicated it had been effective but relatively few indicated awareness (22% of 120 health practitioners and 25% of the four AMS respondents). Awareness varied by health profession, as can be seen in Figure 48.

Figure 48: Percentage of survey respondents who indicated they were aware of the OOHC Advisor position



Support provided by the OOHC Advisor role to clinicians

The OOHC Advisor has provided a range of advice and support to clinicians according to the surveys. This has included:

- advice about steps in the OOHC Health Pathway process including referrals and assessments
- clinical and process advice in relation to individual cases
- referrals to paediatric services and information about previous assessments that had been completed
- information provided through a quarterly newsletter – a review of program documentation yielded the 'Health on Track: a newsletter for health professionals working with children and young people in out-of-home care'. Publication of the first two issues occurred in 2012, with the third edition due to be released in the first half of 2014.[43] It contained information such as updates on changes in the OOHC sector, information about the OOHC Health Pathway Program, clinical information, OOHC resources, upcoming professional development opportunities and contact details for the OOHC Advisor and OOHC Coordinators

[43] As reported by the OOHC Advisor, the 'Health on Track' newsletter was not published again in 2012 due to efforts being focused on developing the Clinical Practice Guidelines , and was not published in 2013 when the OOHC Advisor position was vacant for six months.

- education via different mechanisms including face to face, teleconference and audio recordings of presentations – a review of program documentation indicated an education day entitled 'Building connections for kids: a place for health in out-of-home care' was held in September 2012 and provided education and a networking opportunity for 123 participating health professionals who worked with children and young people in OOHC across NSW.

Support clinicians anticipated seeking from the OOHC Advisor in the future

Clinicians who had not previously sought the support of the OOHC Advisor were asked in the surveys to describe the types of support they could anticipate seeking in the future. They consistently identified the following seven areas of support, some of which sit within the role of the OOHC Advisor and some of which do not. This reflects the clinicians' lack of clarity about the roles and responsibilities of the OOHC Advisor and is consistent with the first point below:

- information about the OOHC Advisor role and the support it can offer to clinicians
- information about the OOHC system, OOHC Health Pathway processes and the needs of children and young people in OOHC
- regular updates about the progress of the OOHC Health Pathway Program and any planned changes
- clinical advice about individual cases
- advice about specialist services that are available to this population in both local metropolitan and non-metropolitan areas
- guidance about the needs of carers and how to best engage carers
- access to linkages with other agencies to support interagency collaboration.

4.3.4 Clinician engagement has improved over time and is dependent on ten key factors

Evaluation sub-questions	Key findings
How effectively have clinicians engaged with OOHC Health?	• Clinicians who were aware of the OOHC Health Pathway Program were largely supportive of the process in principle. • Clinician engagement under the OOHC Health Pathway Program improved over time according to consultations and this was supported by survey results which indicated that, overall, clinicians were effectively engaged with the program at the time of the survey (65% of 124 health practitioner respondents and 70% of seven Health OOHC Coordinator respondents agreed or strongly agreed that the clinicians in their respective LHDs engaged effectively with the program).

What are the key dependencies in the engagement between clinicians and NSW Health to ensure the success of the OOHC Health Pathway Program?	• Ten key dependencies to ensure effective engagement between clinicians and NSW Health were identified:
	  ◦ sound clinician knowledge and understanding of the OOHC system and the OOHC Health Pathway Program
	  ◦ strong clinician understanding of the impacts of trauma
	  ◦ effective communication, coordination and feedback at all points throughout the OOHC Health Pathway Program
	  ◦ availability of adequate clinical and administrative resources
	  ◦ awareness and effectiveness of the Health OOHC Coordinator role

Evaluation sub-questions	Key findings
	○ manager support for clinicians to participate in the OOHC Health Pathway Program ○ continuity of staff in roles ○ availability of one point of contact for clinicians ○ proactive approaches to relationship building between clinicians and NSW Health ○ adequate information and support for carers.
Related recommendations	
○ 1 (Implementation of *Clinical Practice Guidelines*), 2 (Service delivery models), 3 (Continuity in roles), 5 (Best practice coordination), 6 (Awareness and understanding), 16 (Engagement principles), 20 (Single point of contact), 21 (Effectiveness of systems and processes)	

How effectively have clinicians engaged with the OOHC Health Pathway Program?

Clinician awareness and support for the OOHC Health Pathway Program

While the majority of clinicians who participated in the evaluation through consultations and surveys were familiar with the OOHC Health Pathway Program, some clinicians were not familiar with the concept of and/or not aware of key components of the program (e.g. the Health OOHC Coordinator and OOHC Advisor roles).

> "The OOHC Coordinator needs to first be known to exist. The rest of the health service needs to made aware of the existence of the role and what it involves…"
>
> *~ Other health practitioner (survey)*

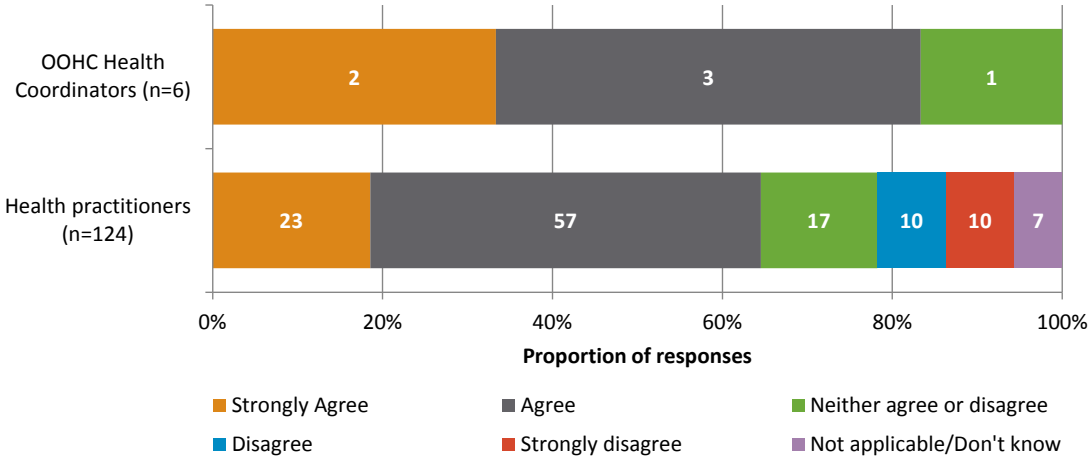
Clinicians who were aware of the OOHC Health Pathway Program indicated through the consultations that they supported the intent of the health assessment process in recognition of the highly vulnerable nature of the target population and their need to be able to access health services to address their often significant and complex needs.

Extent of clinician engagement

According to consultations with both clinicians and non-clinicians, clinicians overall have become more engaged with the OOHC Health Pathway Program over time as the program has matured.

The majority of clinicians within the LHDs were reported to be effectively engaged at the time of the surveys, with 65% of the 124 health practitioner respondents and 83% of the six Health OOHC Coordinator respondents agreeing or strongly agreeing with this view as illustrated in Figure 49. According to the survey, of the health practitioner respondents, other health practitioners were least likely to agree or strongly agree with this view (52%) when compared with paediatricians, primary practitioners and allied health practitioners (66%-75%).

Figure 49: Extent to which survey respondents agreed with the statement "*the clinicians in my Local Health District have engaged effectively in the provision of OOHC Health*"



Source: Health practitioner survey and Health OOHC Coordinator survey

Several factors that contributed to the variations in extent of engagement and to overall engagement not being higher were identified through consultations and surveys with both clinicians and non-clinicians. These included:

- limited resources to complete each component of the OOHC Health Pathway Program – particular examples cited included undertaking psychosocial assessments and provision of speech pathology services

> The number of children/young people entering care in [my area] outstrips any resources provided at a primary, comprehensive, and intervention level. This is an ongoing barrier to meeting guideline expectations for the health pathways.
>
> *~ Allied health practitioner (survey)*

- limited or no understanding of the OOHC Health Pathway Program, including roles and responsibilities, and procedures
- a weak understanding of the impacts of trauma on this population
- poor communication and information flows about individuals between all stakeholders, in particular Community Services and Health, considerably hampered efforts to provide the most appropriate care to children and young people in a timely way
- a lack of GP referrals for paediatric comprehensive assessments resulting in paediatricians being unable to be paid appropriately through Medicare.

The highly effective engagement of oral health clinicians was highlighted through consultations with clinicians and NSW Kids and Families as an example of the results that were achieved by the targeted efforts of Health OOHC Coordinators to provide proactive support to these clinicians.

What are the key dependencies in the engagement between clinicians and NSW Health to ensure the success of the OOHC Health Pathway Program?

Key dependencies

Ten key dependencies to ensure successful engagement between clinicians and NSW Health, listed below, were identified through consultations and surveys with clinicians, AMS health practitioners, Health OOHC Coordinators and the IWG.

- *Sound clinician knowledge and understanding of the OOHC system and the OOHC Health Pathway Program* – clinicians require a good understanding of how the OOHC system works in a broad sense as well as the specifics of the OOHC Health Pathway Program. The latter includes their own roles and responsibilities under the OOHC Health Pathway Program as well as those of other stakeholders, relevant procedures and templates, locally available specialist services for the target population, progress of the program and any proposed changes to the health assessment process.

  The clinician surveys indicated that while the vast majority of health practitioners (87% of respondents), including those in AMSs, agreed an understanding of the role of other agencies and health practitioners in the OOHC Health Pathway Program was important to support their own participation in the initiative, 39% of these same clinicians agreed they had received sufficient information to support their understanding of these roles. The *Clinical Practice Guidelines*[44], released in October 2013, are expected to improve clinician knowledge in these areas.

- *Strong clinician understanding of the impacts of trauma* - a deep understanding of the following aspects of trauma ensure clinicians have the ability and confidence to appropriately prioritise individuals and adequately address their needs: (i) the effects of trauma, including abuse and neglect, on children and young people; (ii) how trauma impacts symptomatology; and (iii) how trauma influences the needs of this population.

- *Effective communication, coordination and feedback at all points throughout the OOHC Health Pathway process* – in particular, clinicians highlighted the importance of: (i) receiving adequate background health information about a child/young person in a coordinated manner before they were assessed; (ii) coordination of appointments to maximise the likelihood of a child/young person attending their appointment; (iii) and being provided with feedback about their recommendations for the child/young person (e.g. by receiving a copy of the HMP).

- *Availability of adequate clinical and administrative resources* – in some LHDs, dedicated OOHC clinics increased the likelihood that clinicians were available to provide services. In other LHDs, strong administrative support freed Health OOHC Coordinators and clinicians up to focus on the coordination and clinical parts of their roles respectively.

- *Awareness and effectiveness of the Health OOHC Coordinator role* – clinicians and Health OOHC Coordinators identified the importance of this role in supporting clinicians, minimising the additional work for clinicians created by the OOHC Health Pathway Program and ensuring the program remains front-of-mind for clinicians.

- *Manager support for clinicians* – clinicians, particularly allied health practitioners, who received support from their direct managers and more senior managers (e.g. LHD Chief Executives) were better able to provide services under the OOHC Health Pathway Program.

[44] NSW Health (2013) Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care.

- *Continuity of staff in roles* – this was identified as necessary to support the establishment of strong working relationships and was noted particularly in relation to the Health OOHC Coordinator role.
- *Availability of one point of contact for clinicians* – while the role that comprised the one point of contact differed between LHDs, and included the Health OOHC Coordinator and Health Case Manager role, the availability of a single point of contact was more efficient and effective for clinicians.
- *Proactive approaches to relationship building between clinicians and NSW Health* – these helped strengthen relationships and clinician engagement.
- *Adequate information and support for carers* – good carer understanding of the OOHC Health Pathway Program and its importance in combination with support to enable carers to bring children and young people to appointments is necessary to increase the likelihood of attendance at health appointments.

5 Recommendations

In conducting this evaluation, Nous identified twenty-four recommendations across seven areas to enhance the OOHC Health Pathway Program. The areas for recommendations are illustrated in Figure 50, and the recommendations for enhancement are outlined in further detail in Table 8.

Figure 50: Areas of recommendations

For each recommendation, Table 8 identifies:

- the sections of the report for which the key findings are relevant
- the timeframes for full implementation to be achieved, are proposed as follows:
  - short term: within 6 months
  - medium term: within 6-12 months
  - longer term: within 12-18 months.

Table 8: Recommendations

No.	Recommendation (responsibility is in bold)	Relevant key findings (by report section)	Timeframe for implementation
Sustainable and continually improving service models			
1.	**LHDs** should continue to implement all steps of the OOHC Health Pathway Program as per the *Clinical Practice Guidelines* (including the adoption of the assessment and HMP templates).	4.1.1, 4.1.2, 4.1.3, 4.1.4, 4.1.5 4.2.1, 4.2.2, 4.2.3 4.3.3, 4.3.4	Short term
2.	**LHDs** should assess their current service delivery models against the best practice initiatives (section 4.2) and identify any improvements they could make. These best practice initiatives include: • allocation of a clear Primary Medical Contact for each child and young person • earlier engagement of carers to assist them to provide appropriate support throughout the process • utilisation of formal multidisciplinary teams • co-location of health assessment and intervention services • clearer responsibility and accountability for the completion of HMP reviews • development of mechanisms to manage high volumes of referrals.	4.1.1, 4.1.2, 4.1.3, 4.1.4, 4.1.5 4.2.1, 4.2.2, 4.2.3 4.3.1, 4.3.3, 4.3.4	Short term
3.	**LHDs** should identify opportunities to make OOHC Health Pathway Program roles, particularly the OOHC Coordinator role, either permanent positions or extended contract periods to reduce turnover and to maintain continuity in these roles.	4.2.2, 4.2.3 4.3.1, 4.3.2, 4.3.3, 4.3.4	Short term
4.	**NSW Kids and Families and LHDs** should establish and maintain mechanisms (eg through the IWG) to periodically collate and distribute examples of effective best practice components of local service delivery models across all LHDs.	4.1.2, 4.1.3, 4.1.4, 4.1.5 4.2.1, 4.2.2, 4.2.3, 4.2.4 4.3.1	Medium term
5.	**NSW Kids and Families** should establish and maintain mechanisms (eg through the IWG) to periodically collate and distribute examples of NSW Health OOHC Coordinator best practice throughout the network.	4.1.2, 4.1.3, 4.1.4, 4.1.5 4.2.1, 4.2.2, 4.2.3, 4.2.4 4.3.1, 4.3.4	Medium term

No.	Recommendation (responsibility is in bold)	Relevant key findings (by report section)	Timeframe for implementation
6.	**LHDs** should investigate additional mechanisms to increase awareness and understanding of the OOHC Health Pathway Program within the LHD including identification of local champions and key clinical leaders.	4.1.2, 4.1.3, 4.1.5 4.2.1, 4.2.2, 4.2.3 4.3.3, 4.3.4	Medium term
Improved enrolment in the OOHC Health Pathway Program			
7.	**Community Services** should ensure referrals from Community Services occur in a timely manner: i.e. within the first 14 days of entering statutory OOHC to allow sufficient time for 2a primary assessments to be conducted.	4.1.1	Short term
8.	**Community Services** should give priority to increasing enrolments of young people entering statutory OOHC in the 13-18 year age group in the OOHC Health Pathway Program, for example through the expansion of, or better linkages with youth services.	4.1.1	Medium term
9.	**Community Services** should improve the quality of referral data (including ensuring all required data is provided) to LHDs for each child/young person.	4.1.1	Medium term
Better and more timely access to services			
10.	**LHDs** should improve access to assessments and services for children/young people living in rural/remote areas, including through the greater use of telehealth and web-based technologies.	4.1.2, 4.1.4, 4.2.1	Medium term
11.	**NSW Kids and Families and Community Services** should leverage the outcomes of the economic appraisal to prepare a jointly authored business case to increase funding for the OOHC Health Pathway Program.	4.1.6	Short term
Improved engagement of carers			
12.	**LHDs** should, where possible, work to ensure that the assessment staff profiles match the diversity of the communities in which the OOHC Health Pathway Program initiatives are being implemented.	4.2.1 4.3.3	Medium term

No.	Recommendation (responsibility is in bold)	Relevant key findings (by report section)	Timeframe for implementation
13.	**Community Services, NGOs and LHDs** should examine ways in which the existing processes for engagement of carers can be enhanced to increase their awareness and understanding of the OOHC Health Pathway Program and to provide appropriate support.	4.1.1, 4.1.2, 4.1.3, 4.1.4 4.2.1, 4.2.2, 4.2.3 4.3.3	Short term
Improved engagement of service providers			
14.	**LHDs** should improve engagement of Aboriginal Medical Services and Aboriginal NGOs by establishing formal linkages such as regular meetings and MoUs (where they don't already exist).	4.2.1, 4.2.2, 4.2.3 4.3.3	Medium term
15.	**NSW Kids and Families** should use the planned communication and education strategy for the *Clinical Practice Guidelines* to improve engagement of service providers (GPs, GP Practice Nurses, AMSs) with a particular focus on: • the effects of trauma, abuse and neglect and the associated needs of this target population • clarifying responsibility for developing HMPs and undertaking periodic reviews • streamlining arrangements to facilitate timely GP referrals to a paediatrician.	4.1.3, 4.1.4 4.2.1	Medium term
16.	**LHDs** should adopt the following principles to guide effective engagement with clinicians: • clinicians have a sound knowledge and understanding of the OOHC system and the OOHC Health Pathway Program • clinicians have a strong understanding of the impacts of trauma (including abuse and neglect) on children and young people in OOHC • effective communication, coordination and feedback occurs throughout the OOHC Health Pathway process • appropriate clinical and administrative resources are available to support the OOHC Health Pathway Program	4.1.4 4.2.1, 4.2.2, 4.2.3 4.3.1, 4.3.3, 4.3.4	Short term

No.	Recommendation (responsibility is in bold)	Relevant key findings (by report section)	Timeframe for implementation
	◦ clinicians are aware of the Health OOHC Coordinator role which provides effective support to clinicians ◦ managers support clinicians to provide services under the OOHC Health Pathway Program ◦ the importance of continuity of staff in roles is recognised and maintained ◦ clinicians have one point of contact within their LHD for OOHC Health Pathway Program related matters ◦ proactive approaches to building relationships between clinicians and NSW Health are implemented ◦ carers receive adequate information about and support children and young people in their care to participate in the OOHC Health Pathway Program and particularly attend appointments.		
Development of a better evidence base			
17.	**Community Services** should ensure that all relevant data, including CALD status, is entered into the Community Services database and integrated with the NSW Kids and Families data.	4.1.4 4.2.4 4.3.2	Medium term
18.	**NSW Kids and Families and Community Services** should jointly review the most effective way to collect data and the appropriate data sets necessary to monitor implementation and to support periodic evaluations. The review should include consideration of the best mechanism to record and collect data on: ◦ the number and proportion HMP reviews ◦ the extent to which medical interventions have been delivered in accordance with the HMP.	4.1.4 4.2.4 4.3.2	Medium term
19.	**NSW Kids and Families and Community Services** should explore the adoption of the electronic health record system as soon as practical. This may include proposing that the population of children and young people enrolled in the OOHC Health Pathway Program could participate as a pilot group.	4.2.4	Longer term (aligned to eHR rollout schedule)

No.	Recommendation (responsibility is in bold)	Relevant key findings (by report section)	Timeframe for implementation
Strengthened governance and coordination			
20.	**Community Services** should ensure that a consistent single point of contact for the NSW Health OOHC Coordinators and NGO case managers is maintained within Community Services in each region.	4.2.1, 4.2.2, 4.2.3 4.3.1, 4.3.2, 4.3.3, 4.3.4	Short term
21.	**Community Services and NSW Kids and Families** should review the effectiveness of the relationships, systems and processes between the NSW Health OOHC Coordinators, regional Community Services designated contacts and NGO service providers by the end of 2014 and address any areas identified for improvement. The review should include consideration of any changes to: • the quality of data collection • the quality of referrals to the OOHC Health Pathway Program • the administrative load on other stakeholders, particularly the Health OOHC Coordinators • the capacity to track changes in the placement details and circumstances of children and young people enrolled in the OOHC Health Pathway Program.	4.3.1, 4.3.2, 4.3.3, 4.3.4	Medium term
22.	**NSW Kids and Families** should consider extending the funding of the OOHC Advisor for a further 12 months to 30 June 2015. The future focus of the role should incorporate the following: • act as a state-wide clinical leader, providing advice and clinical support to clinicians including GPs • provide clinical advice to raise awareness of and support implementation of the *Clinical Practice Guidelines* • continue to raise awareness of the role and the support it can offer • provide regular updates about OOHC progress and changes to clinicians • provide guidance on the needs of carers and how to best support them.	4.3.3	Short term

No.	Recommendation (responsibility is in bold)	Relevant key findings (by report section)	Timeframe for implementation
Further investigation to be completed			
23.	**NSW Kids and Families** should commission further research to determine the effectiveness and cost-effectiveness of individual service models and to support a comparison of the models in operation.	4.2.1, 4.2.2	Medium term
24.	**NSW Kids and Families** should commission a comprehensive summative evaluation of the OOHC Health Pathway Program prior to the end of 2015 and to be completed by 30 March 2016.	All	Longer term

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