Services
Connect
Evaluation
Report 1

Department of Health and Human Services
20 May 2016
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Executive summary

PricewaterhouseCoopers (PwC), in partnership with the University of Melbourne (UoM) and the Parenting Research Centre (PRC), was engaged by the Department of Health and Human Services (DHHS) to evaluate the Services Connect trial, a model for integrated human services in Victoria implemented by eight Partnerships comprising 115 agencies in the community services sector.

Services Connect

Services Connect is designed to connect people with appropriate support, address the whole range of a person’s or family’s needs and help build their capabilities to improve their lives. The model focuses on streamlining and simplifying access to human services. It is intended to tailor services to the unique needs, goals and aspirations of each client and their family, with an emphasis on building their strengths and capabilities to move out of disadvantage. The two main objectives of Services Connect are:

- To change the way individuals and families are supported so that they can achieve lasting positive outcomes based on their personal goals and aspirations
- To improve productivity by reducing duplication and inefficiency across the human services system.

It seeks to improve the system by reducing duplication, intervening earlier to reduce the need for intensive statutory or crisis responses, and achieving long-term positive change for families and individuals. A key component of the model is client support, which comprises the following key features:

- one key worker who is the primary support worker for individuals and families with complex needs
- one needs identification that is accepted by all service providers and workers involved in a client’s life instead of multiple assessments that duplicate each other
- one client record instead of multiple records held by different services, so that people do not need to tell their story multiple times
- one plan that covers the full range of an individual’s or family’s needs, goals and aspirations, and covers the full range of services they will receive.

Evaluation overview

The purpose of the evaluation is to assess the implementation of the model and associated client outcomes over the two year trial between October 2014 and October 2016. This is the first of three evaluation reports. This report looks at achievements and challenges in the implementation of the model over the first 18 months. It has a particular focus on: the initial establishment activities associated with operationalising Partnerships and setting up the model; implementation of key aspects of the model – client support and integrated access; monitoring processes; and achievements and challenges.

The main data collection activities on which this report is based include:

- review of existing documentation from the Services Connect trial, including: Partnerships’ quarterly reports; performance and learning bulletins; and state-wide reference and working group minutes and associated working papers
- interviews with Departmental staff with responsibility for implementation
- a workshop with Partnership representatives focused on establishment activities
- site visits involving in-depth consultations with stakeholders from three out of the eight Partnerships
Executive summary

- high level findings from a Services Connect client experience survey which was conducted, analysed and reported on by DHHS

The subsequent two evaluation reports will build upon the preliminary findings in this report and include: analysis from visits to all eight Partnerships; interrogation of a data extract from the Services Connect Interim Platform (SCIP) covering an extended time period with a specific focus on client outcomes; and analysis of client data from linked datasets.

The second evaluation report is intended to further validate insights and supplement findings from the desktop review to present deeper insights about implementation from an ‘on-the-ground’ perspective. This will consider barriers and innovation more fully and describe additional results from the client experience survey and MySupport app implemented by DHHS. A provisional overview of client outcomes will be presented however this will be more fully explored in Report 3. If data linkage has been successful, the Consortium will provide a preliminary descriptive analysis of client experience in relation to ‘business as usual’. However, the feasibility of this analysis depends on the availability of SCIP data as well as extracts from relevant datasets that are linked to individuals in SCIP.

The final evaluation report is intended to analyse and synthesise findings from the desktop review, quantitative findings (including SCIP data) and qualitative data (consultations) to answer the core evaluation questions and present conclusions and recommendations about overarching achievements, challenges, best practice and client outcomes.

**The Services Connect trial: progress to date**

The purpose of this report is to respond to the following questions:

- What were the key activities undertaken by Partnerships to establish the Services Connect trial?
- Are there monitoring issues? What action is recommended to resolve these?
- Has client support commenced and been implemented as intended in all Services Connect trial sites?
- Has Integrated Access commenced and been implemented as intended in all Services Connect trial sites?
- Are there implementation barriers or issues that need to be resolved?
- What have been the key areas of achievement and innovation?

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A ‘business as usual’ comparison (Q8 and Q20) will involve an examination of client outcomes history pre (business as usual) and post service intervention (Services Connect). This approach is dependent on the extent to which relevant DHHS data holdings can be linked with SCIP data. DHHS is exploring whether, and to what extent, relevant DHHS data holdings can be linked with SCIP data. Advice from the Consortium will be sought on elements to be included in the linkage. If successful linkages can be made (i.e. reliable, valid, covers required population(s)), DHHS will provide the consortia with the linked data. DHHS will ensure the accuracy and reliability of the data and the robustness of linkages. In this instance, Q8 and Q20 will be included in the outcomes evaluation, however even with successful data linkage, comparisons between Services Connect and ‘business as usual’ will be limited.
### Preliminary findings in relation to the evaluation questions

Table 1 sets out preliminary findings in relation to the key evaluation questions and lines of inquiry that have informed this report.

<table>
<thead>
<tr>
<th>Evaluation questions</th>
<th>Preliminary findings from the evaluation to date</th>
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</thead>
</table>
| What were the key activities undertaken by Partnerships to establish the Services Connect trial? What were Partnership perceptions of this process? | • The Services Connect trial involved a significant weight of effort during the initial months following signing of Service Agreement and Memorandums of Understanding (MOUs).  
• Many of the initial activities have extended beyond the initial establishment phase and overlapped with service delivery (as shown in Figure 1).  
• There is agreement across Partnerships that timeframes allocated did not allow for the extensive range of activities required.  
*Further explanation of these points can be found in Chapter 4*                                                                                                                                                                                                                                                                                                                                                                                            |
| Are there any monitoring issues? What action is recommended to resolve these?          | • Partnership targets related to the number of managed, guided and self-support cases were not finalised until May 2015, however progress is measured since the commencement of client support in February / March 2015.  
• Several key stakeholders have questioned the appropriateness of the targets and how realistic they were to achieve within a trial environment. As recommended in the literature on program implementation, a more phased approach to targets would have been beneficial to take into account the different stages on implementation.  
• Several Partnerships have reported that definitions related to key target groups (self-support, young people leaving care, young people at risk of entering care) took some time to be clarified and that this impacted on progress.  
*Further explanation of these points can be found in Chapter 5*                                                                                                                                                                                                                                                                                                                                                       |
| Has client support commenced and been implemented as intended in all Services Connect trial sites? | • Client support commenced in each Partnership between February and March 2015  
• Partnership performance in relation to quantitative targets - focused on the number of managed, guided and self-support cases and key cohorts – has fallen below expectation.  
• However, the evaluation has identified significant ‘intangible’ impacts and achievements related to implementation of client support. These include embedding practice principles such as client-centred and holistic practice and removing the need for clients to re-tell their story multiple times through the provision of one key worker.  
• A key achievement of the trial has been the opportunities for professional development amongst key workers. Those who have participated in the evaluation to date were extremely positive about the opportunity that the trial has provided for broadening their knowledge of the service system and different agencies and enhancing the ways they support clients to achieve their goals.  
*Further explanation of these points can be found in Chapter 6*                                                                                                                                                                                                                                                                                                                                                   |
| Has Integrated Access commenced and been implemented as intended in all Partnerships?  | • Processes for the design and implementation of Integrated Access have commenced and are still undergoing refinement.  
• The process of co-design is relatively new for the sector and some Partnership stakeholders commented on the value of the state wide Integrated Access Reference Group (IARG) as a key mechanism for facilitation, support and guidance. A key outcome from the IARG was the development of ten operating principles to underpin Integrated Access.  
• Examples of innovative practice developed by Partnerships include key workers spending 1-2 days a week at Services Connect first tier and second tier...  
*Further explanation of these points can be found in Chapter 7*                                                                                                                                                                                                                                                                                                                                                     |
Executive summary

<table>
<thead>
<tr>
<th>Evaluation questions</th>
<th>Preliminary findings from the evaluation to date</th>
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<tbody>
<tr>
<td>Are there implementation issues or barriers that need to be resolved?</td>
<td>In addition to those already mentioned, the evaluation has identified several key challenges as well as achievements related to the implementation of the Services Connect trial. For example:</td>
</tr>
<tr>
<td>What have been the key areas of innovation?</td>
<td>• The ambitious scope of Services Connect in terms of the range of components and processes that are being tested. This has impacted the level of in-kind support required to facilitate the Partnership.</td>
</tr>
<tr>
<td></td>
<td>• Bringing multiple different organisations together as Partnerships was viewed as a challenge but also a key achievement of the trial.</td>
</tr>
<tr>
<td></td>
<td>• All Partnerships have experienced issues with staff recruitment and attrition however, this was more significant in some Partnerships than others.</td>
</tr>
<tr>
<td></td>
<td>• SCIP has presented several key challenges in terms of staff on-boarding, functionality and resolution of issues. Whilst it has been acknowledged by Partnerships that SCIP is a work in progress, it has also been a source of frustration impacting the trial.</td>
</tr>
</tbody>
</table>

The Services Connect trial brings with it a focus on innovation and a culture of learning, flexibility and adaptation in its delivery. The trial has provided an opportunity to test new approaches to integrated working between agencies in the community sector. Preliminary achievements the evaluation has identified include:

• Progress towards interagency working and breaking down siloes
• Enhancements in practice and client support
• The effectiveness of one key worker and one plan in removing the need for a client to tell their story multiple times and supporting them to navigate the service system
• The opportunities provided for reflective practice
• Improved relationships between agencies in the sector
• Enabling clients to access to all networks within a Partnership without barriers
• The development of co-design approaches between the Department and Partnerships as a relatively new concept for the sector.

Further explanation of these points can be found in Chapter 7

Preliminary observations

Services Connect represents an important yet small scale trial of a model of integrated human services in Victoria. While the trial will conclude in October 2016, the findings of the evaluation provide important insights to inform the development and implementation of other integrated human services reforms aimed at reducing silos in the sector and improving outcomes for clients.

Despite the early stages of the evaluation, the following four observations can be made about the Services Connect trial:

• Services Connect represents an ambitious trial that has yielded successes, but has not been without its challenges.

• The Services Connect trial has involved significant commitment and engagement across participants in the community services sector in trialling new approaches to integrated working including establishment and maintenance of Partnerships.
Executive summary

- Services Connect has included a variety of capacity building opportunities at both the agency and individual worker level, which appear to have been of significant value.

- Services Connect is complex and realising the full potential of the model has been a challenge given the time-limited nature of the trial.

**An ambitious trial yielding significant successes, but not without challenges**

The two-year Services Connect trial in the community sector represents an ambitious transformational change program. It has set out to change ways of working, culture and service delivery, as well as embed new organisational, technical and practice structures. The scope of the trial was significant, given the range of components to be tested. Services Connect was designed as a state-wide model with Partnerships responsible for designing their own implementation approach – how to establish staff support, staff locations and approaches to key client cohorts. Through previous work undertaken on Services Connect Departmental lead sites, the Department developed insights directly relevant to the current trial. The community sector agencies involved in the trial did not have the benefit of these learnings and were therefore engaging in the trial from a different starting point.

Data gathered as part of the evaluation has painted a picture of achievements and challenges that would not be unfamiliar to those who have attempted to bring about transformational change in allied areas in the past.

The trial has made progress towards developing a new and more integrated approach to support a wide range of vulnerable clients. This has been achieved at a time of significant change in the external policy environment. However, the challenges encountered should not be underestimated.

It is notable that despite challenges in the initial stages of implementation related to the amount of effort required within constrained timelines and events in the broader context external to the trial, all eight Partnerships began taking clients between February and March 2015. Key service components such as client support appear to be working as intended, although Partnership performance in relation to quantitative targets has failed to meet expectations.

However, within a trial environment an overarching focus on meeting quantitative targets risks concealing non tangible yet significant impacts that are occurring such as improved professional relationships. As emphasised by McNulty and Ferlie (2002), an over focus on targets during a pilot can prove unhelpful if participants perceive not meeting targets to be a ‘failure’ rather than an inevitable state of affairs, particularly during the early stages of implementation.

As reflected in program implementation literature, implementation of any new model, particularly one involving the roll out of new technology, can be expected to encounter challenges. Within Services Connect, SCIP reflects a new way of working for the sector and there have been documented challenges in terms of modifications and refinements to the product and the need to develop workforce capacity to engage with the new technology. There have also been issues accessing SCIP in the first instance however following on-boarding, it is considered a stable platform. In addition, there have been discussions about the functionality of SCIP. DHHS has taken this feedback on board and sought to remedy issues through successive SCIP updates. The platform remains a work in progress.

Given that the Services Connect trial will conclude in October 2016, it is important to situate the trial within the larger context of integrated service delivery. In this respect, it has played an important role in testing components intended to facilitate more integrated approaches, in particular:

- bringing together multiple different agencies as Partnerships with specific governance structures
- the multi-disciplinary key worker role
- client support model
- SCIP
- integrated access.
Moving forward there is an opportunity for the Department and the sector as a whole to retrieve, capitalise and harvest the foundations of integrated service delivery established through the Services Connect trial. This includes consideration of the lessons learnt, elements to replicate and processes to avoid in order for integrated approaches to be further developed and refined so clients and their families can be supported to achieve their goals.

**Demonstrable commitment and engagement across the community services sector with integrated working**

There has been a high level of commitment and investment across the Services Connect Partnerships to embrace new and more integrated ways of working, and agencies have demonstrated preparedness to work with the Department on this reform. In addition, agencies made significant in kind contributions to the establishment and maintenance of Partnerships before and during the trial.

It has also garnered a real willingness amongst agencies to embrace and participate within a trial environment and all this entails, such as: engaging in reflective practice; implementing components within sometimes uncertain contexts; processes of co-design with the Department; innovation; appropriately refining aspects to suit local contexts; and ongoing refinement and re-testing.

A clear message from program implementation literature is that there is no accepted ‘single approach’ to integration and that initiatives must be built to suit the local context and match the concerns of the local area.

**Capacity building activities appear to be yielding benefits**

The Services Connect trial appears to have generated benefits in terms of: providing a strategic opportunity for agencies to participate in interagency working, which is rapidly gaining prominence within the current policy context; strengthening knowledge of service and information flows between agencies; reducing silos between agencies; mandating a greater sharing of skills and expertise to enhance approaches to client support; and facilitating professional development and capacity building amongst key workers. Notwithstanding this, there is evidence that the process of engagement in practice change took varying lengths of time across the Partnerships and in some instances remains an ongoing process.

**Realising the full potential of the model was an inevitable challenge given the time-limited nature of the trial**

The key overarching challenge is the constrained timeframe for the trial of two years. Based on findings to date and good practice identified in the literature, preliminary observations are that while some achievements have been made, the two year time frame was probably insufficient for the full potential of the model to be realised.

This is particularly relevant within the context of co-design. Co-design is a new approach for the sector and one which necessitates a different skill set to the traditional service delivery role; as such this has been a steep learning curve for Partnership staff and a time-intensive process.

**Recommendations**

On the basis of these preliminary findings and conclusions we suggest the following recommendations to inform any future roll out of models of integrated service delivery. The recommendations support the implementation of the Services Connect model to maximise outcomes for the service sector and for clients and their families.

**Recommendations related to establishment activities**

As confirmed in program implementation literature, the foundations of any program need to be: considered; rolled out incrementally; and allocated sufficient time to bed in before any benefits or innovation is realised. Bertram et al. (2011) recommend four stages of implementation over a four year timeline, namely: exploration; installation; initial implementation; and full implementation. Whilst it may not be feasible for all new programs to run over a four year timeframe, the application of a staged approach may help in structuring implementation processes and stakeholder expectations.

It is recommended that:
Executive summary

- Implementation strategies involve realistic timeframes for installation activities. This will avoid delays in service delivery and limit inappropriate overlap between installation activities and program implementation activities.

- Given co-design processes may be relatively new to the individuals and agencies involved, there is a need to support participants in developing the necessary skills sets, which may differ to those of regular service delivery.

- Consideration should be given to the timing of the installation process, taking into account external events to enable a sufficient level of support, guidance and availability of key implementation staff within government.

Recommendations to enhance and support future Partnership working

- Within the context of a new integrated reform agenda, it is recommended that Partnerships continue to work on relationship building at a local level and consider structured or systematic approaches. This could entail: joint working ventures; development of strategic plans; periodic meetings; and shared professional development forums to further develop, refine and sustain Partnership relations beyond the Services Connect trial.

- Realignment of key workers is one of the core foundations of the Services Connect trial and has created achievements in relation to: facilitating referral pathways; sharing of specialist expertise; and raising the profile of Services Connect within home agencies. However, any future processes which require re-aligning staff need take due account of:
  - the willingness and suitability of staff being re-aligned (skills, qualifications, level of experience, motivations)
  - methods for ensuring key workers within a co-located model are able to retain contact with their home agency to ensure they are kept up to date with professional developments in their area of specialism and to ensure they retain their specialist knowledge
  - variations in policies and procedures between home agencies and new Partnerships, for example related to human resources, health and safety, performance management and supervision
  - the impact of the loss of a re-aligned resource for the home agency and on the capacity of the organisation to continue to meet unchanged demand. A reduction in targets may not necessarily be adequate compensation to deal with the re-alignement of a worker.

Recommendations to inform the roll out of new technology

Perceptions of SCIP amongst Partnerships were variable. Whilst some Partnerships view it as a positive enabler of their role, others feel it represents too structured a process and may not adequately capture and respond to clients with multiple and complex needs. It is also worth noting that the Department and Partnerships undertook SCIP case audits, which identified practices that strayed from the model. A balanced view is required that appropriately distinguishes between the limitations of new technology that is being trialled and gaps that might be uncovered in workforce capacity.

Based on the achievements and lessons learnt from the trial, it is recommended that future roll out of new technology platforms ensure:

- Smooth registration and on-boarding processes for users

- When updates are implemented (as is expected within a trial environment), users are provided with sufficient advice and guidance about the nature and implications of the change

- Releases and development of the product are iterative and responsive to feedback from users (as was reported by DHHS to have occurred during the Services Connect trial)
Responsive and timely feedback and resolution of issues

Adequate support from a dedicated help desk

IT systems replicate or complement the model that is being implemented.

**Recommendations to inform performance and monitoring**

In relation to setting up and implementing processes for performance and monitoring, care should be taken to ensure:

- Transparency in the method for calculating targets and key definitions associated with targets are clear, transparent and understood from the outset.

- Consideration of local context – ensuring quality improvement benchmarks are consistent across agencies and quantitative targets are calculated to reflect the size (i.e. number of full time equivalent staff) of Partnerships.

- Targets are realistic and incremental to take into account the length of time required for establishment and implementation activities.

- Monitoring processes are not overly onerous and are designed to collect meaningful data which can be fed back to Partnerships as part of a regular and rigorous performance process.

- An appropriate balance between tangible impacts (such as targets) and non-tangible impacts (such as identifying where and how areas of practice can be further developed or refined) particularly within a trial environment.

**Next steps for the evaluation**

The process component of the evaluation has relied heavily on document review for this report, supplemented by visits to three Partnerships. Visiting the remaining five Partnerships will enable greater exploration of variations between Partnerships and to gather more information and ‘on the ground perspectives’ about how aspects of the model, in particular client support and integrated access, are implemented. Further qualitative research in these areas will provide for greater certainty and explanation in assessing the implementation of the model and ultimately understanding the pattern of client outcomes.

Data collection and analysis as part of this first evaluation report has identified the following lines of inquiry that will be further investigated through the remaining two reports:

- Understanding the impact of the local context on the implementation of the Services Connect trial, particularly differences between urban and regional areas, the nature of the client cohorts, and services already operating in the area.

- Investigating the strengths and challenges associated with the three types of Services Connect Partnership model – co-located, connected and dispersed.

- Examining in more detail the key mechanisms associated with implementing client support from the key worker ‘on the ground’ perspective.

- Examining Partnerships’ perceptions of the appropriateness of Services Connect for clients experiencing family violence. Through discussions with DHHS, up to two Partnership sites will be selected to explore in more detail how responses to family violence are being coordinated. Findings will be written up as high level case studies.

- Analysis of:
  - a SCIP extract (to be extracted in June 2016) that will be used to determine impact of the Services Connect trial on client outcomes
Executive summary

- a data linkage exercise (facilitated by the Victorian Data Linkages (VDL)) matching, at a client level, SCIP data with data from other DHHS and government databases in order to profile the client cohort and as far as possible demonstrate the role and impact of the Services Connect trial.
# Contents

Disclaimer i  
Executive summary ii  
1 Introduction 1  
2 Overview of Services Connect 10  
3 Partnership profiles 17  
4 Services Connect establishment 23  
5 Monitoring 34  
6 Implementing client support 45  
7 Implementing integrated access 55  
8 Achievements and challenges 68  
9 Conclusions 77  
Appendix A Outcome measures 87  
Appendix B Sample outcome questions 89  
Appendix C Quality review key elements and descriptions 91
# Introduction

## 1.1 The Evaluation Consortium

PricewaterhouseCoopers (PwC), the University of Melbourne and the Parenting Research Centre (PRC) as an Evaluation Consortium have been contracted by the Department of Health and Human Services (DHHS) to evaluate the Services Connect trial. This report, as the first of three reports and presents findings on the implementation of Services Connect to date. It also provides a status update on Services Connect data that will be used in the second and third reports to consider client outcomes. Data collection and analysis for this first report was carried out between February and April 2016 and focused on the period between October 2014 and April 2016.

## 1.2 Services Connect

Improving the wellbeing of all Victorians is the aim of Victoria’s Department of Health and Human Services (DHHS). Achieving this goal requires a coordinated effort by all parts and levels of government, the community sector and the broader community in order to build an integrated system of care. At the core of integration is providing tailored and holistic responses to achieve better outcomes for people who use services. Services Connect has provided the opportunity to test components of integrated community care.

The Services Connect trial was designed in recognition that most people experiencing disadvantage need support across a broad range of programs and services. This two year trial was intended to provide users with a flexible and tailored response based on what they need and their situation, and what they have identified as their goals. Services Connect has two primary objectives:

- To improve the way individuals and families are supported so that they can achieve lasting positive outcomes based on their personal goals and aspirations
- To improve productivity by reducing duplication and fragmentation across the human services system.

At the heart of Services Connect is an integrated client support model, which is based on one key worker, one needs identification, one plan and one client record, to create a holistic approach to supporting clients to achieve their personal goals and aspirations.

The small-scale trial of this integrated support model began in 2012 in departmental lead sites. In October 2014, testing was expanded to the non-government sector through eight Services Connect Partnerships. These Partnerships bring together more than 115 community service providers to deliver integrated child and family support, mental health, alcohol and drug treatment, family violence, homelessness, housing, disability and Aboriginal specific services. The eight Services Connect Partnerships are located in metropolitan and regional communities across Victoria, with the following lead agencies:

- Barwon Services Connect, led by Barwon Child Youth and Family
- Brimbank Melton Connect, led by MacKillop Family Services
- Hume Moreland Services Connect, led by Kildonan UnitingCare
- Loddon Connect, led by Haven, Home Safe
- North East Services Connect, led by The Children’s Protection Society and Berry Street
- Outer Eastern Melbourne Services Connect, led by Anglicare Victoria
- Outer Gippsland Connect, led by Gippsland Lakes Community Health
• Southern Melbourne Services Connect Partnership, led by Youth Support and Advocacy Service and Connections UnitingCare

The Partnerships are also involved in the development and testing of the following elements:

• SCIP that is intended to support the practice model

• the Services Connect Practice Manual was developed as part of a co-design process based on feedback and an identified need from the Partnerships. The Manual articulates expected practice and processes across all aspects of the model

• approaches to integrated access

• a needs identification process that is focused on goal setting and outcomes.

The trial will conclude in October 2016

1.3 Overview of the evaluation

The overarching purpose of this evaluation is to:

• Determine the success factors and barriers to implementation of Services Connect. This will be addressed as part of a process evaluation.

• Measure client outcomes and the effectiveness of the human services system change as a result of Services Connect. This will be addressed as part of an outcomes evaluation.

Two key objectives for the evaluation are to:

• provide clear and credible evidence of the achievements and impact of Services Connect on clients and the productivity of the human services system.

• inform ongoing investment, design and implementation decisions.

The scope of the evaluation is defined by a set of core evaluation questions developed by DHHS at the commencement of the trial, which will be addressed by the process and outcome evaluation as outlined below:

Table 2: Evaluation questions addressed by the process and outcome evaluations

<table>
<thead>
<tr>
<th>Evaluation question</th>
<th>Process evaluation</th>
<th>Outcome evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>How and to what extent has there been change in client outcomes for client cases that are both open and closed?</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>What are the characteristics of clients to date? (NB. also included as part of the process evaluation)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Has Client Support commenced and been implemented as intended in all Services Connect trial sites?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Are there implementation issues or barriers that need to be resolved? What action is recommended to resolve these?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Areas of innovation?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Are there any monitoring issues? What action is recommended to resolve these?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>What has been the client experience of Services Connect?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>How does the client experience of Services Connect relate to ‘business as usual’</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Evaluation question | Process evaluation | Outcome evaluation
--- | --- | ---
approaches? |  |  |
Have Services Connect Client Support project outcomes (as stated in the Benefits Management Framework) been achieved? | ✓ |  |
Have previous barriers been resolved? | ✓ |  |
Are there any new implementation issues or barriers that need to be resolved? What action is recommended to resolve these? | ✓ |  |
What are the consolidated barriers and recommendations and areas of innovation? | ✓ |  |
What are the critical success factors and barriers to scaling up Services Connect? | ✓ |  |
Have Services Connect intermediate effectiveness benefits (as articulated in the Benefits Management Framework) been achieved? |  | ✓ |
What are the causal drivers of effectiveness benefits? |  | ✓ |
Has Integrated Access commenced and been implemented as intended in all Services Connect trial sites? | ✓ |  |
Have Services Connect Integrated Access project outcomes (as stated in the Benefits Management Framework) been achieved? |  | ✓ |
For previously closed cases, have improvements in client outcomes been maintained? |  | ✓ |
What impact has Services Connect had on client outcomes? |  | ✓ |
How do the client outcomes of Services Connect compare to those of 'business as usual approaches'? |  | ✓ |

In addition to the core evaluation questions, the Evaluation Consortium has identified four further lines of enquiry which are fundamental to understanding the implementation of Services Connect, and processes which have characterised the move to an integrated model. These key lines of inquiry cut across and supplement the core evaluation questions and include:

- **Establishment of Partnerships (set-up)**
  This will examine the key activities involved in setting up the Partnerships, for example signing Memorandums of Understanding (MOUs), establishing governance arrangements, recruitment and realignment processes, minimum training requirements and other base-line activities.

- **Information, communication and tools (tools)**
  This will examine ICT platforms, outcomes-based planning tools and outcomes measurement tools to understand whether the tools and infrastructure have been sufficient and supportive to implementing Services Connect.

- **Skills and leadership capacity (people)**
  This line of inquiry will, at a high level, consider the types of skills required by both key workers and those in leadership positions necessary to lead Partnerships through processes of change and integrated service delivery.

- **Co-design process (approach)**
This key line of enquiry will explore the approach to Services Connect in terms of this being a model of ongoing development and refinement. It will consider its evolution and whether this has been an effective and inclusive method, as well as any issues that have occurred from this approach.

A further line of enquiry which will provide an additional lens to explore Services Connect from will be an examination of Partnerships’ perceptions about Services Connect for clients experiencing family violence. Through discussions with DHHS, up to two Partnership sites will be selected where the consortium will explore in more detail how responses to family violence are being coordinated. Findings will be presented as high level case studies. The two Partnerships will be informed and agreed upon through discussions with DHHS but could potentially include Partnerships with a high number of family violence clients or a Partnership that is demonstrating innovative practices to support this cohort.

1.4 **Evaluation and monitoring framework**

The Evaluation Consortium developed a detailed Evaluation and Monitoring Framework (standalone document) to guide all data collection, analysis and reporting activities. The purpose of the framework was to:

- link all evidence collection and analysis back to the evaluation questions
- provide a comprehensive reference point for all stakeholders involved in the evaluation
- set out a detailed methodology and associated data collection approach/strategy for both evaluation strands.

The Evaluation and Monitoring Framework was agreed in consultation with DHHS and the Services Connect Evaluation Reference Group².

1.5 **Ethics approval**

The Evaluation Consortium has been granted ethics approval for the methodology set out in the Evaluation and Monitoring Framework from the Human Research Ethics Committee of the University of Melbourne.

1.6 **Purpose of this report**

This is the first of three evaluation reports. Consistent with the Evaluation and Monitoring Framework the focus of the report are findings in relation to the following evaluation questions:

- What are the characteristics of clients to date? (Q2)
- Has Client Support commenced and been implemented as intended in all Services Connect trial sites? (Q3)
- Are there implementation issues or barriers that need to be resolved? What action is recommended to resolve these? (Q4)
- Areas of innovation (Q5)
- Are there any monitoring issues? What action is recommended to resolve these? (Q6)
- Has integrated access commenced and been implemented as intended in all Services Connect trial sites? (Q16).

An overview of client demographics will be provided in report 2 (August 2016). In relation to client outcomes, while a provisional overview will be reported in terms of client outcomes this will be fully explored in Report 3 (December 2016). Report 3 will provide a comprehensive evaluation of the Services Connect trial.

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² According to the Terms of Reference for the group, The Evaluation Reference Group assists and oversees the evaluation, ensuring that the evaluation objectives are achieved and to provide independent advice on the implications of evaluation findings. The group consists of the following representatives: Central DHHS, Services Connect Partnerships, DHHS Divisions; and Victorian Government
1.7 **Methodology**

Key activities for this first evaluation report have included:

- desktop analysis of key documents
- information request disseminated to Partnerships regarding establishment activities
- stakeholder consultations with three of the eight Partnerships
- stakeholder consultations with DHHS staff
- a high level review of findings from a client experience survey that was designed, disseminated, analysed and reported on by DHHS
- a high level review of implementation literature provided by DHHS
- overall analysis and reporting.

*Desktop analysis of key documents*
Table 3 below sets out the key documents received from DHHS that were analysed and synthesised as part of the desktop review. Key findings were extracted from the documents related to:

- Overall purpose and intention of Services Connect
- Contextual information about the model and individual Partnerships
- Requirements and obligations of Partnerships in implementing the model
- Establishment activities
- Barriers and challenges to implementation
- Achievements to date
- Progress with implementing client support
- Progress with implementing Integrated Access
- Partnership activity and progress against targets.
Table 3: Key documents analysed as part of the desktop review

<table>
<thead>
<tr>
<th>Purpose of Services Connect</th>
<th>P’ship info</th>
<th>Establishment activities</th>
<th>Barriers</th>
<th>Success stories</th>
<th>Client support</th>
<th>Integrated access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call for submissions</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Partnership submissions</td>
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<tr>
<td>Services Agreements</td>
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<td>MOUs</td>
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<td>Quarterly reports</td>
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<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minutes and working papers from the following group meetings:</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Services Connect Implementation Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partnership and Systems Reference Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Integrated Access Reference Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP updates document</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Access implementation plans</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

**Information request regarding establishment activities**

DHHS developed a template for all eight Partnerships to complete about key establishment activities and dates, including: infrastructure and procedures; Partnership engagement; governance; workforce recruitment and retention; and practice change. As part of the evaluation meta-analysis was carried out across the completed templates in order to build a timeline of key establishment activities.

**Stakeholder consultations**

Consultation with key stakeholder groups with experience of Services Connect implementation was fundamental to determining key challenges and achievements. Table 4 sets out the stakeholder groups who participated in consultations for this report.
This report includes findings from site visits to three out of the eight Partnerships. The remaining five sites will be visited during the course of May and June 2016 and findings incorporated into the second evaluation report. Site visits involved consultations with representatives from the following groups:

- Partnership Executive Leadership Group
- Partnership Senior Operations Group
- Partnership Facilitation function
- Practice Leader/Team Leader
- Key workers.

Table 4: Summary of stakeholder consultations undertaken

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Key consultation mechanism</th>
<th>Number of participants</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS</td>
<td>Interviews (2)</td>
<td>6</td>
<td>March 2016</td>
</tr>
<tr>
<td>Partnership Coordinators</td>
<td>Interview</td>
<td>4</td>
<td>March 2016</td>
</tr>
<tr>
<td>Partnership representatives involved in establishment activities</td>
<td>Workshop</td>
<td>8</td>
<td>March 2016</td>
</tr>
<tr>
<td>Partnership A site visit</td>
<td>Interviews with representatives from the following groups:</td>
<td></td>
<td>April 2016</td>
</tr>
<tr>
<td></td>
<td>• Executive Leadership team</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Senior Operations Management Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Partnership Facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Practice Leader / Team Leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Key workers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interviews were recorded with the consent of the participants. Recordings were listened to by the evaluation team and comprehensive notes taken. Notes were then analysed according to a framework derived from the evaluation questions and lines of inquiry.

Review of DHHS Client Experience Survey results

A high level review was undertaken of findings from a Client Experience survey that was designed, disseminated and analysed by the Department. The survey was conducted between 9 November and 18 December 2015. A survey package was mailed to 439 Partnership clients who were: aged 18 years and over, had open or closed cases, and were receiving guided and managed support. The Department received 129 responses representing a mail out response rate of 29 per cent.

High level review of implementation literature provided by DHHS

DHHS searched relevant databases to identify a selection of 13 key research reports focused on implementation of transformational change programs within allied sectors such as health. The documents were reviewed by the Evaluation Consortium in order to develop a high level framework for the purpose of analysis of the Services Connect evaluation data and to inform, validate, support and contextualise many of the findings identified through the evaluation.

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3 Due to illness key workers were only available to be interviewed at two out of the three site visits
Analysis and reporting

Following completion of the consultation program thematic analysis of consultation comments was undertaken to distil key themes. These were triangulated with findings from the desktop review and analysis of establishment templates to produce overall evaluation findings in order to respond to the key evaluation questions. Through this process of analysis, the Evaluation Consortium sought to understand how, and how effectively the Services Connect trial has operated at a strategic level and across the eight Partnerships, as well as identifying factors that have facilitated or hindered implementation.

1.8 Limitations of the report

The main form of data collection that has informed this report is desktop review of existing Services Connect trial documentation. This method has proved useful in terms of: gathering background information on the trial; understanding key components of the model; and uncovering implementation challenges and achievements raised by Partnerships through quarterly reports and presentation at state-level governance and reference groups. However, the limitations of this method must be acknowledged in that the majority of reports have been produced for their own purposes, which do not necessarily align directly to the questions the evaluation is seeking to address. Document review has been supplemented with two interviews with Departmental staff, a workshop with representation from seven out of the eight Partnerships, and in-depth consultations with three Partnerships.

The preliminary findings presented here will be built upon and further developed in the second evaluation report, which will include findings from in-depth consultations with all eight Partnerships involved in the trial. This will also provide a greater opportunity to draw out significant differences between Partnerships in terms of their local contexts and implementation of the model.

Interviews with Departmental staff and Partnership representatives aimed to capture and highlight views about achievements and issues associated with implementation. As such, we describe the extent to which views are shared qualitatively, rather than indicating the number of people who might share a particular view.

1.9 Report structure

- Chapter 2 provides an overview of the Services Connect model.
- Chapter 3 sets out a high level description of Partnerships.
- Chapter 4 outlines the establishment process for operationalising the Services Connect Partnerships, including key activities and timelines.
- Chapter 5 outlines and analyses the monitoring process that are in place to determine Partnership progress and performance.
- Chapter 6 considers the implementation of client support.
- Chapter 7 describes the co-design process and progress with implementation of Integrated Access.
- Chapter 8 analyses the achievements and challenges experienced through the implementation of Services Connect within the context of evidence from the implementation literature.
- Chapter 9 provides conclusions and recommendations to inform future reform effort.
2 Overview of Services Connect

This chapter presents an overview of Services Connect, and the intent of the model, drawing key documents issued by DHHS, namely:

- Services Connect Practice Manual
- Services Connect Client Support Practice Framework
- Outcomes Framework: How to track outcomes (March 2015)
- Advertised Call for Submissions (July 2014)
- Request for tender: Services Connect Evaluation (October 2014).

It steps out the structural components of the model, before proceeding to describe key components being Client Support and Integrated Access and associated principles and tools.

2.1 The Services Connect delivery model

The Services Connect trial is testing a model for integrated community and human services, designed to connect people with appropriate support, address the whole range of a person's or family's needs, and help people build their capabilities to improve their lives.

The model is intended to improve how government and non-government service providers work together and how people access and use services, including:

- how people access information and services
- how a person's range of needs is identified
- how support and services for people are planned
- how services are delivered to improve people's lives

As shown in Figure 1, Services Connect spans the stages of: Access; Identify; Plan and Service Response.

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5 Department of Human Services Request for Tender: Services Connect Evaluation (DHS C3764) August 2014
6 Department of Human Services Advertised Call for Submissions: Services Connect Partnerships P0139 July 2014
Stage 1: Access
In the access stage, it is intended that clients access information and services via an integrated network of access points across the human service system. Services Connect Integrated Access seeks to improve the service provided at first contact and provide faster and more meaningful referrals to the most appropriate service response, including client support or crisis responses where relevant. The Department, Services Connect Partnerships and other key stakeholders have been involved in a process to co-design a state-wide Integrated Access model, trial schedule and implementation plan.

Stage 2: Identify
In the identify stage, it is intended that Services Connect staff work with clients and their families as part of a case, to identify and assess relevant aspects of their life and family context. A comprehensive needs identification process is undertaken in collaboration with the client. Strengths and needs are considered across a range of outcome areas and the level of support is determined, based on the information gathered.
Stage 3: Plan

The intention of the plan stage is to provide differing levels of planning and support according to clients’ needs. Both long term aspirational goals and short-term outcome focused goals are developed. The key worker is the main contact for the client, responsible for coordinating other services involved, developing a plan, reviewing and supporting progress towards achieving the goals outlined in the plan and transitioning or ceasing support when an agreed level of self-management is achieved.

Stage 4: Service response

A range of other services identified in the plan may also be utilised, such as mainstream services, informal community connections, attendant care, family services, psychological assessments or public housing.

2.2 Client support

Client support is depicted as the horizontal bars of Managed Support, Guided Support and Self Support in Figure 1. Client Support aims to support people to build better lives and achieve their potential by providing a strengths-based, family sensitive, person-centred, holistic and outcomes-focused service response.

Client support is comprised of the following key features:

- one key worker to be the primary support worker for individuals and families with complex needs
- one needs identification that is accepted by all service providers and workers involved with a client’s life instead of multiple assessments that duplicate each other
- one client record instead of multiple records held by different services, so that people don’t need to tell their story multiple times
- one plan that covers the full range of an individual’s or family’s needs, goals and aspirations, and covers the full range of services they will receive.

As set out in the DHS: Advertised Call for Submissions document, these features are supported by:

- targeted tiered support tailored to the level of need and individual capacity of the client
- outcomes focused service delivery with services designed and delivered according to a set of outcomes agreed with the client.
- new technologies enabling one client record and needs assessment, and integrated and coordinated service planning and delivery. This was developed as SCIP.

2.3 Key workers

A key feature of the Services Connect model is that key workers are not just coordinators or generalists. They are intended to be the lead professional working with clients and hold responsibility for identifying and achieving mutually agreed goals with clients across the range of services and supports they require. As part of this responsibility it is intended that they engage with any specialist services required by the client and their family to achieve the goals and outcomes in their plans.

2.4 Outcomes framework

According to the Services Connect Practice Manual, the Outcomes Framework provides an approach to help fully understand whether the services being funded and delivered are having a real and lasting impact on people’s lives. Traditionally human services have measured inputs, such as the amount of funding provided and outputs, such as the number of services delivered. The Outcomes Framework is intended to shift the focus to
beginning to measure outcomes. The Framework contains a series of outcome areas, which are underpinned by indicators and measures that have been validated and trialled. The outcome areas include:

- Housing – people and families have suitable and stable housing
- Work and meaningful use of time – people and families are meaningfully engaged
- Learning and development – people and families are learning and developing
- Cultural and social well-being – people and families are culturally and socially connected
- Health – people and families are culturally and socially connected
- Safety – people and families are safe
- Behaviours – people and families practice positive behaviours

According to the Outcomes Framework document, outcomes tracking begins in SCIP once the needs identification has been completed and approved. Workers select up to four prioritised needs which will be linked to outcomes indicators [see Appendix A]. This does not mean that a person does not have needs in other areas, rather the maximum of four chosen indicators are considered to be the most important for the purposes of tracking.

SCIP has been programmed to generate a set of questions that allows measurement of the chosen outcome indicator(s). Each question has a set of possible responses and the worker must select the most appropriate answer from the drop down box. These questions need to be completed within two weeks of the team leader’s approval of the needs identification. SCIP will not allow the case to progress if there are unanswered questions.

2.5 Outcomes Stars

Outcomes Stars are evidence-based resources developed in the United Kingdom. An outcomes star consists of a number of scales based on a particular model of change and is presented in the form of a star chart. Outcomes Stars are a feature of key worker models and are used to plot progress and are typically completed by a keyworker and the service users. Outcomes Stars are proprietary products with use governed by licences. The Department has purchased licences for two Outcomes Stars for use by Services Connect Partnerships although their use is not mandated:

- Homelessness Outcomes Star: This star can be used with all individual clients, not just homeless clients and includes ten core areas: motivation and taking responsibility; self-care and living skills; managing money and personal administration; social networks and relationships; drug and alcohol misuse; physical health; emotional and mental health; meaningful use of time; managing tenancy and accommodation; and offending.

- Family Star Plus: this star is for use when there are parenting or child safety issues. Includes ten core areas found to be critical in enabling children to thrive: physical health; wellbeing; meeting emotional needs; keeping children safe; social networks; education and learning; boundaries and behaviour; family routine; home and money; and progress to work.

As set out in the Services Connect Practice Manual, Outcomes Stars have the following features:

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8 Outcomes Framework: How to track outcomes (March 2015)
• strengths-based and holistic tools that focus on all areas of a client’s life, not just the areas of service provision

• promote social inclusion by focusing on a client’s strengths, achievements and aspirations

• support workers to focus on work that achieves positive outcomes for clients

• visual tools that helps clients and key workers track progress towards the achievement of client outcomes over a period of time

• support consistent practice and a common language across programs and services

• enables organisations to measure and summarise change and progress towards the achievement of client outcomes.  

According to the Services Connect Practice Manual, at the beginning of the planning stage, the key worker starts with a list of prioritised needs developed through the needs identification stage. The Outcomes Star tool is designed to initiate a conversation with the client about:

• where they see themselves on the relevant arms of the Star

• why they place themselves at that point on the Star

• where they would like to be on the arms of the Star

• what it would take to move up the arms of the Star.

The client’s responses are intended to be used to assist with goal setting and developing actions as part of their plan.

### 2.6 Services Connect practice principles

A number of core principles are intended to underpin the Services Connect approach to delivering human services (see below). It was intended that these principles underpin the practice of all Service Connect workers as they deliver an effective and person-centred service to clients.

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The practice principles outlined in the *Services Connect Client Support Practice Framework* include:

- **self-management**: helping people achieve change in their life and greater levels of independence and self-management

- **person-centred**: respecting the contribution the client can make to identifying and meeting their own needs

- **strengths-based**: acknowledging that all clients have strengths and capacities that can be harnessed to engage change

- **holistic**: considering the needs of clients across all outcome areas such as housing, meaningful use of time, learning and development, cultural and social wellbeing, physical and mental health, safety and behaviours and risks

- **family-sensitive and child-focused**: recognising that supporting positive relationships within the family network may significantly help individuals experiencing major challenges

- **gender awareness**: the principle of ‘family sensitive, child focused’ acknowledges that men and women can be victims and perpetrators of family violence and sexual assault. While client support prioritises the safety of all people experiencing family violence, statistics and research clearly indicate that the majority of family violence is perpetrated by men against women and children. As set out in the practice manual, a gendered analysis is a critical component of family-sensitive, child-focused practice when working with families and identifying abuse.

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11 Services Connect Client Support Practice Framework February 2015: 6
• **cultural competence**: understanding, communicating and interacting effectively with people of different cultures and socio-economic backgrounds.

• **aboriginal cultural competency**: supporting improved outcomes for Aboriginal peoples and embedding cultural responsiveness in the service delivery model.

• **Culturally and Linguistically Diverse (CALD) communities**: awareness and sensitivity to the range of factors affecting participation of CALD background communities in human, community and health services.

• **trauma-informed**: understanding that traumatic events are powerful and upsetting incidents that intrude upon daily life and can significantly impact on the mental health and development of children and adults.

• **communication**: using a variety of methods or mediums such as plain English, print or social media while considering what best suits the client.

### 2.7 Integrated access

The trialling of integrated access in Services Connect partnerships is intended to explore new approaches to data sharing, reducing duplication at entry points and providing timely and appropriate supports including earlier responses, new ways for clients to access services and new pathways. It is trialling new approaches to data sharing, new ways for clients to access services and new pathways. The co-design process with Partnerships has included establishing a set of principles and operational requirements. A number of workshops were held to determine elements of a more integrated approach and to capture innovative practices already underway in Partnerships. This work identified three pillars of change required to improve integration, namely:

• skills and attitude

• improved processes

• appropriate responses.
3 Partnership profiles

This chapter describes the eight Partnerships involved in the Services Connect trial. The chapter includes information about worker realignment, governance and the different models of delivery, and concludes with a high-level table of the key features of Partnerships.

3.1 The eight Partnerships
There are eight Services Connect Partnerships. These are located in metropolitan and regional communities across Victoria and comprise:

- Barwon Services Connect, led by Barwon Child Youth and Family
- Brimbank Melton Connect, led by MacKillop Family Services
- Hume Moreland Services Connect, led by Kildonan UnitingCare
- Loddon Connect, led by Haven, Home Safe
- North East Services Connect, led by The Children’s Protection Society and Berry Street
- Outer Eastern Melbourne Services Connect, led by Anglicare Victoria
- Outer Gippsland Connect, led by Gippsland Lakes Community Health
- Southern Melbourne Services Connect Partnership, led by Youth Support and Advocacy Service and Connections UnitingCare.

Collectively there are 115 non-government agencies which comprise the eight Partnerships. The number of member organisations within each Partnership ranges from seven to thirty-nine partner agencies between the sites. 12

Locations of Partnerships are presented in the map below.

12 DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016
3.2 Worker realignment

Partner agencies are identified as either first tier (those which have committed realigned, or repurposed, funded positions) or second tier (those which support Services Connect but have not transferred realigned staff to the model). Workers are realigned from DHHS funded program areas being including alcohol and drugs, mental health services, housing and homelessness, family violence, child first, family services, Aboriginal services, youth justice, intensive adolescent case management and leaving care. However staff configuration from these areas differs across Partnerships. DHHS stipulated a minimum of 7 FTE position should be realigned from existing funded positions. In total, there are 80.3 realigned workers with a total realigned funding of $7.3 million. Realignment of workers was achieved through an ‘exchange’ of targets from program streams.

3.3 Governance

Partnerships have two tiers of governance:

- the Executive Leadership Group leads the Partnership and provides strategic oversight (typically comprising CEO’s of agencies, Partnership Facilitator, Practice Leader and Operational Manager)

- the Senior Operations Management Group monitors local operations and embedding new practices, as well as identifying service gaps and issues.

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13 DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016: 3
15 DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016: 2
In terms of leadership, all Partnerships have employed a Partnership Facilitator and a Practice Leader funded by the Department as part of the trial. Key responsibilities of these roles are set out in Table 5 below.

### Table 5: Key roles and responsibilities in each Partnership

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Partnership facilitation | • Coordinate and facilitate Partnership governance  
• Provide a primary contact point for departmental Services Connect divisional coordinators  
• Undertake a coordination role to support consistent service delivery across the Partnership  
• Work with the Department’s Services Connect divisional coordinators to ensure that testing is aligned, consistent and effective  
• Monitor and maintain oversight of testing deliverables for each of the service components  
• Coordinate data collection and evaluation tasks across the Partnership  
• Develop and maintain relationships with other relevant Area-based networks, Partnerships and services that may not be formal members of the Partnership  
• Engage stakeholders in identifying and resolving service gaps and other service delivery issues. |
| Practice Leader        | • Ensure consistent high quality practice during the trial period in line with the Services Connect approach  
• Lead systemic change of client support  
• Ensure a skilled and culturally competent workforce through clinical and case practice support  
• Monitor goals and plans aligned with the model intent, and case duration  
• Develop and implement strategies for staff learning and development  
• Establish a continuous learning culture  
• Capture client outcomes and support evaluation activities. |

Three Partnerships have merged the governance groups as the membership of both groups was considered broadly similar and it was perceived to be more efficient to merge meetings.

Four Partnerships have also employed team leaders, one Partnership a client support facilitator, and another Partnership an intake coordinator.

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16 DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016: 3  
18 DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016: 3  
19 DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016
3.4 **Partnership approaches to implementation**

Services Connect was designed as a state-wide consistent model. Partnerships were tasked with designing their own implementation approach that included how to establish staff support, staff locations and approaches to key client cohorts. The models employed across the Partnerships range from co-location, connected to dispersed arrangements (as in Figure 4 below).

**Figure 4: Partnership operating model**

- **Co-location**: at one site with no return to home agencies
- **Connected**: key workers spend time both at the Partnership location and home agency.¹
- **Dispersed**: key workers remain at their home agency and convene as a virtual Partnership team

3.5 **Service specification**

The broad model of service delivery outlined in the service specification included: a single holistic needs identification; a single case plan; a key worker and three modalities of intervention with specified hour allocations of service: self-support (up to 6 hours), guided-support (up to 29 hours) and managed support (up to 66 hours).² In addition, the four key reform components that Partnerships are required to deliver are:

- testing and refining Services Connect Client Support
- testing and refining associated ICT platforms, tools and data-sharing processes
- participating in the design, development and testing of Integrated Access
- developing Services Connect skills and leadership capacity at an Area level.³

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² DHHS (2016) Key Learnings from Partnerships v0.2. Services Connect Implementation Group. February 2016: 1
### 3.6 Partnership features

<table>
<thead>
<tr>
<th>Location type</th>
<th>Model</th>
<th>No. agencies</th>
<th>No. primary agencies</th>
<th>Secondary agencies</th>
<th>Committed FTE realignment</th>
<th>Actual No’ realigned FTE (Jan 2016)</th>
<th>No. Staff (Jan 2016)</th>
<th>Client support commenced</th>
<th>Distinct features</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barwon</strong></td>
<td>Regional</td>
<td>Co-located</td>
<td>22</td>
<td>6</td>
<td>11</td>
<td>8.6</td>
<td>8.6</td>
<td>11</td>
<td>Clients transitioned from 27 Jan 2015</td>
</tr>
<tr>
<td><strong>Brimbank</strong></td>
<td>North-west</td>
<td>Dispersed</td>
<td>28</td>
<td>12</td>
<td>16</td>
<td>11.2</td>
<td>12.2</td>
<td>12</td>
<td>9 March 2015</td>
</tr>
<tr>
<td><strong>Melton</strong></td>
<td>Metropolitan</td>
<td>Co-located</td>
<td>22</td>
<td>13</td>
<td>9</td>
<td>11</td>
<td>6.9</td>
<td>8</td>
<td>Technology enablers, including eReferrals</td>
</tr>
<tr>
<td><strong>Hume</strong></td>
<td>Regional</td>
<td>Co-located22</td>
<td>22</td>
<td>14</td>
<td>13</td>
<td>11.7</td>
<td>8.4</td>
<td>11</td>
<td>4 Feb 2015</td>
</tr>
<tr>
<td><strong>Moreland</strong></td>
<td>Regional</td>
<td>Co-located</td>
<td>22</td>
<td>13</td>
<td>9</td>
<td>11</td>
<td>6.9</td>
<td>8</td>
<td>Technology enablers, including Ultrabooks</td>
</tr>
<tr>
<td><strong>Loddon</strong></td>
<td>Regional</td>
<td>Dispersed</td>
<td>8</td>
<td>4</td>
<td>4</td>
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<td>7</td>
<td>23 Feb 2015</td>
</tr>
<tr>
<td><strong>North Eastern</strong></td>
<td>Metropolitan</td>
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<td>27</td>
<td>14</td>
<td>13</td>
<td>11.7</td>
<td>8.4</td>
<td>11</td>
<td>9 Feb 2015</td>
</tr>
<tr>
<td><strong>Melbourne</strong></td>
<td>Regional</td>
<td>Connected</td>
<td>27</td>
<td>14</td>
<td>13</td>
<td>11.7</td>
<td>8.4</td>
<td>11</td>
<td>Dual-line management for key workers</td>
</tr>
</tbody>
</table>

22 Whereas the Hume Moreland Services Connect model was intended to transition to a dispersed model, they have maintained the existing arrangement.
## Partnership profiles

<table>
<thead>
<tr>
<th>Location type</th>
<th>Model</th>
<th>No. agencies</th>
<th>No. primary agencies</th>
<th>Secondary agencies</th>
<th>Committed FTE realignment</th>
<th>Actual No’ realigned FTE (Jan 2016)</th>
<th>No. Staff (Jan 2016)</th>
<th>Client support commence</th>
<th>Distinct features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outer Eastern Melbourne</td>
<td>Metropolitan</td>
<td>Co-located(^2)</td>
<td>7</td>
<td>7</td>
<td>NA</td>
<td>8.5</td>
<td>8</td>
<td>8</td>
<td>Referrals from 15th Jan 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Focus on earlier intervention</td>
</tr>
<tr>
<td>Outer Gippsland</td>
<td>Regional</td>
<td>Dispersed</td>
<td>10</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>12 Mar 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spread across 200km</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Technology enablers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Trans-disciplinary team”</td>
</tr>
<tr>
<td>Southern Melbourne</td>
<td>Metropolitan</td>
<td>Dispersed</td>
<td>39</td>
<td>11</td>
<td>28</td>
<td>11.3</td>
<td>13.3</td>
<td>16</td>
<td>2 Mar 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Largest consortium of agencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Technology enablers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>including eReferrals</td>
</tr>
</tbody>
</table>

\(^2\) Whilst staff initially were to spend 1 day a week at the office of origin (Connected model) in reality workers were co-located full time and disconnect occurred with home agencies. Staff now spend 2 days a week as part of the formal supervision arrangements.
4 Services Connect establishment

This chapter presents findings about the establishment of Services Connect Partnerships. Key sources of information that have been analysed include: DHHS consultations; establishment activity templates competed by the eight Partnerships; the establishment activity workshop; SCIG meeting minutes and Quarterly reports. The chapter includes information about:

- The establishment timeline
- Key establishment activities associated with operationalising the Partnerships, including: recruitment and realignment processes; resources and technological acquisitions; and SCIP on-boarding
- Commencing client services
- Key reflections on establishment related to good practice in the implementation literature.

4.1 Establishment timeline

4.1.1 Timelines

Service Agreements were made between DHHS and the Partnership sites with the milestones as outlined in Table 6:

Table 6: Service agreement milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement reviewed and accepted by Partnership</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>Memorandum of Understanding (MoU) signed by all Partnership partners and submitted to DHS</td>
<td>14 November 2014</td>
</tr>
<tr>
<td>Partnership Governance Established and submitted to DHS</td>
<td>14 November 2014</td>
</tr>
<tr>
<td>Partnership Facilitation Function established</td>
<td>14 November 2014</td>
</tr>
<tr>
<td>Client support teams established and accepting referrals</td>
<td>31 January 2015</td>
</tr>
<tr>
<td>Client support workers complete required training</td>
<td>31 March 2015</td>
</tr>
</tbody>
</table>

Figure 5 sets out the timeline for Services Connect activities. It has been constructed based on Partnership establishment activity templates, minutes from SCIG and Operational Review meetings, Reference group meeting updates, analysis and working papers, supporting documents (i.e. training schedules and SCIP logs) and consultation findings. Key dates have been marked on the timeline (such as Service Agreements signed) to present a comprehensive visual representation of implementation. This is intended as a high-level and phased ‘typical’ overview, acknowledging that Partnerships have shown different and diverse implementation journeys since Partnership commencement in October 2014.
Figure 5: Services Connect Timeline

- **2014**
  - September: MOU’s
  - December: IT Agreements

- **2015**
  - January: Service Agreements
  - March: Client support officially commenced
  - August: IT Agreements
  - September: Operational planning, guidance material and practice manuals
  - October: Resources/technology acquisitions
  - November: Recruitment/realignment

**Key Events:**
- **January:** DHHS provided mandatory training (ie additional to SCIP)
- **March:** Train the trainer
- **October:** SCIP on-boarding and training
- **December:** 80% of users trained
- **March 2016:** SCIP releases

**Additional Notes:**
- Partnership establishment: governance, inter-agency protocols and premises
- Premises/coalition if applicable
- Internal eval’ns some partnership
- Performance monitoring (bulletins)
- Leaving care cohort defined

**Legend:**
- ▲ Train the trainer
- ▲ Leaving care cohort defined
4.2 Key establishment activities

4.2.1 Call for Submissions, Service Agreements and Memorandums of Understanding (MOUs)

The Advertised Call for Submissions (ACS) was released in July 2014 with Partnership responses due by 14th August 2014. Interviews were subsequently conducted by the former Department of Human Services (DHS) in September 2014. Partnerships were selected based on the quality of their submission and client demographics in the area, as well as ensuring an even sample of metropolitan and regional Partnerships. Successful Partnerships were notified in October 2014 and officially commenced operations on the 28th October.

The majority of Service Agreements – outlining high-level requirements associated with service delivery, compliance with standards and funding arrangements – were signed during October 2014. In addition Memorandums of Understanding (MOUs) between the agencies involved in each Partnership were signed during November 2014.

Service Agreements and MOUs were designed as high-level rather than prescriptive documents to give Partnerships the opportunity to develop their own operational models, with the premise of the trial being to “test a range of integration approaches to the delivery of more integrated services.”

4.2.2 Operationalising the Partnerships

Following successful submissions, Partnerships convened to operationalise their respective Partnerships. These first three months were dedicated to setting-up governance, interagency protocols, recruitment (see below) and office premises. Whilst Service Agreements and MOUs provided guidance, and service specifications outlined the broad models of service delivery including the practice framework. However, Partnerships reported that detailed information around governance (i.e. clear roles and responsibilities, and accountability), operations or model specifics (i.e. referral pathways) would have been beneficial to steer establishment.

In November 2014 caretaker conventions were implemented ahead of the state election on 29 November. In practical terms this meant that Partnerships were provided with limited guidance during the period between the 4th and 29th November. Following the change of Government there continued to be a period during which the capacity of the Department to provide specific advice to Partnerships was limited. Notwithstanding this, the Department held five sessions with the sector to view SCIP and held an information session. As a result, most Partnerships indicated that establishment was challenging. This was particularly difficult in the context of the compressed time frame allowed for an expansive range of essential activities. Reflecting the diversity of experiences in the Services Connect implementation, one Partnership reported that establishment was relatively straightforward given the Partnership was well established prior to the Services Connect trial noting that “nucleus of agencies were already formed.”

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25 Partnership A (2016) Activity Analysis: 1
26 DHHS Consultation (March 2016)
28 Partnership C. Service Agreement Version 1. 23 Feb 2015. By comparison, Partnership F signed in November 2014 and Partnership D in January 2015 (see Activity Analysis templates)
29 Partnership Activity Analysis templates 2016.
30 SCIG (2016) Key Learnings from Sector Partnerships. SCIG Paper. February 2016: 1
32 SCIG (2016) Key Learnings from Sector Partnerships. SCIG Paper. February 2016: 1
34 DHHS Consultation (March 2016)
35 Partnership workshop 21 March 2016
4.2.3 Recruitment and realignment

The process of recruitment and re-alignment of key workers commenced from November 2014. Appointments were typically made from January 2015, with Partnerhsips reporting that “most” staff had been recruited by mid-March 2015.  

Partnerships have taken different approaches to recruiting staff and realigning workers, including:

- through expressions of interest processes
- staff being appointed by their home agency
- formal competitive processes.

For the majority of Partnerships recruitment has been challenging. It appears that the method of appointment to these realigned role has played a role in the success of the realignment process with motivated workers identified through an EOI or competitive process appearing to be more likely to remain in the roles for longer. For example, one Partnership advertised positions across the Partnership and recruited staff through a competitive process and reported that despite being a longer process which delayed service commencement, this appeared to be beneficial with staff recruited via these means “show[ing] a greater understanding of the Services Connect model and commitment to implementation over the course of the trial”. By comparison, Partnerships which nominated staff appear to have had greater attrition, with stakeholders suggesting that in some instances staff were forcibly moved, and were not always suitable for the role.

Subsequent rounds of recruitment have been necessary due to staff-turnover and the requirement to fill vacant positions. As specified in the quarterly reports, the Practice Leader role was particularly challenging for some Partnerships to fill.

4.2.4 Resources and technology acquisitions

Resources were acquired generally between January and March 2015, although there has been variation across Partnerships.

In December 2014, the Department disbursed funds to Partnerships for the purchase of technology. Ultrabooks were purchased in several Partnerships between December 2014 and April 2015 to facilitate remote working and streamline the data entry process. Delays to these acquisitions have been noted, with one Partnership reporting a lag of 3 months between requesting Ultrabooks and receiving them. A further complication has been the necessity to develop user guidelines, as well as drawing up agreements between partner agencies. For one Partnership, several months elapsed between purchases and being able to use Ultrabooks since IT agreements had to be drawn before they could be configured for use.

40 DHHS Consultation (March 2016)
44 See for example Partnership G (2016) Activity Analysis
45 Partnership F (2016) Activity Analysis
46 Partnership D (2016) Activity Analysis
47 DHHS Consultation (March 2016). See also Partnership C (2016) Activity Analysis: 3
48 Partnership E (2016) Activity Analysis
49 Partnership H (2016) Activity Analysis: 5
51 Partnership C (2016) Activity Analysis: 3
configuration lay at each agency. ^52^ Similarly, policies and procedures had to be developed in some Partnerships for mobile phones which took time. ^53^ Despite such challenges, other Partnerships have commented that Ultrabooks “easily integrated into existing IT structures” demonstrating contrasting experiences across Partnerships. ^54^ Laptops were generally acquired and operational by February 2015, although some Partnerships have procured more later in the trial. ^55^ Vehicles were generally acquired between January and February 2015. ^56^ The online ‘wiki’ team space was operational by April 2015. ^57^

4.2.5 Operational planning and practice manuals

Operational planning and the development of practice manuals has been a requirement of partnerships. Whilst the Advertised Call for Submissions outlined policies and procedures about the model, and practice guidelines (updated through a co-design process and then converted to an on-line Practice Manual) and advice has been provided by DHHS to “bridge the gap between the architecture and practice”, partnerships have been responsible for operationalising the model and driving the delivery of Services Connect. DHHS co-designed with the Partnerships was concurrently finalising the state-wide practice approach and business rules for Services Connect during the establishment phase. On reflection, stakeholders have suggested that it would have been beneficial for this to have been finalised prior to partnership commencement. However, as reported by DHHS, this would have meant that no co-design would have been possible and therefore reduced the quality of the final product.

Operational planning has entailed a complex array of activities, including: processes around Human Resource functions (such as supervision structure, meeting priorities and frequency); processes around how the model will function (including access and prioritisation of clients, developing flowcharts for intake, allocation and co-location processes); and stakeholder engagement plans (including communication strategies, promotional materials and branding). ^62^ Partnerships have described this as an on-going process, with DHHS frameworks and operational guidelines being used in the first instance, and Partnership tailored guidelines and procedures being developed over time. ^63^ Whereas some processes were described to have been established in February and March 2015 (for example Intake and Allocation), ^64^ the nature of a co-design approach and a trial environment has necessitated revisions and iterations to policies and processes as an on-going activity as: “Partnership reviewed the relevance of the policy to their operations.” ^65^ In addition, the DHHS Services Connect Manual (and additional resources for key workers) has and will continue to be developed in conjunction with the Partnership sites throughout the trial period, ^66^ demonstrating operations as a fluid and evolving activity.

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^52^ Partnership C (2016) Activity Analysis: 3
^53^ Partnership F (2016) Activity Analysis: 4
^54^ Partnership A (2016) Activity Analysis: 3
^56^ Partnership B (2016) Activity Analysis
^57^ Partnership E (2016) Activity Analysis. See also Partnership B Activity Analysis
^62^ Partnership F (2016) Activity Analysis: 2
^63^ Partnership H (2016) Activity Analysis: 1
^64^ Partnership B (2016) Activity Analysis: 3
^65^ Partnership A (2016) Activity Analysis
4.2.6 SCIP on-boarding

SCIP on-boarding is a single process that occurs for each worker when they commence. It is a security measure to ensure the only people with a business need are able to access sensitive client information. It is a two phase process involving e-business registration and SCIP provisioning once approvals are granted by the Organisational Authority. Partnership staff have received training and access at various times since January 2015. Most partnerships commenced using SCIP in March 2015, with the majority of partnerships confirming that key workers were on-boarded by April 2015.

Following some delays early on in the test, DHHS took on board feedback about the SCIP on-boarding process directly from the users and in response developed a SCIP registration manual to clearly articulate the process. The process was also modified to become more streamlined and the registration forms were revised.

SCIP on-boarding has been on-going as new staff are recruited, and different sessions are conducted for different users (i.e. some admin staff received training in June 2015; Report training for managers in July 2015). Additionally, there have been numerous iterations to SCIP over the course of the trial as new components and functionalities have been added, with only a basic version being ready (client and case recording, and needs identification) in time for service commencement on 2nd February 2015. Intake was manually recorded until this functionality could be added in July 2015.

Department staff suggested that the accelerated development and rolling-out of SCIP has contributed to the requirement for subsequent SCIP updates and enhancements being necessary with eight SCIP ‘releases’ to date over the Services Connect trial period. After each major release workers were retrained in the new process and functionality, user guides were developed for each change and SCIP bulletins explaining the enhanced functionalities were distributed to all users.

4.2.7 DHHS mandatory training

There were 9 mandatory training modules which Services Connect staff were required to undertake over 8.5 days. These modules were initially delivered in January and February 2015, however have been repeated throughout the year to accommodate for staff on-boarding at different times, or for those unable to attend the first sessions. Whilst most of this training has occurred between January and July 2015, one Partnership has suggested that this has been a much longer and ongoing activity, with some staff completing mandatory training in February 2016. 84 Four of the nine mandatory modules were coordinated and/or delivered by DHHS and as set out in Table 7:

**Table 7: Core training modules coordinated/delivered by DHHS**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Brief description</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Connect and Client Support</td>
<td>Provides an overview of the Services Connect model, key elements and client support</td>
<td>One day</td>
</tr>
<tr>
<td>Client Support Key Work</td>
<td>Describes the main stages of Client Support key work, in-depth practice and process to competently use available tools, operational guidelines and other resources, including SCIP</td>
<td>One day</td>
</tr>
<tr>
<td>Family Violence Risk Assessment and Risk Management Framework (CRAF)</td>
<td>Identify risk factors associated with family violence and better identify and respond to women and children who are victims or at risk</td>
<td>Half day</td>
</tr>
<tr>
<td>Building Aboriginal Cultural Competence</td>
<td>Cultural respect and understanding embedded into the service delivery and people management practices of staff</td>
<td>One day</td>
</tr>
</tbody>
</table>

Source: Services Connect L&D Strategy May 2015 and corresponding course descriptions (February 2015)

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84 Partnership B (2016) Activity Analysis
In addition, five of the mandatory modules were externally provided and had to be arranged by Partnerships. Staff had to complete these modules within their first month, either upon or before commencement of client support:  

- Introduction to the Outcomes Star (one day)
- Motivational Interviewing (one day)
- Single Session Service Delivery (one day)
- Family Sensitive Practice (one day)
- Community and Economic Participation (one day).

SCIP ‘Train the Trainer’ sessions for Practice Leaders/Team Leaders were conducted in July 2015 to expedite SCIP on-boarding.

4.2.8 Additional training

A wide range of additional training has been organised and attended by Partnerships in order to broaden staff skills and knowledge base, with some Partnerships targeting training to ensure staff skills adequately respond to the needs of their clients. Partnership-level training commenced from March 2015, with sessions being conducted at various times throughout the trial. Examples of training sessions have included:

- Mental Health First Aid Training
- Introduction to Working Respectfully with Aboriginal Children, Families and Workers
- Child Protection training/discussion
- Economic & Community Participation training
- Cross Cultural (working with refugee & migrant families) training
- Permanency Reforms training and Single Session Engagement training
- Gender Equality at work
- Responding to trauma
- Working with Family Violence

87 Partnership B (2016) Activity Analysis
89 Partnership C (2016) Activity Analysis
90 Partnership G (2016) Activity Analysis
91 Partnership E (2016) Activity Analysis
93 Partnership H (2016) Activity Analysis
95 Partnership H (2016) Activity Analysis
Developing Independence. Additional training has been an on-going activity to ensure the continued learning and development of workers. In addition, some Partnerships have conducted skills audits with external training being arranged in response to identified gaps, therefore has been an on-going process.

### 4.3 Service commencement

Service commencement across Partnerships officially commenced on 2nd February 2015. However, DHHS reported that only one Partnership was ready to go on this date (due to having an already established consortium). The other Partnerships commenced later. Partnerships overwhelmingly attribute the delay in service commencement to establishment activities requiring much longer than was provisioned:

"Timeframes indicated by DHHS were short in most areas of the trial, including training of staff, development of new frameworks and new policies & procedures." 

As a result, Partnerships have felt that they have had to ‘set up’ “processes on the run” in terms of continuing establishment activities even after client support commenced. Establishment activities were reported to still be impacting on staff time even in October 2015, demonstrating the extended nature of implementation. Partnerships have suggested that a record of time attributed to each establishment activity would have been beneficial to demonstrate the extent of effort that has been necessary to implement Services Connect.

### 4.4 Integrated access development

The Advertised Call for Submissions outlined high level concepts and objectives of integrated access with the expectation that Partnerships would co-design the state-wide model with the Department.

Despite this, it was decided that Partnerships should maintain their existing intake arrangements in order to “limit the scope of change” and provide time for state-wide principles and operational requirements to be established. The Integrated Access co-design phase commenced later in March 2015 with Partnership members, DHHS representatives and other key stakeholders forming the Integrated Access Reference Group in order to co-design and develop agreed principles which could underpin implementation at the Partnership level.

Following the agreement of principles for implementation, Partnerships commenced the planning phase of integrated access, and were required to develop and submit implementation plans by 30 July 2015. Testing was to commence from this point, with a review of the intake testing scheduled from November 2015.

Partnerships have exhibited varying levels of understanding and progress towards an integrated approach to access, however DHHS has reported that the co-design approach has assisted Partnerships to advance their thinking and promote further innovation.

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96 Partnership B (2016) Activity Analysis
100 DHHS Consultation (March 2016). Also Activity Analysis
102 Partnership C (2016) Activity Analysis
106 DHHS (2016) Key learnings from sector Partnerships Paper. February 2016: 1
107 Whilst maintaining existing intake arrangements has had some repercussions, Partnership coordinators (consultation 30 March 2016) reported that some Partnerships did embark on a new intake processes
4.5 Performance reporting

Partnership performance is important for understanding the effectiveness and productivity of the Services Connect model. On the 9th July 2015, the Services Connect Implementation Group (SCIG) discussed Partnerships’ performance, appreciating that Partnerships were engaged in the ‘trial’ phase of implementation, and therefore were balancing innovation and development with monitoring case performance. As a result, it was decided that “in the spirit of cooperation and learning... a single report be developed and distributed to all Partnerships showing data from all eight Partnerships.” As a result, Performance and Learnings Bulletins were produced from September 2015 containing information drawn from existing DHHS reports:

- Throughput and KPI reports
- Model Efficiency & Effectiveness Reports
- Client Support Progress Report
- Client Demographics Report.

Stakeholders noted that whilst Partnerships were concerned about the interpretation of performance data being reported so early on in the testing phase, they have all been very open and eager to share their performance and associated experiences in order to learn from each other. DHHS stakeholders have suggested that this has been a beneficial process. Importantly, Performance and Learnings Bulletins capture not just quantitative performance data, but also include a qualitative ‘learnings on the run’ section to provide context for performance figures and to facilitate the share and learn process. This has been critical in order to gain a broader understanding of implementation and ensure Partnerships saw their effort reflected within performance reporting.

4.6 Reflections on the establishment and implementation of Services Connect

A number of observations can be drawn from the Services Connect installation timeline, including that:

- the Services Connect trial, whilst small scale, was ambitious in terms of the range of components and processes it has sought to test, including the weight of effort expended in terms of operationalising the model within Partnerships
- insufficient time was allocated for the extensive range of establishment activities required to embed and implement Services Connect
- the political context including the change of government led to the provision of limited guidance in the initial set-up phase
- the transition to SCIP was a significant shift from traditional ways of working and represented challenges due to SCIP development, worker readiness, and the timetable for release
- establishment requires strong planning, clear direction and should be sequenced into manageable phases with realistic timelines. This should take into account the significant culture shift required by workers and agencies and the co-design approach

113 DHHS Consultation (March 2016)
• the majority of co-design needs to occur prior to implementation commencement. Working in a co-design paradigm is new for both agencies and the department and it took longer to create an agreed platform than expected. This meant that agencies had a period of uncertainty during early implementation.

The key observations are discussed further below and in relation to good practice examples garnered from program implementation literature.

4.6.1 Political climate in which Services Connect was implemented
The concentration of initial set-up activity (i.e. consortium establishment, office arrangements and HR protocols) coincided with the caretaker arrangements; a change in government and associated machinery of government (MOG) restructures and changes in DHHS staff, as well as the Christmas period which complicated establishment. These compounding factors have contributed to Partnerships having limited time to sufficiently prepare, plan and establish Services Connect prior to service commencement, which is necessary for successful implementation.

4.6.2 Co-designed approach
In the context of a two year trial the requirement for Partnerships to develop their own localised implementation approach and co-design the approach to integrated access has presented challenges. Whilst allowing Partnerships flexibility in their model design, a co-design approach has required a greater amount of time and effort as takes longer to share the development, decision-making, delivery and accountability together with Government. This has involved new ways of working and the use of different skill sets, therefore has been a steep learning curve for Partnership workers and, unsurprisingly, time-intensive.

This relates to the extent of culture change that has been required for implementing Services Connect, and the shift towards different ways of working, greater accountability and cross-disciplinary working within Partnerships. Stakeholders considered that the scale of this change was under-estimated in the set-up of Services Connect with the time allocated for cultural change being insufficient.

4.6.3 Lessons from the program implementation evidence base
Implementation of large-scale reform is an extensive process. The Services Connect trial commenced in 2012 with internal Department sites testing the client support model. The Department has reported that the two years of internal testing provided a design foundation for the delivery of support to guided and managed clients when this element commenced in the sector. The understanding and the evaluation of the approaches of guided and managed cases allowed specific practice advice and direction to be given to the Partnerships unlike self support approaches and integrated access which are being co-designed and tested for the first time in the sector.

Best practice identified in the literature suggests that between two and four years should be allocated for implementation of large scale reform. By comparison, Services Connect has conducted a considerable amount of establishment and implementation activity over 10 months (from October 2014 until July 2015), whilst also providing client support 4 months into this process. In addition, aspects of ‘planning’ are still ongoing (see Integrated Access Chapter 8) given the co-design approach being taken (see 4.2.2). Best practice further indicates that implementation activity should be arranged into manageable phases.

The implementation sciences identify four broad stages of implementation over four years which may have been more realistic and achievable for Services Connect. These are outlined in Table 8.

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115 DHHS Consultation (March 2016)
<table>
<thead>
<tr>
<th>Implementation phase</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration</td>
<td>Assess needs, examine innovations, examine implementation, assess fit</td>
</tr>
<tr>
<td>Installation</td>
<td>Acquire resources, prepare organisation, develop data systems, prepare implementation, prepare staff</td>
</tr>
<tr>
<td>Initial Implementation</td>
<td>Establish implementation drivers to promote outcomes, and manage change</td>
</tr>
<tr>
<td>Full Implementation</td>
<td>Practitioners providing a fully-functional and consistent service; systems are established</td>
</tr>
</tbody>
</table>

Purposeful development of key components and activities per stage (as suggested above) not only promotes a methodical and realistic approach, but can ensure efficient anticipation of problems, and adjustments to be made to fully implement effective and sustainable initiatives. Significantly, when such incremental implementation is achieved, “sustainability and further innovation will be more likely” than in projects without systematic attention to the implementation process. As the literature affirms, successful outcomes and further innovations are dependent upon effective interventions and their effective implementation; the foundations of any program need to be well-considered, rolled-out incrementally and allocated sufficient time to bed-in before any benefits or innovation is realised. By comparison “…diving into initial implementation contributes to false starts, crises that require time and resources to negotiate, and derailed projects that do not survive.”

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5 Monitoring

The purpose of this chapter is to describe the key monitoring activities implemented as part of the Services Connect trial, and is intended to inform key evaluation question 6: Are there any monitoring issues? What action is recommended to resolve these?

Key sources of information that have been analysed include: Service Agreements, Performance Monitoring Framework, documents concerning targets and target calculations, Performance Measures for Client Support and Performance and Learning Bulletins. The chapter includes information about:

- Good practice from the literature in relation to monitoring
- DHHS performance and outcomes monitoring
- Mechanisms for monitoring Services Connect Partnerships
- Analysis of monitoring processes, including issues and recommendations.

5.1 Introduction

As outlined in the program implementation literature, monitoring is a critical component of program implementation in order to “identify and help resolve problems, provide feedback to sites, and ensure that programs (are) implemented with fidelity to their original intent and design.” Monitoring implementation can further help create “hospitable environments” for practice change; that is, oversight of performance and outcome data can “inform continuous quality improvement.” In relation to the Services Connect trial, monitoring has been important to ensure the core principles and requirements were adhered to, as well as to inform the evolution and co-design processes.

5.2 DHHS Performance Monitoring Framework

Subsequent requirements were developed for Partnerships in accordance with the Department’s Performance Monitoring Framework. The Framework – as part of the Department’s quality assurance approach – outlines the key tools and processes for monitoring organisations funded through a Service Agreement, and sets out the following components:

- **Service Agreement Monitoring:** ensure compliance with Service Agreements through collecting information and regular engagement between DHHS and Partnership staff
  
  “The Service Agreement sets out the key obligations, objectives, rights and responsibilities of the organisation delivering services and the Department providing funding to the organisation”

- **risk assessment of performance issues:** assess performance and severity of any identified performance issues
  
  DHHS website: Role of Service Agreements.

- **respond to performance issues:** support organisations to meet requirements of their Service Agreement where an issue has been identified.

  See: www.dhs.vic.gov.au

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The Framework prescribes that certain tools or mechanisms are put in place to gather evidence, and track the outcomes and achievements of funded organisations. The tracking of outcomes is an important component for Services Connect, in terms of understanding whether the services provided are making a lasting difference to peoples’ lives.

### 5.3 Services Connect monitoring mechanisms

The mechanisms that were put in place to monitor and report on the Services Connect trial are displayed in Figure 6 below.

**Figure 6: Monitoring mechanisms in the Services Connect trial**

<table>
<thead>
<tr>
<th>Monitoring Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection requirements</td>
</tr>
<tr>
<td>Key Performance Measure Targets</td>
</tr>
<tr>
<td>Supporting Operational Measures</td>
</tr>
<tr>
<td>Performance and Learning Bulletins</td>
</tr>
<tr>
<td>Quality Reviews</td>
</tr>
<tr>
<td>Quarterly Reporting</td>
</tr>
<tr>
<td>Partnership Facilitator role</td>
</tr>
<tr>
<td>Partnership Divisional Coordinator</td>
</tr>
<tr>
<td>Meetings: i.e. Practice Leader, CEO’s and Divisional Coordinators</td>
</tr>
</tbody>
</table>

#### 5.3.1 Data collection requirements

Service Agreement documents (incorporating funding schedules) outlined specific data collection requirements for each Partnership. This formed one information source to feed into DHHS oversight of Partnerships. Core requirements common to all Partnerships included:

- client and Case management records
- key performance measures for client support include indicators of client outcomes, client experience and number of cases
- other reports as requested (i.e. case studies)

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• operational reports.\textsuperscript{128}

### 5.3.2 Targets

While broad targets were outlined in Service Agreements and Service Agreement Variations in October 2014, specified quantitative targets were finalised in May 2015.

Service Agreement Variations produced in October 2014 outlined the following target areas for the trial:

- total number of clients (guided, support and managed). \textit{These correspond to 3 of the Department’s 7 Key Performance Measures produced prior to Services Connect} \textsuperscript{129}
- percentage of clients receiving and initial response within 5 working days of referral (100\% by trial completion) \textit{Differs from the Department’s Key Performance Measures produced prior to Services Connect.}

Client support targets were calculated based on the number of pro-rata realigned staff per Partnership, with a minimum of seven realigned staff being the requirement (see Table 9 for base performance). These targets were intended to ensure client throughput, as well as support the capacity to validate and refine the Services Connect model. \textsuperscript{131} Table 10 includes information about client outcomes targets.

**Table 9: Base performance measures (based on the minimum staff requirement of seven FTE) \textsuperscript{132}**

<table>
<thead>
<tr>
<th>Year</th>
<th>Self-Support Cases (1 FTE)</th>
<th>Guided Support Cases (3 FTE)</th>
<th>Managed Support cases (3 FTE)</th>
<th>Leaving Care</th>
<th>At risk of entering care</th>
<th>Total 7 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 – 2015</td>
<td>140</td>
<td>80</td>
<td>35</td>
<td>8</td>
<td>8</td>
<td>271</td>
</tr>
<tr>
<td>2015 – 2016</td>
<td>240</td>
<td>135</td>
<td>60</td>
<td>15</td>
<td>15</td>
<td>465</td>
</tr>
<tr>
<td>2016 – 2017</td>
<td>100</td>
<td>55</td>
<td>25</td>
<td>7</td>
<td>7</td>
<td>194</td>
</tr>
</tbody>
</table>


**Table 10: Performance Measure 3: Achievement of targets for client outcomes \textsuperscript{136}**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Measure</th>
<th>Unit</th>
<th>Target</th>
<th>Frequency</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client outcomes</td>
<td>% of short term goals (set for client support intervention) met at case closure</td>
<td>Goals</td>
<td>66%</td>
<td>Quarterly</td>
<td>SCIP</td>
</tr>
<tr>
<td></td>
<td>% of quality assessed plans that met the quality assessment</td>
<td>Plan quality</td>
<td>80%</td>
<td>Quarterly</td>
<td>Case reviews produced collaboratively by the</td>
</tr>
</tbody>
</table>

\textsuperscript{128} These measures were not found in the Service Agreement Variations provided to the evaluators for two partnerships


\textsuperscript{130} DHHS (2014) Partnership A Service Agreement: Funding variation for equipment, contingency. October 2014

\textsuperscript{131} DHHS (2015) Services Connect Business Process 1: Calculating and recording revised Services Connect targets. 27 January 2015

\textsuperscript{132} DHHS (2015) Services Connect Business Process 1: Calculating and recording revised Services Connect targets. 27 January 2015

### Monitoring

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Measure</th>
<th>Unit</th>
<th>Target</th>
<th>Frequency</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>criteria in relation to goals (linked to primary needs, achievable within the support intervention)</td>
<td></td>
<td></td>
<td></td>
<td>Department and Partnerships</td>
</tr>
</tbody>
</table>

Additional performance measures were further outlined in Partnership Service Agreements such as:

- targets met for achievement of client goals and client experience
- number of hours of service provided

#### 5.3.3 Partnership Facilitators

Partnerships were required to implement a ‘Partnership Facilitation function’ which includes the following responsibilities:

- coordination of Partnership governance
- ensuring consistency of testing alongside the divisional coordinators
- developing relationships with other area-based networks
- identifying and resolving service gaps
- monitoring and maintaining oversight of testing deliverables for each of the service components. ¹³⁷

In summary, Partnership Facilitators were tasked with overseeing and facilitating implementation and service delivery, as well as serving as the conduit for partners, and reporting on performance to the Department through quarterly reports. ¹³⁸

#### 5.3.4 Outcomes framework

The Department seeks to move to an outcomes tracking approach rather than focusing on outputs. An Outcomes Framework was developed to be tested for the first time within the Services Connect Test. Tracking of outcomes has been important for the Department to understand if Services Connect is making a difference to peoples’ lives. This represented a shift away from more quantitative or static measures such as exploring inputs (i.e. funding) and outputs (i.e. number of services delivered), to focus on outcomes for clients, and the value these services bring. For Services Connect outcomes are measured for Guided or Managed Support clients.

Outcomes are defined as any actual change or the difference made to a person’s life caused by a service or intervention. The Outcomes Framework provides the architecture to measure change, and in particular focuses on key areas of need, and those which clients’ are likely to see change occur within. These outcome areas are set out in Table 11, underpinned by the corresponding indicators and measures:

---

¹³⁸ Partnership A (2016) Consultation
### Table 11: Summary of Services Connect Outcome measures

<table>
<thead>
<tr>
<th>Outcome area</th>
<th>Indicators</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Housing</strong></td>
<td>People and families have:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Suitable housing</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>• Stable housing.</td>
<td>8</td>
</tr>
<tr>
<td>Work &amp; meaningful use of time</td>
<td>People and families are meaningfully engaged</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• engagement in the labour market</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• engagement in meaningful activity.</td>
<td>1</td>
</tr>
<tr>
<td>Learning and Development</td>
<td>People and families are learning and developing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• early childhood development</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• school achievement</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>• post compulsory learning</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• Independent living skills</td>
<td>11</td>
</tr>
<tr>
<td>Cultural and Social</td>
<td>People and families are culturally and socially connected</td>
<td></td>
</tr>
<tr>
<td>Wellbeing</td>
<td>• family and relationships</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>• sense of place and belonging</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>• social involvement</td>
<td>1</td>
</tr>
<tr>
<td>Health</td>
<td>People and families are mentally and physically well</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• mental health</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• physical health</td>
<td>12</td>
</tr>
<tr>
<td>Safety</td>
<td>People and families are safe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• abuse and neglect</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>• family violence</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• injury</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• safe environment</td>
<td>7</td>
</tr>
<tr>
<td>Behaviours</td>
<td>People and families practice positive behaviours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• alcohol and other drug use</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>• sexual risk</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>• financial stability</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• gambling</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>• offending</td>
<td>12</td>
</tr>
</tbody>
</table>

There are 135 questions which provide the method for determining a client’s prioritised needs, and to which outcome area this relates (see Appendix B). Some questions are of a personal and sensitive nature, therefore are to be used as a guide and can often be answered based on previous information gathered as part of the needs identification process.

Outcomes data is collected to enable the Department to:

- measure the impact of change and the extent to which the service makes a difference to peoples’ lives
• determine where services are most needed
• direct investment to where it will have the greatest impact
• adopt a targeted approach to tackling disadvantage and deprivation.

5.3.5 Quality Reviews

Quality Reviews are another mechanism to monitor Partnerships’ performance, and oversee how the testing phase of Services Connect is going. The review takes a sample of 10 managed or guided support cases per Partnership across different workers. Cases do not have to be closed, however must have had one plan approved, therefore fall within the Service Response stage, as illustrated below in Figure 7 Quality review sample cases:

Figure 7: Quality Review Sample Cases

Workers have to report on 5 key elements involving the model, including:

• Intake

---

Monitoring

- Needs Identification
- Closure
- Data Collection
- Practice Principles by way of key workers’ competency and compliance with the principles.

To aid this process and for workers to determine whether these criteria are being met or not met, 45 descriptors are included across the key elements (see Appendix B).

5.3.6 Quarterly reports
Quarterly reporting commenced in May 2015, with the first report incorporating data over the previous 5 months’ establishment phase. Quarterly Reports are completed by Partnership Facilitators, and submitted to the Department.

<table>
<thead>
<tr>
<th>Quarterly report</th>
<th>Quarter</th>
<th>Period of time data collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Establishment)</td>
<td>Nov ‘14 – March ‘15</td>
<td>5 months</td>
</tr>
<tr>
<td>2</td>
<td>Apr ‘15 – Jun ’15</td>
<td>3 months</td>
</tr>
<tr>
<td>3</td>
<td>Jul ‘15 – Sep ’15</td>
<td>3 months</td>
</tr>
<tr>
<td>4</td>
<td>Oct ’15 – Jan ’16</td>
<td>3 months</td>
</tr>
</tbody>
</table>

Quarterly Reports incorporate:

- Service throughput performance (client support numbers and percentage of short terms goals met at case closure – as outlined in 8.3.2 Targets above)
- Status and schedules for key milestones/deliverables (such as completed training and SCIP registration)
- Key learnings (such as observations about staff practice, challenges encountered by Partnerships or opportunities identified)
- Key activities (such as building the team and establishing processes and practices)
- Risk log (identification of top rated risks may affect the project and their associated rating)
- Issue log (issues that are current and rating as to the severity of impact).

5.3.7 Performance and Learning Bulletins
As outlined in Chapter 4, the Department produced Performance and Learning Bulletins from September 2015, as a way to report on Partnerships’ achievements against their targets.

The Performance and Learning Bulletins originally contained data on 5 output measures, \(^{140}\) listed in Table 123 below with additional measures added over time. These output measures correspond to some of the 7 Key

\[\text{\footnotesize{\textit{140} Five measures included in the September and October 2015 Bulletins; from November Stage Duration was incorporated}}\]
Performance Measures and 36 Supporting Operational Measures that were produced by the Department prior to Services Connect (revised in July 2015) 141:

Table 13: Reported performance compared with original Performance Measures

<table>
<thead>
<tr>
<th>Performance and Learnings Bulletin measures</th>
<th>Timeframe data extracted for</th>
<th>Correspondence to key performance measures and supporting operational measures</th>
<th>Full or partial match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client pipeline</td>
<td>Year to date (YTD)</td>
<td>Supporting Operational Measure 5, 6</td>
<td>Matches with 2</td>
</tr>
<tr>
<td>Target performance</td>
<td>From February 2015 to month prior to bulletin publication</td>
<td>Key Performance Measures 3 – 7 (Efficiency benefits) Supporting Operational Measure 7, 8, 9</td>
<td>Matches with 8</td>
</tr>
<tr>
<td>Closure Reasons</td>
<td>YTD</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Outcomes achieved Total number of achieved goals by outcome area (cases closed)</td>
<td>From July 2015 to bulletin publication</td>
<td>Supporting Operational Measure 1 refers to % of clients where progress made against one or more short term goals. Bulletins assess this by 2/3 of goals achieved.</td>
<td>Partial – different goal unit measures</td>
</tr>
<tr>
<td>Total cases closed with at least 2/3 of goals achieved</td>
<td>Qualitative findings drawn from</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Referral sources</td>
<td>YTD</td>
<td>NEW</td>
<td>N/A</td>
</tr>
<tr>
<td>Learning on the run</td>
<td>Qualitative findings drawn from</td>
<td>NEW</td>
<td>N/A</td>
</tr>
<tr>
<td>From November 2015</td>
<td>YTD</td>
<td>Supporting Operational Measure 16 refers to Average hours of service by activity type.</td>
<td>Partial – bulletins measure time by support type not by activity</td>
</tr>
<tr>
<td>Stage Duration (across support level: average and median hours)</td>
<td>From February 2015 to bulletin publication</td>
<td>Supporting Operational Measure 16 and 17 Steps out time in intake, needs identification and client support to demonstrate concentration of effort</td>
<td>Matches with 2</td>
</tr>
<tr>
<td>Client Demographics</td>
<td>YTD</td>
<td>Supporting Operational Measure 35 – total number of current clients by cohorts</td>
<td>Matches with 1</td>
</tr>
<tr>
<td>From December 2015</td>
<td>YTD</td>
<td>Supporting Operational Measure 16 and 17 Steps out time in intake, needs identification and client support to demonstrate concentration of effort</td>
<td>Matches with 2</td>
</tr>
<tr>
<td>From March 2015</td>
<td>YTD</td>
<td>Supporting Operational Measure 16 and 17 Steps out time in intake, needs identification and client support to demonstrate concentration of effort</td>
<td>Matches with 2</td>
</tr>
<tr>
<td>From Noval 2015</td>
<td>YTD</td>
<td>Supporting Operational Measure 16 and 17 Steps out time in intake, needs identification and client support to demonstrate concentration of effort</td>
<td>Matches with 2</td>
</tr>
</tbody>
</table>

Of the 7 Key Performance Measures, 5 are reported on in the Performance and Learnings Bulletins. Of the 36 Supporting Operational Measures, 8 can be found within the bulletins. In addition, DHHS are reporting on:

• **Closure reasons:** Number of closures to date, and reasons for normal closures across Partnerships, as well as reasons for early closures.
  
  - These additional outputs may help to explain why client numbers are not necessarily stable or incremental over time, therefore provide important context for performance.

• **Referral sources:** provides a state-wide total of referral sources from 6 July (when Access was developed on SCIP) to date.  
  
  - These additional outputs may help identify key access points into Services Connect and where further development may be required (i.e. Courts and Advocacy services), to inform subsequent design of intake.

• **Learning on the run:** provides qualitative information on reflective experiences to date, and is drawn from quarterly reports produced by Partnerships, focus groups and integrated access development planning.

Specifically, the Performance and Learning bulletins have been a way to for Partnerships to see how they are performing in relation to each other, and in relation to their targets. This is based on data from the *Model Efficiency and Effectiveness Report and Throughput & KPI report*. However, as recorded in the April 2016 Performance and Learnings Bulletin Partnership performance has not kept pace with targets.

### 5.4 Monitoring issues

#### 5.4.1 Quarterly reports

Quarterly Reports provide an overview of Partnerships’ performance over the quarter, as well as providing critical qualitative information about the activities of Partnerships, compliance with Integrated Access plans, progress made and any issues or achievements to date. It is therefore important that:

- Partnerships understand the importance of quarterly reports
- DHHS explain how quarterly reports are used, and identify which content is useful to this end
- DHHS provide advice on the length and content that is required
- DHHS assist Partnerships to improve their reporting.

#### 5.4.2 Performance reporting

There is a range of diverse perspectives about performance reporting amongst Partnerships. Some Partnership stakeholders have suggested that there was an overt switch towards monitoring performance from September 2015 when the Bulletins commenced, which has overshadowed the focus on testing and refining the models. Partnership stakeholders have said this change in emphasis gave “mixed messages” to Partnerships with the initial message being about practice reform and ‘testing’ in a supportive space context, to then be monitored on performance and questioned about not meeting targets with apparent disregard for the evolving nature of the model. Partnership stakeholders considered whether more time should have been allocated for ‘testing’ of the model before performance became monitored, or at least compensated for this with targets being incremental over time to reflect this. While this is a valid perception from some Partnerships, it needs to be balanced by other perspectives including the Department’s responsibility to monitor progress (or performance) and account for public monies.

By contrast, other Partnerships have welcomed performance monitoring, and particularly the Performance and Learning Bulletins as provided the opportunity to reflect on practice and identify any practice gaps. One Partnership suggested that whilst it took time to understand and engage with the reports – as another form of practice change – they have been useful for identifying areas which needed improvement.

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5.4.3 Targets

Targets were discussed by stakeholders as a particular issue. This was in terms of:

- targets calculated on FTE re-alignment
- targets were unrealistic and performance against targets in *Performance and Learning Bulletins* is presented cumulatively
- targets do not take into consideration the time and effort involved with intake
- case closures are ambiguous
- the impact of targets.

Documents suggest that targets were tailored for each Partnership, and were developed collaboratively (see 8.3.2). Despite this, some Partnerships consulted cited a lack of awareness about how the final targets were calculated. Whilst the guidance provided suggests that client support targets were calculated by the number of pro-rata realigned staff, some Partnerships have observed discrepancies with this, when comparing their targets to a comparable Partnership.

Partnership stakeholders have reported that targets were unrealistic for several reasons. First, targets were based on the assumption that key workers’ case load in Services Connect could mirror their case load from their home agency. Stakeholders questioned this since the Services Connect model has demanded much more from key workers by the way of the practice and cultural change involved (i.e. training, changes to how they support clients, reflective group practice, and secondary consults), as well as the dual accountability key workers have in terms of reporting to both Services Connect supervisors and their home agency. In essence, there were much greater obligations on staff within Services Connect than business as usual, which Partnerships have felt was ignored when allocating targets based on existing case load.

Secondly, targets are reported in Performance and Learning Bulletins cumulatively, and were not staggered to take into consideration the establishment phase of Services Connect. Instead targets were based on Partnerships being fully functional from day one. For Partnership stakeholders, this has made targets unrealistic and unachievable. Best practice notes that targets should be incremental to reflect that “large-scale change takes significant amounts of time... and years to bed in,” 148 and achieving outcomes will be a slower endeavour. Best practice warns against setting unachievable ambitious targets at the outset as can be demoralising for those engaged in the reform. 149

5.4.4 Key reflections

In relation to setting up and implementing processes for performance and monitoring, a future roll out would need to ensure:

- Transparency in the method for calculating targets
- Consideration of local context
- Targets are realistic, incremental and not overly ambitious
- The development of targets is informed by evidence from the roll out of similar trial programs in allied sectors

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148 Partnership H (2016) Consultation
Monitoring processes are not overly onerous and are designed to collect meaningful data which can be fed back to Partnerships as part of a regular and rigorous performance process.

Key definitions associated with targets are clear, transparent and understood from the outset to avoid issues down the track.

An appropriate balance between tangible impacts such as targets and non-tangible impacts such as identifying where and how areas of practice can be further developed or refined, particularly within a trial environment.
6 Implementing client support

This chapter presents findings in relation to the implementation of client support, and is specifically intended to inform key evaluation question 3: Has Client Support been implemented as intended in all Services Connect trial sites? Key sources of information that have been analysed include: quarterly reports completed by Partnerships; the establishment activity workshop with Partnership representatives; and site visits to three Partnerships. The chapter includes information about:

- Defining client support and levels of support offered
- Implementation of key features
- Analysis of practice principles
- The shift to new ways of working

6.1 Overview of Services Connect client support

Client support is intended to:

“... focus on streamlining and simplifying access to human services to ensure that people are connected with appropriate services. It tailors services to the unique needs, goals and aspirations of each client and their family, with an emphasis on building their strengths and capabilities to move out of disadvantage.”

“The model aims to improve the way people access information and services; how a person’s range of needs is identified; the way we plan with people to determine the services they need; and deliver the service response needed to improve people’s lives.”

Appropriate clients are offered one of three levels of flexible support, depending on their circumstances (as set out in Figure 8). A client’s level of support is calculated by an algorithm in SCIP based on information gathered from a variety of sources and individuals and profiling exercise undertaken between the key worker and client. A key component of the process is determining a client’s level of engagement.
Figure 8: Levels of client support available

Self-support is a relatively new concept for the sector.

Based on description provided in the Services Connect Practice Manual, Figure 10 below provides a high level overview of the steps involved in an episode of client support.

152 Figure based on diagram available at: http://www.dhs.vic.gov.au/for-service-providers/for-funded-agencies/services-connect/what-is-services-connect
6.2 Commencement of client support

The evaluation has identified a range of ‘softer’ achievements related to client support. These findings are explored in more detail below and are based on preliminary analysis of evidence reported by Partnerships – either through quarterly reports, the establishment workshop or consultations during site visits (although it must be cautioned that just three out of the eight Partnerships have been visited to date). These findings are supplemented by ‘headline findings’ from a client experience survey that was designed, implemented and analysed by DHHS.

Client support commenced in the eight Services Connect trial sites between February and March 2015. Data included in the April 2016 Performance and Learning Bulletin produced by DHHS shows that while no Partnership has met their targets in relation to the number of managed, guided and self-support cases or priority cohorts (young people leaving care and young people at risk of entering care) there has been some reported improvement in performance against targets over time. This will be further explored in future reports.

6.3 Analysis of implementation in relation to key features

The key elements of the client support model are specified as:

- one key worker who is the primary support worker for individuals and families with complex needs
- one needs identification that is accepted by all service providers and workers involved in a client’s life instead of multiple assessments that duplicate each other
- one client record instead of multiple records held by different services, so that people do not need to tell their story multiple times
- one plan that covers the full range of an individual’s or family’s needs, goals and aspirations, and covers the full range of services they will receive.

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Figure 9: Steps of client support

<table>
<thead>
<tr>
<th>Needs and Entry</th>
<th>Client Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Needs identification &amp; prioritisation</td>
<td>1. Actively engage client (i.e. Outcomes Star)</td>
</tr>
<tr>
<td></td>
<td>2. Identify one long-term aspiration</td>
</tr>
<tr>
<td></td>
<td>3. Identify up to six short-term goals</td>
</tr>
<tr>
<td></td>
<td>4. Develop actions to achieve goals</td>
</tr>
<tr>
<td></td>
<td>5. Document the plan</td>
</tr>
<tr>
<td>2. Establish level of support</td>
<td>6. Track of progress – Outcomes Star</td>
</tr>
<tr>
<td>3. Develop a plan</td>
<td>7. Identify positive changes or barriers</td>
</tr>
<tr>
<td>4. Implement the plan</td>
<td>8. Identify if different action required</td>
</tr>
<tr>
<td>5. Review the plan</td>
<td>9. Emphasise progression towards independence</td>
</tr>
<tr>
<td>6. Case Closure</td>
<td>10. Link client to relevant community services</td>
</tr>
</tbody>
</table>

---

153 Based on information derived from the Services Connect Practice Manual and the Services Connect Interim Platform Workflow (Release 5) diagram
Preliminary findings gathered through the evaluation in relation to each key element are set out below. These findings are based on:

- Evidence reported by Partnerships – through their quarterly reports, workshop establishment templates and workshop and site visits
- Findings from a Client Experience survey that was designed, disseminated and analysed by the Department. The survey was conducted between 9 November and 18 December 2015. A survey package was mailed to 439 Partnership clients who were: aged 18 years and over, had open or closed cases, and were receiving guided and managed support. The Department received 129 responses representing a mail out response rate of 29 per cent.

### 6.3.1 One key worker

*What is the evidence reported by Partnerships?*

Key workers involved in consultations valued the ‘multi-disciplinary’ nature of their role, which they felt enabled them to help clients with a wide range of goals, rather than single issues.

Some key workers reported that they found this shift to becoming ‘all rounders’ challenging to begin with, particularly when faced with clients with multiple and complex needs. During an interview, one key worker reflected back to how she felt at the start of the trial when faced with a particularly complex case outside her usual specialism. She compared this experience to how much she has grown in confidence through working with different clients and their families on a wide range of goals. For her, participating in the Services Connect trial has provided the opportunity for critical reflection on the way she previously supported clients within her own specialised area.

It was acknowledged by key workers during Partnership visits that having one key worker has reduced the need for a client to re-tell their story multiple times and removed the distress and frustration for some clients that comes with reliving this process.

The relationship between the key worker and client, particularly in managed and guided cases, was highlighted as a critical success factor in terms of enabling a client to achieve their own goals. However, several key workers reported that developing this relationship often took significant periods of client engagement. This is often a time-consuming, yet necessary process as one participant explained:

> “It took persistence to engage with the client. The key worker adopted creative strategies, including suggesting that she would just drop around to provide some information. Over time this proved to be effective as on subsequent visits, she was able to bring along an interpreter and engage on more meaningful level.”

Key workers reported a perceived limitation of the trial is that this engagement effort is not adequately captured in SCIP. However, in response to this feedback DHHS explains that engagement effort is intended to be recorded in case notes which have a time allocation.

From the perspective of key workers who participated in the evaluation to date, Services Connect has provided significant opportunities for professional development in terms of: expanding their knowledge of different sectors; exposure to different ways of working; developing relationships and links with other agencies; engagement with different tools and processes (for example outcomes star, motivational interviewing and single-session working); and working with a variety of clients on a range of different goals.

The key mechanisms that have enabled this key worker professional development to occur have been identified as: shadowing models; secondary consultations; joint case working for families with particularly complex needs; and formal and informal opportunities for reflective practice presented through team meetings, supervision and Partnership events.

*What has been the client experience?*

In terms of the relationship with their key worker, of the Services Connect clients who responded to the survey:

- 88 per cent felt comfortable talking to their key worker about their support needs
Implementing client support

• 85 per cent believed their key worker understood their situation
• 84 per cent agreed they could get in touch with that worker when they needed to
• 80 per cent agreed their key worker helped them get the services they needed.

This suggests that the majority of clients who responded to these survey questions perceive that they are building meaningful relationships with one designated key worker who was able to successfully connect them to the services they need.

6.3.2 One needs identification
What is the evidence reported by Partnerships?

According to several participants, the Services Connect trial has been successful in filling a gap in the human services system by providing a service to vulnerable people who may ‘fall between the gaps’ of other service providers. For example, one key worker reported that she was able to help a client navigate appropriate supports as they fell between aged care services and disability services but due to the service eligibility requirements was initially unable to access the right supports.

Some partnerships have commented that the initial co-designed needs and identification tool and comprehensive needs identification tool within SCIP is too static, and is not currently facilitating an efficient needs identification process.

Key workers at one Partnership reported that as their understanding of practice tools has developed, so they have been better equipped to support clients set clear achievable goals which has resulted in better outcomes for clients.

Use of outcomes stars appears to be variable, however the benefit of having common tools across the sector was highlighted by one participant as a way of developing a shared language and shared approaches.

Amongst the Partnerships visited, perceptions of the outcomes framework questions (see Appendix A) are mixed: key workers at one Partnership described them as a valuable tool to determine clients’ needs, whereas at another Partnership, workers raised significant concerns about the appropriateness of the questions. These key workers reported that clients often found the questions deeply personal and in many cases asking for inappropriate information. They also reported feeling uncomfortable and unequipped to ask some questions, particularly those related to sexual assault and mental health, without specialist support in place for the client from a counsellor or other specialist worker.

What has been the client experience?

In relation to the one needs identification process, of the Services Connect clients who responded to the survey:

• 83 per cent felt they had enough say in goal setting
• 75 per cent agreed their goals felt realistic and achievable
• 84 per cent talked regularly with their key worker about the support they needed
• 80 per cent talked regularly with their key worker about their progress towards goals.

Qualitative information collected via the survey also indicates that clients “appreciated the support and advice provided by their key worker, as well as their specific assistance in issue resolution, advocacy and helping clients connect to services.”

6.3.3 One plan
What is the evidence reported by Partnerships?
Implementing client support

The strength of the one plan approach was emphasised by key workers involved in consultations. As one described, the role of the key worker and associated plan is similar to the ‘Bunnings help desk person’ located at the entrance to the store:

“my easiest analogy is that we’re like the front person of the Bunnings store, and the customer comes in and just speaks to the front person and tells the front person that they want paint, wood, lighting and anything else, and the front person does all the running around for them while they come with them, and it’s all done, and they don’t have to re-tell their story over and over to the paint person, the wood person and the lighting person about what they want, and it simplifies it, it keeps the person engaged because they don’t have to re-live their story and re-tell their story, and they get results quickly”

What has been the client experience?

When considering their one plan, of the Services Connect clients who responded to the survey:

- 83 per cent of clients agreed with the statement: ‘I’ve had enough say in setting my personal goals and deciding how to get there’
- 75 per cent agreed with the statement ‘My plan and my goals feel realistic and achievable’, with 29 per cent of those in strong agreement
- 70 per cent of clients agreed with the statement ‘I’ve been able to involve my family or my carer to help me make decisions if I wanted to’.

The survey sought to understand the extent to which clients felt that they had authority in composing their plans and setting goals, how realistic and achievable their plans and goals were, and how involved their family was in the process. The strong positive findings suggest that plans are being integrated, and are considered practical and realistic by clients.

6.3.4 One client record

What is the evidence reported by Partnerships?

The intent of one client record is to promote efficiency and a holistic approach to client support by removing multiple records held by different service providers. This has been a significant undertaking for the sector; development of a common database shared by multiple agencies has never been attempted in the human services. However, this shift is practice was perceived as challenging by some stakeholders, particularly for key workers and agencies who had previously relied on paper based intake and assessment tools. Challenges were also identified whereby second tier agencies that function as intake points do not have access to SCIP, thereby requiring duplication of effort.

In terms of the functionality of SCIP, whilst participants acknowledged that it is a work in progress, key challenges that were reported to impact client support included that:

- SCIP imposes a linear process for working with clients, which is not necessarily reflective of case work or the complexity of some clients’ lives. However this requires further investigation. The Services Connect practice framework comprises intake, assessment and client support. Within client support there is potential for issues raised to be managed and worked through with the client for example new challenges or risks.
- In the early stages of implementation there were significant challenges in relation to client consent and concerns amongst Partnerships and clients that client information would be accessible to other agencies during out of hours services, in particular Child Protection
- Once a decision has been made there is limited flexibility within SCIP to change direction

In addition, several participants reported that SCIP was too onerous, particularly when dealing with self-support clients. As they described it, in many instances a self-support client will have relatively straightforward support needs, which can be achieved through a single-session. However, completing the mandatory fields on SCIP, particularly in relation to client demographics was perceived as a significant undertaking and disproportionate to the time spent actually supporting the client. In the context of the Auditor General’s (2015)
Early Intervention Services for Vulnerable Children and Families report finding in relation to data recording the issues of Partnerships’ data recording in SCIP warrants further investigation.

### 6.4 Implementation of practice principles

As described in Chapter 2, a number of core principles are intended to underpin the Services Connect approach to delivering human services. It was intended that these principles underpin the practice of all Service Connect workers as they deliver an effective and person-centred service to clients.

Table 14 below sets out preliminary findings from the evaluation in relation to a sample of practice principles. It is anticipated that this table will be populated further following site visits to the five Services Connect trial sites that have not yet been visited.

**Table 14: High level evaluation findings in relation to a sample of practice principles**

<table>
<thead>
<tr>
<th>Practice principle and description</th>
<th>How this is reflected in practice</th>
</tr>
</thead>
</table>
| **self-management:** helping people achieve change in their life and greater levels of independence and self-management | • The concept of working with, rather than for a client was noted several times in quarterly reports and consultations. As one key worker reflected: “Services Connect provides more opportunities for workers to support and empower clients to collaboratively assess risk and need with clients rather than for them. Doing something with someone provides a much more powerful experience for both worker and client than doing things for or to clients.”

• As described by several participants during consultations, a small number of clients have re-entered Services Connect for brief self-support interventions. From their perspective, this demonstrates that the initial intervention has increased their independence and ability to manage independently when faced with a challenging situation.  

• Despite this, several quarterly reports report that a practice shift has occurred, and key workers are increasingly relinquishing authorship of plans to allow clients to define their own goals, aspirations and actions. Consultation findings further confirm this transition with stakeholders asserting that plans are increasingly being constructed using ‘clients’ own words’, evidencing the move to a person-centred approach. During consultations, key workers reflected that person-centred approaches provide a far more empowering way for clients to work on their own goals, |

| **person-centred:** respecting the contribution the client can make to identifying and meeting their own needs | • The evaluation gathered evidence to suggest that Partnerships are beginning to exercise a person-centred approach and give clients’ control over their plans and services they receive.  

• However, several quarterly reports acknowledge the challenge of transitioning from current practice where key workers had been responsible for determining priority areas and what clients should work towards.  

• A DHHS representative explained that in reality it has taken a year for workers to realise that they do not operate a true person-centred approach and are only now starting to consider the contribution a client can make to identifying their own needs.  

• Despite this, several quarterly reports report that a practice shift has occurred, and key workers are increasingly relinquishing authorship of plans to allow clients to define their own goals, aspirations and actions. Consultation findings further confirm this transition with stakeholders asserting that plans are increasingly being constructed using ‘clients’ own words’, evidencing the move to a person-centred approach. During consultations, key workers reflected that person-centred approaches provide a far more empowering way for clients to work on their own goals, |

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155 Partnership G Quarterly Report 4  
156 DHHS Consultation (March 2016)  
157 Partnership B Consultation (March 2016)  
158 DHHS Consultation (March 2016). See also Partnership A Consultation  
159 DHHS Consultation (March 2016). See also Partnership A Consultation  
160 Partnership B Consultation
Implementing client support

with some key workers noting greater accountability in their clients as a result. In addition many reflected how plans constructed by clients tend to be ‘better’ plans as they are meaningful, tangible and resonate with clients.

Below is an illustrative case study from one Partnership showcasing a person-centred and family-centred approach

‘Sarah’ lacked confidence and had low self-esteem due to her past history of family violence. In addition, her children have complex health issues. Through Services Connect, the key worker was able to connect ‘Sarah’ and her daughter with counselling services; link Sarah to a mother’s group at a partner agency so she could establish social connections; provide practical assistance to enrol Sarah’s youngest child into school; provide encouragement for Sarah to return to the workforce in her chosen field; and provide advocacy and support at family court hearings. As a result, ‘Sarah’ has reported that her family are doing well, her children are enrolled in school and she feels motivated to look for a job next year.

- strengths-based: acknowledging that all clients have strengths and capacities that can be harnessed to engage change

- family-sensitive and child-focused: recognising that supporting positive relationships within the family network may significantly help individuals experiencing major challenges

- Key workers involved in consultations discussed the application and value of the strengths-based approach, indicating how the principle is being used:

  “I think it’s good that the process involves identifying strengths because a client might be all about the negatives... but it’s about having those conversations and being able to identify their strengths, which can be quite challenging for the client.”

The evaluation has found some anecdotal evidence of the transition to family-sensitive approaches and “child focussed” practice. Several participants involved in consultations reported benefits from being able to help support a family as a whole, rather than just working with individual clients.

As reported by some participants, a perceived challenge that detracts from family-sensitive approaches is the requirement to input all family members into SCIP. It was reported that this is perceived as a “cumbersome and time consuming” process, especially when there are numerous family members since each member “requires a file created and needs assessment”, thereby curbing efficiency savings and impacting a supposedly “seamless” transition into Services Connect. Additionally, it was reported that if new family members come to light whilst in the planning stage of SCIP, key workers are unable to add them to the case at that stage.

Partnerships have suggested that there needs to be greater “flexibility in SCIP and an ability to reflect changes in a client situation”.

Results from the Client Experience Survey indicate that a family-sensitive approach has – on the whole - been successfully implemented, with 70 per

161 Partnership A (2016) Consultation
162 Partnership A (2016) Consultation
166 Partnership B (2016) Consultation
Implementing client support

<table>
<thead>
<tr>
<th>6.5 New ways of working</th>
</tr>
</thead>
<tbody>
<tr>
<td>As presented in Chapter 4 (Establishment), Services Connect has required extensive culture change in order for workers to progress towards new ways of working. This has been a significant undertaking which numerous stakeholders believe was hugely underestimated.</td>
</tr>
<tr>
<td>Despite this, stakeholders note that practice change is now beginning to occur at some Partnerships as workers are beginning to fully understand Services Connect and its features (i.e. what it is to be client-centred), how this is different from current practice and the value this brings. Stakeholders noted that many workers were initially confused about transitioning since many already believed they were exhibiting features of Services Connect. Instead the move to new ways of working has been a slow endeavour based on engaging workers to critically think about current service provision, as well as being dependent on the appetite to disrupt conventional practice and embrace change.</td>
</tr>
<tr>
<td>Stakeholders note that most Partnerships now exhibit a willingness to learn, and are enthusiastic to develop and absorb these new principles in their work. For some stakeholders, the act of co-design has facilitated this process through engaging workers to think about how client support could be better. At other Partnerships, sessions have been run which specifically focus on new ways of working, and function through sharing ideas and experiences which can encourage this transition.</td>
</tr>
<tr>
<td>Despite a slow transition to new ways of working, numerous client support practice changes have been reported, including:</td>
</tr>
<tr>
<td>• the change from being crisis driven and reactive to being proactive</td>
</tr>
<tr>
<td>• earlier engagement (and therefore intervention) with clients (such as getting out into the community and working in schools)</td>
</tr>
</tbody>
</table>

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171 DHHS Consultation (March 2016)
172 DHHS Consultation (March 2016)
174 Partnership A (2016) Consultation
• use of technology to facilitate client support off-site\textsuperscript{176}

• key workers delivering support beyond their core area: “key workers involved in Mental Health are now jumping in and doing complex work in housing”\textsuperscript{177}

• multi-disciplinary approach to client support: “key workers are able to bring along an AOD worker so the client does not have to navigate the system”

• secondary consultations: drawing on expertise when it is needed.\textsuperscript{178}

\textsuperscript{175} Establishment Workshop (2016) Consultation with Partnership representatives. 21 March 2016.
\textsuperscript{178} DHHS (2016) Key learnings from Sector Partnerships.
7 Implementing integrated access

This chapter presents findings in relation to the implementation of integrated access, and specifically seeks to inform core evaluation question 16: has integrated access been implemented as intended in all Services Connect trial sites? Key sources of information that have been analysed include: minutes of the Integrated Access Working Group meetings; Partnership Integrated Access Plans; quarterly reports completed by Partnerships; and site visits to three Partnerships. The chapter includes information about:

- Intent and process for designing Integrated Access
- Supporting Integrated Access: reference group and guidance

Critique of whether Integrated Access have been implemented as intended

7.1 Introduction

This chapter has been structured to consider Integrated Access and the implementation process. It will first describe the intention of Integrated Access. It will then describe the process for setting up Integrated Access (i.e., the exploration/installation phase), as well as the plans Partnerships produced as an outcome of this process. It will then compare Partnerships plans and outcomes with state-wide principles and requirements, based on the material provided to PwC as part of the desktop review. Since Integrated Access is an on-going activity, with Partnerships in the test and review phase, report 2 will seek to update these findings based on consultations with the eight Partnerships to present a comprehensive account of progress and the extent Integrated Access has been implemented.

7.2 Intention of integrated access

As outlined in Chapter 2, Integrated Access is a key component of Services Connect, in terms of this being clients’ entry into the model (Stage 1 Access). The intention of Integrated Access is to improve the referral process by ensuring clients receive a meaningful service at their first point of contact, and are referred to appropriate service faster.¹⁷⁹ This is anticipated to improve service delivery through reducing inefficiency and duplication,¹⁸⁰ as well as improve client experience of the human services.

7.3 Establishment process: context and co-design

As discussed in the establishment chapter, despite Integrated Access being the entry into the new client support model – and therefore (intuitively) should comprise as one of the first processes to be established – planning and implementation commenced later in the trial from March 2015. This was due to a co-design approach being taken (that is, the direct involvement of stakeholders in the process to ensure their needs could be met)¹⁸¹ as well as resistance from the wider sector in terms of the scope for Integrated Access not being defined accordingly.¹⁸² In summary, there were conflicting ideas about what should be defined within the parameters of a co-design approach.

Besides Partnerships being responsible for developing referral pathways and intake points for their own local models, they were also – in conjunction with DHHS – to “co-design state-wide principles and operational

¹⁸² DHHS Consultation (March 2016)
requirements, determine consistent key innovations and learn from innovations underway”\(^{184}\). Fundamentally, co-design has necessitated a longer period of “exploration and installation”\(^{185}\) of Integrated Access (or planning and establishment) as co-design by nature is an iterative and evolving endeavour as outlines in Figure 10.

**Figure 10: Principles and Practice Co-design process\(^{186}\)**

![Principles and Practice Co-design process](image)

The co-design process occurred in parallel with accelerated establishment and implementation of Services Connect. While best practice suggests the four stages of implementation (*exploration, installation, initial implementation* and *full implementation*) should be executed between two – four years,\(^{187}\) Services Connect has embarked upon this process over 18 months.

In addition, best practice timeframes are based on implementation of pre-determined models; the Integrated Access component of Services Connect was not pre-determined but has involved co-design and testing at the state-level, as well as at the sector level. In the case of Integrated Access, the establishment timeline shows how the initial design and testing phase has necessitated 8 months of effort, with on-going review and refinements continuing at the time of this report.

### 7.4 Reference Group

To commence the co-design process, the Integrated Access Reference Group (IARG) was set up to establish state-wide agreed principles and operational requirements; develop the testing schedule and implementation plan. In addition the reference group was the vehicle to support implementation and learning.

This has been particularly important since the process of co-design was a completely new undertaking for the sector, and has required a significant shift to new ways of working (and levels of accountability) which needed additional guidance. Stakeholders commented that central facilitation has been vital in order to encourage Partnerships to engage in the process of co-design and think creatively. Without this, Partnerships may have been restricted by having too much of a “blank canvas”.\(^{188}\)

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\(^{184}\) DHHS (2016) Key learnings from Sector Partnerships.


\(^{188}\) DHHS Consultation (March 2016)
The IARG is comprised of Partnership members, DHHS representatives and other key stakeholders. The purpose of the IARG – as outlined in the terms of references – is to:

“...lead the co-design and testing of a person-centred, family focused Integrated Access function that improves ease of access and information provision and facilitates efficient and effective referrals...”

The model was to be designed from examining “existing access points” and building on expertise from Partnerships and departmental lead sites to create a seamless responsive client journey. The IARG convened on the 27th March 2015 to workshop and formulate ideas which could guide design and development activity.

As a result of the March 2015 IARG session, key actions were developed for Partnerships to undertake. These included:

- identification of innovations around integrated intake processes
- development of a set of operating principles to underpin agreed Integrated Access Principles (see Figure 11)
- state-wide services (i.e. family violence services) to offer expertise in the area, and the design needs to reflect such expertise
- development of solutions to manage information barriers to better integration identified in the L17 process, recording Youth Justice (YJ) and Child Protection (CP) referral documentation and managing housing applications and cases
- incorporate cultural change support in the implementation plan.

The IARG further produced an agreed set of 13 service delivery principles to guide the development of access and intake in Services Connect.

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In addition, workshops were held with Partnerships to “determine elements of a more integrated approach and capture innovative practices and processes underway in Partnerships”. These workshops identified three pillars of change required to improve integration which included:

- skills and attitude
- improved processes

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Implementing integrated access

- appropriate responses

7.5 Referral and intake establishment – challenges

Intake is one key element of an integrated access approach. Whilst service delivery referrals commenced in February 2015, the planning phase for constructing new intake points and referral pathways – particularly for specific cohorts – has extended beyond July 2015. Difficulties in creating the ‘front door’ and entry into Services Connect have been experienced for numerous reasons including:

- the decision to maintain existing intake arrangements and extend the co-design phase for integrated access (as aforementioned) noting that options were limited because Services Connect was a trial and business as usual intake arrangements could not be completely dismantled
- definitions around client cohorts
- existing processes, protocols and legislation
- the perceived value of Services Connect
- problems with collaboration.

Establishing referral pathways for Leaving Care clients – as a target group of Services Connect – has been problematic due to Partnerships considering definitions outlined in the ACS ambiguous. Partnerships sought additional clarity, although centrally-approved definitions which were only finalised in June 2015 (published on the Services Connect website in 21 May 2015). This has impacted on developing role requirements for Key Workers providing client support to this cohort, and therefore delaying delivery of a tailored service. By comparison, in one Partnership where the entire leaving care program was incorporated into Services Connect, the process has been much smoother since with the acquisition of experienced leaving care staff.

Existing processes, protocols and legislation have also compromised planning and establishing integrated intake processes. For example, Child Protection advised that “Functional Contracts” were required for leaving care referrals to be made into Services Connect and that their endorsement for referrals was required. Additionally, the integration between family violence agencies and Partnerships has been challenging “due to the interpretation of legislation as it relates to L17 reports”. As a result, most Partnerships have developed “work-arounds” in order to provide a service to this cohort, and some have developed promising models.

In addition, Partnerships reported that there have been doubts about the value of Services Connect for this cohort over and above the funded leaving care service, which may have deterred the directing of clients into Services Connect, compromising testing of alternative pathways. As a result, only 3 of the 8 Partnerships had

197 Partnership A Consultation
200 DHHS (2016) Key learnings from Sector Partnerships: 3
201 DHHS (2016) Key learnings from Sector Partnerships
202 DHHS (2015) Leaving Care Cohort Analysis
Implementing integrated access

any leaving care clients by July 2015, with the majority being unable to accurately ‘test’ pathways since had limited or no clients from the cohort.\(^\text{203}\)

In addition to the ‘value’ of Services Connect, some agencies do not feel the model is appropriate for clients with complex issues, therefore will not refer their clients to the model. Some stakeholders consider the model too generalist and that key workers do not have the appropriate skills or expertise to deal with clients with complex issues, such as family violence, despite key workers undertaking CRAF training.

The process of developing referral pathways is particularly dependent on strong collaborative working. This is due to the extent of reform and practice change required to establish new and integrated pathways across multiple agencies. For some Partnerships this has been problematic – and particularly for larger Partnerships – with difficulties experienced coordinating meetings between agencies and ensuring all relevant interests could be involved to collectively develop and agree on the process.\(^\text{204}\) This is likely to be an issue for Partnerships operating a dispersed model.

### 7.6 Referral and intake establishment – Innovations

Some of the innovations emerging from co-design of Integrated Access have included:

- development of an e-referral system
- broadening intake beyond Services Connect
- earlier intervention

In some Partnerships, intake has been broadened out to other services – such as schools – to facilitate the referral process, as well as extend and build connections beyond Services Connect. This further promotes earlier intervention in terms of “getting out into the community” as opposed to “waiting for clients to present”.\(^\text{205}\)

Some Partnerships have developed, or are intending to develop, the practice where key workers spend time at intake points to streamline and strengthen the intake process. For one Partnership, the establishment of four intake points with key workers devoting 1 – 2 days a week at these points has meant that clients receive a response within 1 – 2 days, prompting a seamless and effective response for clients at the access stage of Services Connect.

Partnerships using this method have also reported achievements in raising the profile of Services Connect at these agencies.

### 7.7 Has Integrated Access commenced and been implemented ‘as intended’?

Whilst this chapter has highlighted the challenges (and innovations) encountered with the implementation of Integrated Access, it is important to note that the concept of an ‘intended’ model is ambiguous in light of the approach to co-design. Instead, innovation and emergent learnings from sector Partnerships are intended to inform state-wide principles and understanding, with the concept of a universal model that can be ‘achieved’ across Partnerships being redundant.

Instead it may be relevant to consider:

- Has Integrated Access commenced in all Services Connect trial sites: what stage is each Partnership at with Integrated Access?

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\(^{203}\) DHHS (2015) Leaving Care Cohort Analysis: 15

\(^{204}\) Partnership E (2015) Analysis of Leaving care cohort in Partnerships

Implementing integrated access

- Has Integrated Access been designed in accordance with state-wide principles? gap analysis between requirements and plans/principles vs challenges encountered
- Has Integrated Access been implemented in accordance with implementation plans? (i.e. as Partnership’s intended model)
- Has the co-design approach been an effective approach for Integrated Access?
- Has the implementation of Integrated Access demonstrated innovation?

7.7.1 Has Integrated Access commenced?

As outlined above, commencement has been delayed due to challenges around collaboration and the planning required for designing Integrated Access. As aforementioned, the decision to “limit the scope of change” and “maintain existing intake points” while state-wide principles were established has meant that Partnerships were designing intake points and processes up until September 2015, with the roll out of Integrated Access components intended to commence from October 2015.

Whilst Integrated Access has commenced across Partnerships – By way of submitting plans and through the intake of clients – it is still within the ‘developmental phase’ according to some stakeholders therefore cannot be deemed to have “commenced” in terms of implementing and testing a ‘finalised’ version. Establishing and implementing an integrated service access system (as well as a new service model) has been a challenge within timeframes, especially in large and diverse Partnerships and establishing referral pathways with broader agencies has been reported as slow.

Whilst intake is occurring, Integrated Access is essentially in the ‘exploration’ stage (if applying best practice literature); aspects have been ‘installed’, however ‘initial’ and ‘full implementation’ (as planned and delivered processes) have yet to be realised across all of the Partnerships. By comparison trialling the Client Support approach was considered underway even before the design phase of Integrated Access commenced.

This has been critiqued by some Partnership stakeholders. Whilst appreciating co-design as an important part of Services Connect, they considered that Integrated Access – as the “front door” to the model – should have been designed from day one. Instead, the design of Integrated Access commenced from January.

At the beginning of the trial, Integrated Access was deferred with the decision to maintain existing intake arrangements while state-wide operational requirements and key components were developed. This was an effective strategy to:

- ensure these necessary features were understood and agreed by Partnerships
- form a robust foundation (through establishing agreed principles) from which could enable and facilitate the process of co-design
Implementing integrated access

- reduce the scope of change and avoid a ‘big bang’ implementation (as per best practice advice).\textsuperscript{216}

Despite this, the strategy has potentially served to undermine the underlying principle of Services Connect to facilitate better access and “assist the most vulnerable and disadvantaged Victorians.”\textsuperscript{217} This was because existing intake points are predominately program or service driven and thereby function to “screen people according to a narrow cohort of eligibility.”\textsuperscript{218}

7.7.2 Target cohort access

The Services Connect Practice Manual stipulates that: “Partnerships must include a minimum of 15 clients in each of the following two groups: Young people leaving care and Young people at risk of entering care.”\textsuperscript{219} Looking across active cases of these cohorts (see Table 15) shows how there have been difficulties achieving these targets over the last 12 months, with indications that this may be due to referral and intake issues.

Table 15: Client pipeline (YTD at 31 March 2016)\textsuperscript{220}

<table>
<thead>
<tr>
<th>Partnership</th>
<th>At risk of Entering Care (active cases)</th>
<th>Clients in Leaving Care (active cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Brimbank Melton</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Hume Moreland</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Loddon</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>North East Melbourne</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Outer East</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Outer Gippsland</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Southern Melbourne</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>State Total</strong></td>
<td><strong>34</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Difficulties associated with maintaining existing intake points, during the design phase, attention was paid to developing Integrated Access plans in accordance to the agreed principles Figure 11. This was facilitated through regular LARG meetings to support co-design and extensive effort being devoted to thinking around how Integrated Access would operate.\textsuperscript{221} There is evidence that Integrated Access has been designed in accordance – or at least with attention paid – to the state-wide principles, with most Partnerships explicitly linking implementation plans back to these principles. For each designed element of the Integrated Access model, most Partnerships have provided rationale for the course of action or process, and stepped out which key principles the component relates to and fulfils. This demonstrates a methodical approach to instilling the key principles in the co-design process, as well as efforts to incorporate a number of these principles. Despite this, some Partnerships do not provide a level of detail in terms of how each principle will be ‘met’, with the indication that principles have been simply ‘ticked off’ within plans devoid of their application to delivery.


\textsuperscript{218} DHHS (2016) Key learnings from Sector Partnerships: 2


\textsuperscript{221} Partnership A Consultation
Table 16: State-wide principles included in implementation plans

<table>
<thead>
<tr>
<th>State-wide Principle</th>
<th>Barwon</th>
<th>Brimbank</th>
<th>Hume</th>
<th>Moorland</th>
<th>Loddon</th>
<th>North East</th>
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Intake worker appointed and Outreach model  Technology, including e-referral system  Merger of intake points and processes  Lean Principles and efficiency  Online referrals  Key workers have a dual role  Improving cultural sensitivity at intake  Wiki space. Earlier intervention: Family violence worker at police station

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222 Principles have been derived from the Services Connect Practice Manual. Implementation Plans refer to 11 of these principles. These have been cross-referenced within the table. Difference between Practice Manual principles and Plans may be due to additional principles being added to the Manual following Implementation Plan submission.
Differences in the level of detail contained in implementation plans suggests that there is varying understanding of Integrated Access across Partnerships, and subsequently, their practical application of the key principles to the intake model. Despite this variance, there is commonality across implementation plans in terms of efforts to “reduce duplication through streamlining guidelines, simplifying processes or utilising common tools.” Additionally, most Partnerships incorporated action to “streamline and improve collaboration” as well as communication and engagement across and within agencies.

This is a positive finding when considering the extent of practice change required by Partnerships to engage in the co-design process and critically reflect on how current practices could be improved. Furthermore, given the broader practice change involved and the narrow time period of the Services Connect trial, a number of important features have been captured. Realistically, Partnerships would be unlikely to be able to meet all 13 principles during the trial, however this was never expected. Partnerships were asked to select the principles that they wanted to prioritise in their implementation plans.

7.7.3 Has Integrated Access been implemented in accordance with implementation plans?

Significant effort has been invested in constructing Integrated Access plans and co-designing new approaches to the intake process, as well as efforts for plans to be underpinned by state-wide principles. However, given that Integrated Access is a “tested” component, Partnerships have had to review and adjust arrangements within their plans during the testing phase in order to ensure these are “effectively testing the Integrated Access approach” and address any emergent problems.

For example, one Partnership has altered their approach from a rotating intake roster to one designated intake worker in order to provide greater consistency in the service response. From reviewing the rostered system and noting inconsistencies in service delivery, the Partnership moved to appointing one intake worker which has resulted in time efficiencies and a streamlined response for clients. This demonstrates the benefit of flexibility and the ability to review and modify trial components within a large scale test.

Other impacts to delivering Integrated Access ‘as intended’ have been staff attrition and inconsistencies in administrative procedures for Partnerships with multiple access points.

Another Partnership consulted has suggested that some components within their Integrated Access plan were disregarded – such as the rotating roster – due to being too complex. Instead, intake in practice has shifted to focus on demand and “where the clients are,” in order to stem the backlog of clients across services:

“In our Integrated Access plans we were putting a worker out here and a worker out there, this rotating roster, going to places, you know developing all these relationships with people, and trying to get all these referral pathways, whereas really what we knew was there was a backlog of services, a backlog of family violence why didn’t we just plug in right there...”

For some Partnerships, plans were complicated and “time consuming” and distracted from the purpose of streamlining intake. In practice what some stakeholders thought was required was to target clients who had potentially been waiting for up to 3 months in the current system, to ensure that they received a timely response (i.e. Key Principle 3) and to alleviate pressure on the system (i.e. efficiency):

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227 Partnership A (2016) Consultation
229 Partnership A (2016) Consultation
“people have been waiting 12 weeks just to get an assessment, now that cannot be right and meanwhile Services Connect is over here saying "oh I wonder where we should put our front door, I wonder where we should open an access point."”

In this regard, some stakeholders wondered whether there has been disconnect from central ideals and understanding about Integrated Access, and what is appropriate and pragmatic at the Partnership level. Also detracting from implementation ‘as intended’ was the underestimation of time required to embed new practice change. Some agencies have been reluctant to move away from previous intake practices and assessment tools, which has subsequently involved ongoing effort to challenge. Other Partnerships also need to continually “recheck and refresh purposes and objectives” around Integrated Access in order to challenge existing practices and “prevent a business as usual drift.”

Implementation requires substantive time to embed new principles, and to ensure that the ‘trial’ is valid (focused on new rather than existing practices).

Despite this divergence from implementation ‘as intended’, some aspects of plans have been implemented and valued, demonstrating success in the process of critiquing current intake process.

7.7.4 Has co-design been effective for Integrated Access?

The IARG was set-up to lead the co-design of Integrated Access, and has been successful in terms of developing operating guidelines, principles and business rules (May 2015) for Integrated Access, which has supported Partnerships to design implementation plans. Most stakeholders have enjoyed the opportunity and flexibility to construct their own models however some are not convinced that co-design was appropriate for the Integrated Access component of Services Connect.

Some stakeholders considered the developmental process for Integrated Access to be “over-cooked” and reported that it had been a significant drain on resources in terms of the time invested in the planning. Instead, they thought that Integrated Access should have been defined in the Partnership submissions and ready from day one – as the entry point into the model – especially given the nature of Services Connect being a trial:

“...we put out integrated access plans in which was derived from all that thinking in that space, to be honest it was just a little bit over-cooked, and overthought, and trying to be a bit too tricky... so I think that was a really big distraction...”

By ‘too tricky’ stakeholders meant that co-design was focused on re-designing the intake process “from scratch”, which was “too hard an ask” within the confined trial period. Stakeholders thought that this distracted Partnerships, and ultimately for some, proved redundant since plans were not put into practice. Whilst appreciating the co-design approach, stakeholders wondered whether the scope should have been more targeted towards designing manageable and ‘bite-size’ improvements to the current intake model, rather than developing new processes to trial, however this would have meant that co-design would not have been undertaken in the trial.

Stakeholders considered that a gap analysis approach would have been more suitable for the trial in terms of identifying what could be improved and what could be realistically changed in the time frame. A focused effort towards critiquing the current processes used by agencies within the Partnership, as well as an appreciation of the local context, key cohorts and identification of the key blocks to service access and provision (i.e. waiting lists) may have provided Partnerships with a greater steer, without compromising their ability to co-design.

Whilst Partnerships have engaged in the co-design for developing plans, they have not necessarily implemented Integrated Access in accordance with these plans. As a result, they have questioned the value of undertaking a lengthy co-design process for Integrated Access – given the tight timeframes of the trial.

230 Partnership A (2016) Consultation
236 Partnership A Consultation
237 Partnership A Consultation
7.7.5  **Are there any areas of innovation in the design and implementation of Integrated Access?**

It has been noted that the decision to maintain existing intake points while Integrated Access principles were established has compromised Partnerships’ ability to be innovative. Developing change from within the confines of existing intake arrangements has restricted Partnerships from exploring different intake methods, with business as usual practices prevailing over the need to be innovative and test novel approaches. As a result, it has been observed that Partnerships have struggled to “push the boundaries” of current systems and practices “towards greater integration.”

In contrast to this view, some Partnership stakeholders – as outlined above – consider that co-design was a distraction, with innovation – in terms of designing completely new processes and practices – being pursued for the sake of innovation, rather than for realistic outcomes (i.e. to streamline the service and improve client access). Instead they considered that the scope of co-design components should have been limited to the examination and improvement of existing processes. In this regard, improvement and modification to current systems which could contribute and work towards Integrated Access ‘as intended’ is preferable to being ‘innovative’ and reinventing the system within the confines of the trial.

Based on these reflections, future reform may wish to consider realignment of intake:

- at project commencement to avoid reversion to business as usual
- having a predetermined framework and defined principles prior to roll-out, to reduce the scope of co-design (i.e. clear parameters for co-design to occur within)
- targeted co-design focus on the local context and improving current processes.

Notwithstanding perspectives about the impact of the co-design approach on innovation, Partnerships have implemented a range of intake processes and demonstrated innovation. Key examples include:

- a designated intake worker to provide an ‘outreach’ model
- lean thinking principles
- multiple intake points at each first tier agency
- centralised intake point
- a pop-up Hub at a community centre to provide information to local residents, and pop-up intakes at parent groups and Centrelink
- an e-Referral system.

Whether these arose from critical engagement and reflection of processes and practices (i.e. through the co-design process and planning), or as a response to where demand lies (i.e. targeting client backlogs) or even a combination of the two, different approaches have been taken. An evaluation of these approaches and outcomes

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239 DHHS (2016) Key learnings from Sector Partnerships: 2
240 DHHS (2016) Key learnings from Sector Partnerships: 2
242 DHHS Consultation (March 2016)
Implementing integrated access

achieved will be the subject to the subsequent reports, following consultations with all Partnerships, and when sufficient testing and emerging outcomes can be seen.

Provisional findings thus far indicate that:

- the number of self-support clients has doubled in one Partnership with the appointment of an Intake Worker

- the pop-up hub has raised the profile of the service and built networks within the local area

- the centralised intake system promotes a “seamless client journey”

- the allocation of key workers to intake points have resulted in immediate responses for clients, as well as extended to a medium to long term response where appropriate

- shared learnings between key workers and external intake workers

- having a specific intake worker is more effective than cycling key workers through intake.

8 Achievements and challenges

This chapter builds on the analysis outlined in previous chapters and sets out the key barriers and achievements encountered during the implementation of the Services Connect trial. Specifically the chapter aims to inform core evaluation question 13: What are the critical success factors and barriers to scaling up Services Connect – and similar integrated service reform programs – in terms of establishment and implementation activity. Subsequent reports will seek to inform this question further.

Barriers and achievements discussed in this chapter are described within the context of critical components of successful program implementation identified from literature in allied sectors. Consultation findings which are incorporated within this chapter are from visits to three Partnerships.

8.1 Introduction

A high-level review of literature related to program implementation has identified several critical components of successful program implementation, which all have relevance to the Services Connect trial. Using these critical components as a frame, this chapter sets out key barriers or challenges and achievements related to the implementation of the Services Connect trial. Critical components of program implementation identified from the literature include:

- Setting a realistic ambition for the project as a whole, including appropriate implementation phases and measurable and achievable objectives
- Creating a shared vision across a diverse range of organisations
- Bringing a large number of different organisations together
- Agency stability
- Staff skills, qualifications, experience and credentials
- Training and other opportunities for building skills capacity
- Technical infrastructure

8.2 Setting realistic ambition

The Services Connect trial, while small scale was ambitious in terms of the range of components and processes it was seeking to test, namely:

- bringing together multiple agencies from across the sector to form Partnerships
- different models of Partnership delivery: co-located, connected and dispersed
- a staff re-alignment process
- SCIP as a central depository for client records
- for some, significant practice change
- a significant focus on integrated service delivery
Achievements and challenges

- performance targets and outcome measures
- a co-design process for developing Integrated Access

Consultations with Partnership stakeholders has identified that this broad scope represented both a challenge and an opportunity. As several stakeholders explained, the trial environment has provided great opportunities for “creativity”, “to see what can be done differently” and to “challenge the status quo”. According to one participant:

“although some might say that many of the ideas contained in Services Connect are not new, general everyday practice doesn’t allow you to do the types of things you can do in Services Connect. It has provided an authorising environment, removed limits on what people can do.”

However, it was also acknowledged by participants in the establishment workshop from across several Partnerships that perhaps the trial was “trying to achieve too much”, particularly within a short period of two years and that this limited the potential of the trial to be fully realised.

The importance of measureable and achievable objectives has been highlighted in the literature in learnings from previous transformation change programs. As the literature cautions, any change program should be realistic from the outset to avoid disappointment when implementation proves more complex than expected. Setting realistic objectives for the initial stages, enabling achievement and encouragement is vital. However, many Partnership stakeholders felt that targets have been overly ambitious and not well defined or measured (particularly as data was presented to Partnerships in cumulative form). This is reflected by participants being unable to meet their performance targets. SCIP was designed to collect data and generate reports has also come under criticism from users, in terms of the accuracy and reliability of the data.

In addition, it has been recognised at a variety of different state-wide forums and meetings the significant ramp-up time that was required in the establishment phase across the Partnerships have not been adequately accounted for in targets. Good practice suggests the need for appropriate and incremental targets, which allow time for a program to get up and running. DHHS recognised that the targets needed to be revised and adjusted within the first year of trial.

8.3 Shared vision

A shared vision of the program’s goals and objectives by all involved in the program is identified in the literature as a critical success factor to program implementation. According to Mihalic et al., often the emotional and psychological reactions to change are centred on ideological conflicts. Competing philosophies between program goals and agency goals can arise. Within the Services Connect trial, several Partnerships commented on the challenges and opportunities presented by the diversity of philosophies and ways of working that comes with integrating agencies, with different client cohorts, ideologies, principles and practices. Three examples of how Partnerships have set aside time to develop a shared vision are set out below:

- At one Partnership, early on in the tendering process CEOs and senior staff from agencies that were to form the Partnership invested significant time establishing the set-up through a process facilitated by a ‘critical friend’. This process was used to develop a shared vision which resulted in a Strategic Plan (a document that is now refreshed every six months), outlining the role and responsibilities of each organisation and the purpose of the joint venture. This process was perceived as a significant achievement given the historic competitive relationships between agencies in the area.

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257 Partnership C (2016) Consultation
Achievements and challenges

- At one Partnership, the Partnership Manager has hosted small discussion groups with members of the Partnership, discussing matters such as what Services Connect is, how it differs from other programs, how people can access Services Connect, what resources Partnership members wish to provide to the Partnership and what gaps they see in the community that they can address through Services Connect.

- Another Partnership invested time and resources into building team and Partnership trust, culture and expectations, allowing time to set the scene and explore what success looks like. This was achieved through allocating time during weekly team meetings for key workers to present case studies and practice presentations, which enabled the team to be exposed to different ways of working and promoted the sharing of skills and resources across the Partnership.

It would appear that partnerships recognised the challenge and engaged/ actively managed/ initiated process to develop a shared vision, ways of working together at a CEO Executive Leadership level as well as worker level.

8.4 Bringing organisations together

The Services Connect trial, by the nature of the Partnerships involving primary and supporting tiers of agencies, has been successful in bringing a large number of different organisations from across the community services sector around the table together. Key achievements identified through the evaluation include:

- Evidence of multiple examples where the Services Connect model has facilitated bringing together a large number of different organisations, often with complex histories, who would otherwise not work together, to develop a shared vision for delivery

- The level of support and commitment invested in setting up Partnerships and operationalising key elements of Services Connect

- Development of processes and systems for sharing resources, for example online ‘wiki’ team space

- Perceptions amongst stakeholders that progress has been made to breaking down silos within the sector

- High levels of cross sector collaboration, communication and information sharing

- Ongoing positive relationships between agencies, that one Partnership in particular intends to use as a catalyst for harnessing opportunities beyond the life of Services Connect

The literature suggests that the cultural aspect of integration is just as important as governance and targets, but emphasises that it can be difficult to achieve in the short to medium term. 261

As emphasised by several Partnerships, collaboration require significant investment in people’s time and cultural change does not happen quickly. In addition, it needs to be acknowledged that services are operating in a climate where some services have been re-commissioned (e.g. alcohol and other drugs) and where organisations are in a constant state of change 262 Other challenges identified through the course of the evaluation in relation to establishing and maintaining effective Partnerships included:

- The amount of time contributed by in kind/unfunded effort from group members in engaging and maintaining the Partnership has placed significant demands on the lead agency

- Defining roles and responsibilities between home agencies and the lead agency, particularly in relation to realigned staff can be a challenging process


262 Partnership H Quarterly report (Q3 2014/15)
Achievements and challenges

- Challenges working through historical relationships between agencies to create a new dynamic focussed on the Services Connect model
- Engaging partner agencies that do not have realigned staff and are not formally part of the governance structure, throughout the trial
- Over reliance on in-kind support to resource the Partnership, especially for partner agencies covering multiple catchments and in multiple Partnerships
- Maintaining momentum and attendance at governance meetings
- Ensuring ‘buy in’ and accountability from all agencies involved in the Partnership

A Partnership stakeholder commented that it would have been more appropriate to have “started smaller” then grown the size of the Partnership and therefore number of agencies involved over time. 263 Similarly, another Partnership stakeholder advocated for a ‘phasing up approach’ where the first year should be spent building and establishing relationships amongst the core organisations, with the expectation of providing the foundation for greater expansion in subsequent years.264

Within the Services Connect model there is a dual focus on building relationships at both the agency level and key worker level. As reflected by one stakeholder, a co-located model has necessitated the need to be mindful that key workers come from a broad range of disparate sectors and organisations with varying practices, cultures and expectations as well as individual assumptions and experiences. Deliberate and considered efforts were required to create a strong sense of team and purpose, with morning catch-ups arranged in order to:

- get to know each other
- explore the concept of Services Connect and reflect upon early experiences of working from a new perspective
- share experiences about previous ways of working and challenge assumptions
- present on key developments within each partner agency
- build on individual team member and partner agency expertise in order to create shared systems, processes and tools
- document new learnings at the beginning of an operating manual that can be continually refined and built upon.

According to the stakeholder, this has resulted in a profound transition from a group of individual workers to a Services Connect team. As described in their quarterly report, the team is a:

“dynamic, intrinsically motivated team who regularly have robust discussions, readily support their colleagues through difficult times, have a strong sense of ownership and who work with a shared purpose.” 265

One Partnership reported that inter-agency working has presented some challenges in terms of the different levels of risk assessment that individual key workers work to as well as the unique lens through which they view client’s needs. However, this diversity was also recognised as an opportunity which has facilitated access to a wide range of expertise across colleagues, as well as access to broader networks and information.

263 Partnership B (2016) Consultation
264 Partnership C (2016) Consultation
265 Partnership H Quarterly Report (Q1 2015/16)
8.5 Agency stability

The Blueprints for Violence Prevention initiative in the United States, found that a lack of agency stability (i.e. a high rate of staff turnover) had a critical impact on implementation quality by delaying implementation, or increasing caseloads for others, while new staff were hired and trained. Although all of the Services Connect Partnerships experienced staff turnover to some extent, it was more prevalent in some Partnerships than others. At the establishment workshop several participants highlighted the issue of staff turnover and the impact in terms of:

- reducing the capacity of the Partnership to provide a service to clients and meet targets
- increasing the capacity of other key workers or team members to cover the workload
- reduced staff morale
- additional time and resources needed to train new staff members and for SCIP on boarding.

As noted by one Partnership, Services Connect is highly vulnerable and business continuity is significantly disrupted when a staff member is absent for an extended period due to chronic illness, planned leave or resignation. This occurs because the staffing model has been set up in a way that:

- each of the leadership positions are unique and skill sets not easily transferable
- all staff have a high workload that cannot be easily absorbed by other team members
- key workers need to participate in nine core training sessions and be registered on SCIP to properly do their work

8.6 Staff skills

Another factor that enhances the quality of implementation emphasised in the literature is having staff with the requisite skills, experience and credentials for the job.

As reported in the quarterly reports, not all key workers were suited or equipped to work in the Services Connect model and testing environment, where change and evolution is inevitable and where systems are potentially quite different to in their home agency. According to one Partnership, where the Services Connect team has had an integral role in the recruitment process (for example, framing some of the interview questions, participating on the interview panel), this has resulted in much greater success in terms of the worker’s transition, their fit with the model and fit within the team. In addition, it was commented upon that the role that the home agency plays in supporting the key worker makes a significant difference to their success.

A risk identified by several Partnerships is that for full time key workers participating in a co-located model, there is a risk that over time workers will lose their specialist knowledge, linkages and skills associated with their home agency. They argue this would defeat the purpose of having a multi-disciplinary team and would potentially impact on the quality of client support and job satisfaction. There is also an added risk that if key workers return to their home agencies following a significant period in Services Connect that they may find it difficult to perform their role without significant re-training. In order to mitigate against this erosion of skills and professional knowledge, one Partnership suggests the following actions:

- Establishing guidelines and procedures for ensuring that all staff (particularly full time) are able to maintain connection with relevant people and places and that they are given ample opportunities for continuous learning and growth

267 Partnership H Quarterly Report (Q1 2015/16)
Achievements and challenges

- Building learning and development needs into individual work plans
- Holding portfolios for specialist knowledge, acting as a secondary consult for the team in their area of expertise
- Participating in home agency workshops, forums, training and development opportunities
- Retaining home agency email accounts and intranet links for information seeking
- Working from home agency on a periodic basis.

Partnerships consulted to date demonstrated clear difference in experiences in relation to realignment of workers. This prompts the question about the conditions under which realignment of workers is most effective. This will form a line of inquiry in a future report.

8.7 Training and capacity building

A strong, proactive package of training builds confidence and can help agencies overcome and even avoid many implementation barriers. According to DHHS, the mandatory training component was considered fundamental to the set-up of the trial and was supported by significant time and dollar investments. The evaluation uncovered feedback from across Partnerships that the opportunities for professional development, particularly amongst key workers, were significant and valued.

In terms of the mandatory training modules, although no processes were set up to gather comprehensive feedback from across the modules, anecdotal information gathered through the evaluation found that the training was generally perceived to be useful, informative and beneficial. However there appears to be some perceived variety in the quality of the training, appropriate pitch of some modules (particularly for those who have prior experience), and the time taken to complete the full range of mandatory training. Other examples of professional development identified included both formal and informal learning and skills and capacity building that took place through:

- work shadowing practices that allow for sharing of knowledge and expertise and 'learning the Services Connect model together'
- secondary consultations
- reflective practice sessions as part of team meetings or supervision sessions
- exposure to different specialisms and areas of expertise through working with key workers from a range of different backgrounds and exposure to different agencies
- working with clients on a range of goals, rather than just focusing on the key workers or agency’s own specialist area
- key workers jointly working on cases with multiple clients and high complexity
- drawing on experience of realigned health workers for clients presenting with mental and physical health issues

269 Partnership D Quarterly Report (Q3 2014/15)
270 Partnership D Quarterly Report (Q3 2014/15)
271 Partnership G Quarterly Report (Q3 2014/15)
272 Partnership G Quarterly Report (Q4 2014/15)
Achievements and challenges

Site visits to two co-located Partnerships identified that this type of model has resulted in a number of achievements in relation to knowledge enhancement and capacity building. Bringing staff with different backgrounds together at one location has created opportunities for:

- peer support
- professional sharing of knowledge and practice
- formal and informal secondary consultations for clients
- easier access to, and knowledge about, other agencies and services thereby reducing silos and breaking down barriers in the sector.

8.8 Technical infrastructure

Services Connect Interim Platform (SCIP)

Collection of client data has been identified by the Auditor General as a key area for improvement. SCIP was implemented in order to collect consistent quality data on clients and cases in the Services Connect trial.

A central challenge for any integrated service system is effective sharing of information. This is particularly challenging when the integration is occurring across a number of different organisations. This complexity is compounded when those different organisations operate in different sectors or fields, as in the case of Services Connect. For such a complex set of arrangements and relationships to work effectively, strong administrative support is crucial. 273

Recognising the need for an information sharing platform, the trial design included the development of the SCIP. This was intended as a platform for data storage, exchange and sharing across all organisations and practitioners. Issues with SCIP related both to what functions it could perform and ease of use.

Perceived challenges associated with the implementation of SCIP as reported by partnerships include:

- perceived mismatch between the nature of service delivery articulated by Services Connect model and SCIP requirements
- significant delays in registrations for SCIP, due to:
  - IT agreements having to be signed and staff needed to complete SCIP training before they could on-board
  - agencies not appointing a designated ‘organisation authority to sign off on the e-business portal to allow SCIP application access, or details were unknown or unavailable during critical sign off periods
  - issues with registration and on-boarding for new staff members
- issues recording clients on SCIP for ChildFirst referrals where the client is not aware of the referral
- issues recording clients on SCIP when the referral is via L17 process
- inability to accommodate initial crisis response for family violence clients
- issues related to use of Medicare number and DOB as identifiers

Achievements and challenges

- delivery model not supported by SCIP functionality – Static comprehensive needs assessment and Outcomes Star occurring too late in SCIP
- the algorithm takes into account the client’s ability to self-manage and engage but does not consider language and geographical barriers, which may impact on the amount of time that it takes to reach a goal

There has however been a general acknowledgement across Partnerships that SCIP is a ‘work in progress’. In addition, several examples of achievements associated with SCIP have been identified through the evaluation, including:

- Developing efficiencies in administrative tasks
- Being able to extract data in real time helps operational management such as allocations, compliance and data collection
- Ability to work flexibly from multiple locations, particularly partner agencies
- Improves and broadens access to client information
- Invoked practice change from reliance on paper based case notes
- DHHS responsiveness to partnership feedback and subsequent adjustment to SCIP to meet user requirements

Mobile devices

Ultrabooks and other mobile devices were cited by Partnerships as a successful element of Services Connect given that they constitute user friendly technology, integrate into existing IT systems, and according to some stakeholders have made practice more efficient. Ultrabooks have been used by key workers as a portable device to manage client files and support clients in the ownership of their information, as well as enabling key workers to support clients through accessing referral and other information that would not normally be available during home visits.

The use of mobile devices is important to key workers to being able to record case notes with clients. However, the practicalities of doing this continue to evolve as key workers encounter issues such as being able to complete a plan with a client in their home, but not being able to print it off as they do not have portable printers. Issues relating to privacy also arise as key workers work on SCIP with clients, the names of other client may come up during a search function. In addition, if an alert comes up on SCIP that the client sees, a worker needs to be open and transparent about the existence of an alert with that client. However, it was acknowledged that this promotes an honest, transparent, person centred approach to working with the client. Analysis by one Partnership found that anecdotally, it is estimated the portable IT provided to key workers saves approximately 2 hours out of a 7.6 hour day, 5 days per week. The ability to record case notes in real time while on or between client visits decreased the time required on each case, the worker kept up to date and the quality of case notes increased as they were not relying on memory once they are back in the office.

8.9 Ranking achievements and challenges

This chapter has described the overarching barriers and achievements related to the implementation of Services Connect. In order to determine the significance of the challenges that have been encountered, during a workshop targeted at partnership representatives who had been involved in establishment activities, the eight participants were asked to first discuss and then rank the most significant barriers and achievements experienced by their Partnership.

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274 Partnership E Quarterly report (Q1 2015/16)
275 Partnership A Quarterly report (Q2 2015/16)
The most significant achievements were reported to involve:

- **Collaboration** – across agencies, between different areas of practice, between people
- **Creativity** – that the trial offered the authority to be creative, think about novel ways to provide services, to be client centred and challenge conventional ways of working.
- **Client outcomes** – emphasised as outcomes ‘beyond the outcomes framework’, capacity building and widening access for more clients, and earlier intervention
- **Sharing and learning**, particularly cross-disciplinary learning and the opportunities created for professional development

Collation of findings reveals the most significant barriers to implementation to consist of:

- **Unrealistic and poorly defined targets**
- **Staffing issues**, particularly challenges in recruiting certain positions and issues of staff turnover
- **Ambitious scope for the trial model operating over a two year timeframe**
- **Level of practice change required**
9 Conclusions

This chapter summarises the key findings of the evaluation to date to draw a series of overall conclusions, and from these propose concluding observations. Next steps for the evaluation are also outlined.

9.1 Summary of key findings against the evaluation questions

What were the key activities undertaken by Partnerships to install the Services Connect trial?
What were Partnership perceptions of this process?

- The Services Connect trial involved significant effort during the initial months following signing of Service Agreement and MOUs.
- Many of the initial activities have extended beyond the installation phase and overlapped with service delivery. For example, staff recruitment, re-recruitment due to vacancies and the development of policies and procedures.
- It is reported that events in the broader context at the time impacted the level of guidance and support that DHHS was able to provide during this time.
- There is agreement across Partnerships that timeframes allocated were relatively insufficient for the extensive range of establishment activities requested.
- The transition to SCIP constituted a shift from traditional ways of working and Partnerships reported numerous challenges engaging with the technology. However, as reported by the Department it was responsive to feedback and sought to incorporate feedback into successive iterations.
- A further challenge has been the expectation that Partnerships design, develop and trial their own models. Whilst allowing Partnerships autonomy over their models, a co-design approach has required significant time and effort by Partnerships as it places the development, decision-making, delivery and accountability in their hands.
- Co-design is a relatively new approach for the sector, which necessitates a different skill set to the traditional service delivery role; and as such has been a steep learning curve and time-intensive process. Co-design is when you develop a new model in partnership with users, services providers and the funding body. In comparison Services Connect was a state-wide prescriptive model.

Are there any monitoring issues?

- Partnership targets related to the number of managed, guided and self-support cases were not finalised until May 2015, however progress is measured since the commencement of client support in February/March 2015.
- Several key stakeholders have questioned the appropriateness of the targets and how realistic they were to achieve within a trial environment. As suggested in the literature on program implementation, a more phased approach to targets would have been beneficial to take into account the different stages on implementation.
- Finalising the number of targets was related to the number of realigned workers each Partnerships undertook which varied. The bases of targets were outlined in the Advertised Call for Submission against an example for 7 full time equivalent workers. The numbers of cases were customised to each Partnerships once their staffing was finalised. Base line target counting commenced in February 2015. Closure targets were amended to commence from April 2015 as all partnerships showed closures from that month.
- Several Partnerships have reported that definitions related to key target groups (self-support, young people leaving care, clients at risk of entering care) took some time to be clarified and that this impacted on progress.
Has client support commenced and been implemented as intended?

- Client support commenced in each Partnership between February and March 2015
- Partnership performance in relation to quantitative targets, focused on the number of managed, guided and self-support cases and key cohorts, has fallen below expectation.
- However, the evaluation has identified significant ‘softer’ impacts and achievements related to implementation of practice principles such as client-centred and holistic practice and through one key worker removing the need for clients to re-tell their story multiple times.
- A key achievement of the trial has been the opportunities for professional development amongst key workers. Those who have participated in the evaluation to date were extremely positive about the opportunity that the trial has provided for broadening their knowledge of the service system and different agencies; engagement with different tools and processes (for example Outcomes Star, motivational interviewing and single-session working); and working with a variety of clients on a range of different goals.
- The key mechanisms that have enabled this key worker professional development to occur have been identified as: shadowing models; secondary consultations; joint case working for families with particularly complex needs; and formal and informal opportunities for reflective practice presented through team meetings, supervision and Partnership events.
- Two of the Partnerships visited to date operate co-located models, which were reported to be beneficial for developing relationships, support networks and knowledge exchange between key workers and providing access to "information at your fingertips".
- Services Connect is reflecting many of its intended practice principles through providing a responsive and holistic service focused on supporting clients to achieve their own defined goals. Although the extent to which the model can truly achieve its practice principles was questioned by some evaluation participants. For example trauma-informed approaches were reported to take many months of engagement work with a client, which does not necessarily fit with the length of support periods articulated within the model.
- While the evaluation has yet to undertake quantitative analysis of client outcomes, there is qualitative evidence to suggest that the ‘one key worker’ and ‘one plan’ aspects of the model have reduced the need for clients to re-tell their story multiple times to different case workers across multiple agencies.
- An identified strength of client support is the ability to deal with the whole family, rather than on client in isolation.
- A significant challenge associated with the delivery of client support is SCIP, which was reported to impact upon both recording client information and practice itself. Common concerns identified through the evaluation include that:
  - SCIP imposes a linear process for working with clients, which is not necessarily reflective of case work or the complexity of some clients’ lives. However this requires further investigation. The Services Connect practice framework comprises intake, assessment and client support. Within client support there is potential for issues raised to be managed and worked through with the client for example new challenges or risks.
  - In the early stages of implementation there were significant challenges in relation to client consent and concerns amongst Partnerships and clients that client information would be accessible to other agencies in general and Child Protection during out of hours services
  - Issues related to ease of use, functionality and DHHS responsiveness to technical issues
- The outcomes framework questions are perceived as being: inappropriate; not necessarily relevant; intrusive; deeply personal; too many in number and in many cases can induce feelings of anxiety amongst both key workers and clients.
- The evaluation gathered feedback from key workers and other Partnership staff that the model has been effective in facilitating client-centred approaches to service delivery, although the extent to which this has represented a shift from ‘business as usual’ is understood to be variable across agencies.
Has Integrated Access commenced and been implemented as intended?

- Processes for the design and implementation of Integrated Access have commenced and are still undergoing refinement.
- The process of co-design is relatively new for the sector and Partnership stakeholders commented on the value of the state wide Integrated Access Reference Group (IARG) as a key mechanism for facilitation, support and guidance. A key outcome from the IARG was the development of ten operating principles to underpin Integrated Access.
- Examples of innovative practice developed by Partnerships include key workers spending 1-2 days a week at Services Connect first tier and second tier agencies in order to: raise the profile of Services Connect; identify and begin client support with potential clients; and provide a seamless response.

What have been the key barriers to implementation?

In addition to those already mentioned, the evaluation has identified several key barriers as well as achievements during the implementation of the Services Connect trial. Examples barriers include:

- The ambitious scope of Services Connect in terms of the range of components and processes that are being tested. This has impacted the level of in-kind support required to facilitate the Partnership. While the evaluation found evidence of a significant commitment to the Services Connect trial amongst key personnel, it was reported by several participants that this level of investment is unsustainable over the long term. However, this broad scope was also viewed as an opportunity by participants to trial new ways of integrated working.
- Bringing multiple different organisations together as Partnerships was viewed as a challenge but also a key achievement of the trial. Several Partnerships have reported effective mechanisms that helped facilitate this process such as: regular meetings to establish a shared vision; Partnership governance group meetings; team meetings; and other opportunities for engaging in reflective practice.
- All Partnerships have experienced issues with staff recruitment and attrition however this was more significant in some Partnerships than others. Having vacant positions were described by stakeholders as a key impact on the capacity of the Partnership Following recruitment, significant time and effort was spent inducting, training and on-boarding new staff.
- SCIP has presented several key challenges in terms of staff on-boarding, functionality and resolution of issues. Whilst it has been acknowledged by Partnerships that SCIP is a work in progress, it has also been a source of frustration impacting the trial.

What have been the key achievements or areas of innovation?

The Services Connect trial brings with it a focus on innovation and a culture of learning, flexibility and adaptation in its delivery. The trial provides an opportunity to trial new approaches to working integrated working between agencies in the community sector. The shift away from funding tied to defined service specifications was intended to encourage responsiveness and adaptation of the model as learnings emerge. Preliminary achievements the evaluation has identified include perceptions amongst stakeholders about:

- Progress towards interagency working and breaking down silos
- Enhancing practice and client support
- The effectiveness of one key worker and one plan in removing the need for a client to tell their story multiple times and supporting them to navigate the service system
- The opportunities for reflective practice
- Improved relationships between agencies in the sector
- Enabling a client to have access to all networks within a Partnership without barriers
- The development of co-design approaches between the Department and Partnerships as a relatively new concept for the sector.
9.2 Preliminary observations

Despite the early stages of the evaluation, the following four observations about the Services Connect trial can be made:

- Services Connect represents an ambitious trial that has yielded successes, but has not been without its challenges.

- The Services Connect trial has involved significant commitment and engagement across participants in the community services sector in trialling new approaches to integrated working.

- Services Connect has included a variety of capacity building opportunities at both the agency and individual worker level, which appear to have been of significant value.

- Services Connect is complex and realising the full potential of the model was an inevitable challenge given the time-limited nature of the trial.

An ambitious trial yielding significant successes, but not without challenges

The two-year Services Connect trial represents an ambitious transformational change program. It has set out to change ways of working, culture and service delivery, as well as embed new organisational, technical and practice structures. The scope of the trial was significant, given the range of components to be tested. Services Connect was designed as a state-wide model with Partnerships responsible for designing their own implementation approach – how to establish staff support, staff locations and approaches to key client cohorts. Through previous work undertaken on Services Connect Departmental lead sites, the Department developed insights directly relevant to the current trial. The community sector agencies involved in the trial did not have the benefit of these learnings and were therefore engaging in the trial from a different starting point.

Data gathered as part of the evaluation has painted a picture of achievements and challenges that would not be unfamiliar to those who have attempted to bring about transformational change in allied areas in the past.

The trial has made progress towards developing a new and more integrated approach to support a wide range of vulnerable clients. This has been achieved at a time of significant change in the external policy environment. However, the challenges encountered should not be underestimated.

It is notable that, despite challenges in the initial stages of implementation related to the amount of effort required within constrained timelines and events in the broader context external to the, all eight Partnerships began taking clients between February and March 2015. Key service components such as client support appear to be broadly working as intended, although Partnership performance in relation to targets has failed to meet expectations.

However, within a trial environment an overarching focus on meeting quantitative targets risks concealing ‘softer’ yet significant impacts that are occurring such as improved professional relationships. As emphasised by McNulty and Ferlie (2002), an over focus on pilot targets can prove unhelpful if participants perceive not meeting targets to be a ‘failure’ rather than an inevitable state of affairs, particularly during the early stages of implementation.

As reflected in program implementation literature, implementation of any new model, particularly one involving the roll out of new technology, can be expected to encounter some challenges. Within Services Connect SCIP reflects a new way of working for the sector and there have been documented challenges in harmonising the aspirations of the client support model with the methods of recording client data and assessing client need via SCIP. There have also been numerous reports of significant issues with accessing SCIP and its functionality. DHHS has taken this feedback on board and sought to remedy issues through successive SCIP updates. The platform remains a work in progress. It is worth noting that the construction of an electronic integrated client record management system that has been purpose built for a trial is rare.

The completeness and accuracy of SCIP data are issues that make it difficult to reach conclusions at this stage about practice in key areas such as client outcomes. This is largely driven by the quality of data entry. The process component of the evaluation has relied heavily on document review for this report, supplemented by visits to three out of the eight Partnerships. Visiting the remaining five Partnership will enable us to explore in
more detail variations between Partnerships and to gather more information and ‘on the ground perspectives’ about how aspects of the model, in particular client support, are implemented. Information included in documents is limited. Further qualitative research in these areas will provide for greater certainty and explanation in assessing the implementation of the model and ultimately understanding the pattern of client outcomes.

Given that the Services Connect will conclude in October 2016, it is now important to situate the trial within the larger context of integrated service delivery. In this respect, it has played an important role in testing components intended to facilitate more integrated approaches, in particular:

- bringing together multiple different agencies as Partnerships with specific governance structures
- the multi-disciplinary key worker role
- client support model
- SCIP
- integrated access.

Moving forward there is an opportunity for the Department and the sector as a whole to retrieve, capitalise and harvest the foundations of integrated service delivery established through the Services Connect trial. This includes consideration of the lessons learnt, elements to replicate and processes to avoid in order for integrated approaches to be further developed and refined so clients and their families can be supported to achieve their goals.

**Demonstrable commitment and engagement across the community services sector with integrated working**

There has been a high level of commitment and investment across the community services sector agencies involved in the trial to embrace new and more integrated ways of working and agencies have demonstrated preparedness to work with the Department on this reform. It has also garnered a real willingness amongst agencies to embrace and participate within a trial environment and all this entails, such as: engaging in reflective practice; implementing components within sometimes uncertain contexts; processes of co-design and innovation; appropriately refining aspects to suit local contexts; and ongoing refinement and re-testing.

A clear message from program implementation literature is that there is no accepted ‘single approach’ to integration and that initiatives must be built to suit the local context and match the concerns of the local area. This first evaluation report has identified some differences between Partnerships in terms of their approaches to implementing the model (for example co-located, connected and dispersed models; processes for re-aligning key workers and recruitment; and approaches to integrated access). The second evaluation report will focus on drawing out the implications of these variations, particularly in relation to client outcomes and benefits for the sector.

**Capacity building activities appear to be yielding benefits**

The interagency approach trialled through Services Connect appears to have generated significant benefits across all levels of the sector in terms of: providing a strategic opportunity to participate in interagency working, which is rapidly gaining prominence within the sector; strengthening knowledge of service and information flows between agencies; reducing silos between agencies; mandating a greater sharing of skills and expertise to enhance approaches to client support; and facilitating significant professional development and capacity building amongst key workers.

**Realising the full potential of the model was an inevitable challenge given the time-limited nature of the trial**

The key overarching challenge is the constrained timeframe for the trial of two years. Based on findings from the evaluation and good practice identified in the literature, the evaluation concludes that while some achievements have been made, the two year time frame was insufficient for the full potential of the model to be realised.
Outcome measures

This is particularly relevant within the context of co-design, or the expectation that Partnerships develop their own approach of the state-wide model being tested whilst allowing Partnerships autonomy over their implementation.

Co-design is a relatively new approach for the sector, which necessitates a different skill set to the traditional service delivery role and as such has been a steep learning curve for Partnership staff and, unsurprisingly, time-intensive. In light of this there is a need to support participants’ in developing the necessary skill sets.

**Recommendations**

On the basis of these preliminary findings and conclusions we suggest the following recommendations to inform any future roll out of models of integrated service delivery. The recommendations broadly support the key features of the Services Connect approach to maximise outcomes for the service sector and for clients and their families.

**Recommendations related to establishment activities**

As confirmed in program implementation literature, the foundations of any program need to be: considered; rolled out incrementally; and allocated sufficient time to bed in before any benefits or innovation is realised. Bertram et al. (2011) recommend four stages of implementation over a four year timeline, namely: exploration; installation; initial implementation; and full implementation. Whilst it may not be feasible for all new programs to run over a four year timeframe, the application of a staged approach may help in structuring implementation processes and stakeholder expectations.

It is recommended that:

- Implementation strategies involve realistic timeframes for installation activities to avoid delays in service delivery and limit inappropriate overlap between installation activities and program implementation activities.

- Given co-design processes may be relatively new to the individuals and agencies involved, there is a need to support participants in developing the necessary skills sets, which may differ to those of regular service delivery.

- Consideration be given to the timing of the installation process, taking into account external events to enable a sufficient level of support, guidance and availability of key implementation staff within government.

**Recommendations to enhance and support future Partnership working**

- Within the context of the Family Violence Royal Commission recommendations and the Roadmap for Reform, it is recommended that Partnerships continue to work on relationship building at a local level and consider structured or systematic approaches. For example through: joint ventures; development of strategic plans; periodic meetings; and shared professional development forums to further develop, refine and sustain Partnership relations beyond the Services Connect trial.

- Realignment of key workers is one of the core foundations of the Services Connect trial and has created achievements in relation to: facilitating referral pathways; sharing of specialist expertise; and raising the profile of Services Connect within home agencies. However, any future processes which require re-aligning staff need take due account of:
  
  - the willingness and suitability of staff being re-aligned (skills, qualifications, level of experience, motivations)
  
  - methods for ensuring key workers within a co-located model are able to retain contact with their home agency to ensure they are kept up to date with professional developments in their area of specialism and to ensure they retain their specialist knowledge
  
  - variations in policies and procedures between home agencies and new Partnerships, for example related to health and safety, performance management and supervision
Outcome measures

- the impact of the loss of a re-aligned resource for the home agency and on the capacity of the organisation to continue to meet unchanged demand. A reduction in targets may not necessarily be adequate compensation to deal with the re-alignment of a worker.

**Recommendations to inform the roll out of new technology**

Feedback in relation to SCIP remains mixed; whilst some Partnerships view it as a positive enabler of their role, others feel it represents too structured a process and may not adequately capture and respond to clients with multiple and complex needs. It is also worth noting that when the department and Partnerships undertook SCIP case audits, practices were identified that strayed from the model.

While a balanced view is required that appropriately distinguishes between limitations of new technology that is being trialled and gaps that might be uncovered in worker capacity, it is recommended that future roll out of information technology platforms need to ensure:

- Smooth registration and on-boarding processes for users
- When updates are implemented (as is expected within a trial environment), users are provided with sufficient advice and guidance about the nature and implications of the change
- Releases and development of the product are iterative and responsive to feedback from users (as was reported by DHHS to have occurred during the Services Connect trial)
- Responsive and timely feedback and resolution of issues
- Adequate support from a dedicated help desk
- IT systems replicate or complement the model that is being implemented.

**Recommendations to inform performance and monitoring**

In relation to setting up and implementing processes for performance and monitoring, care should be taken to ensure:

- Transparency in the method for calculating targets and key definitions associated with targets are clear, transparent and understood from the outset
- Consideration of local context
- Targets are set that are realistic taking account of the length of time required for establishment and implementation activities
- Monitoring processes are not too onerous and designed to collect meaningful data which can be fed back to Partnerships as part of a regular and rigorous performance process
- An appropriate balance between ‘hard’ impacts such as targets and softer impacts such as identifying where and how areas of practice can be further developed or refined, particularly within a trial environment.
**Next steps for the evaluation**

Data collection and analysis as part of this first evaluation report has identified the following lines of inquiry or implications that will be further investigated in more detail through the remaining two reports:

- Understanding the impact of local context on the implementation of the Services Connect trial, particularly differences between urban and rural areas, the nature of the client cohorts, and services already operating in the area

- Investigating the strengths and challenges associated with the three types of Services Connect Partnership model – co-located, connected and dispersed

- Examining in more detail the key mechanisms associated with implementing client support from the key worker ‘on the ground’ perspective.

- Examining Partnerships’ perceptions of the appropriateness of Services Connect for clients experiencing family violence. Through discussions with DHHS, up to two Partnership sites will be selected in which to explore in more detail how responses to family violence are being coordinated. Findings will be written up as high level case studies.

- The second and third evaluation reports will include analysis of:
  - a SCIP extract (to be extracted June 2016) that will be used to determine impact of the Services Connect trial on client outcomes
  - a data linkage exercise (facilitated by the Victorian Data Linkages (VDL) matching, at a client level, SCIP data with data from other DHHS and government databases in order to profile the client cohort and as far as possible demonstrate the role and impact of the Services Connect trial.

This exercise, while potentially informative, is limited by the extent to which data can be successfully linked and processed within the timeframe of the evaluation. Moreover, and perhaps more importantly, the usable sample obtained from SCIP is relatively limited in terms of time and content. Nonetheless, it represents a major advance in the way in which evaluations are conducted in Victoria and it raises the possibility of employing these methods with more frequency in the future.

The final databases that will be linked are in the process of being finalised with data custodians. However a list of possible linkages being explored for feasibility is out in Table 10 below. Inclusion will depend on permission from the custodians, likelihood of having a good linkage, timing of permissions, and timing of linkage through VDL. Quality of the analysis will also depend on the linkage, content of the datasets, usability of the files received from the custodians through VDL, and the sample size of the base file in SCIP:

<table>
<thead>
<tr>
<th>Database</th>
<th>Program area</th>
<th>Data custodian</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRIS</td>
<td>Child protection, OoHC, Youth Justice, Disability</td>
<td>DHHS</td>
</tr>
<tr>
<td>IRIS</td>
<td>Family Services, Child FIRST, Family Violence Services, Sexual Assault Services, Cradle to Kinder, Stronger Families, Parenting Support Services</td>
<td>DHHS</td>
</tr>
<tr>
<td>HiiP</td>
<td>Public Housing</td>
<td>DHHS</td>
</tr>
<tr>
<td>CRISSP</td>
<td>CSO delivered OoHC, Families First &amp; other placement support services, Disability and Youth Justice</td>
<td>DHHS</td>
</tr>
<tr>
<td>VEMD</td>
<td>Hospital Emergency Department Services</td>
<td>DHHS</td>
</tr>
<tr>
<td>LEAP</td>
<td>Police data</td>
<td>Vic Pol</td>
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</tbody>
</table>
## Outcome measures

<table>
<thead>
<tr>
<th>Database</th>
<th>Program area</th>
<th>Data custodian</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADIS</td>
<td>Alcohol and other Drugs services</td>
<td>DHHS</td>
</tr>
<tr>
<td>PDRSS</td>
<td>Mental health support services</td>
<td>DHHS</td>
</tr>
<tr>
<td>ODS/CMI</td>
<td>Clinical Mental health services</td>
<td>DHHS</td>
</tr>
<tr>
<td>QDC (MCHSS, HACC, DSD)</td>
<td>Mental health services, Disability services, Home and community care</td>
<td>DHHS</td>
</tr>
<tr>
<td>VAED</td>
<td>Hospital presentations/admissions</td>
<td>DHHS</td>
</tr>
<tr>
<td>Courts/Magistrates database</td>
<td></td>
<td>Court Services Victoria</td>
</tr>
<tr>
<td>TRIM Critical incidents</td>
<td></td>
<td>DHHS</td>
</tr>
</tbody>
</table>
Appendices

Appendix A  Outcome measures  87
Appendix B  Sample outcome questions  89
Appendix C  Quality review key elements and descriptions  91
## Appendix A  Outcome measures

### Outcome areas, indicators and what DHHS is attempting to measure

<table>
<thead>
<tr>
<th>Outcome area</th>
<th>Outcome indicator</th>
<th>What DHHS are trying to capture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Suitable housing</td>
<td>Suitability and appropriateness of housing conditions including overcrowding, living conditions and location</td>
</tr>
<tr>
<td></td>
<td>Stable housing</td>
<td>Stability and affordability of current living arrangements including security of housing tenure.</td>
</tr>
<tr>
<td>Work and meaningful use of time</td>
<td>Engagement in meaningful activity</td>
<td>Extent of engagement in paid employment</td>
</tr>
<tr>
<td></td>
<td>Engagement in the labour market</td>
<td>Outside of paid employment, extent of engagement in meaningful activity that may contribute to a range of economic, social, health and wellbeing outcomes</td>
</tr>
<tr>
<td>Learning and development</td>
<td>Early childhood development</td>
<td>Early childhood development and overall wellbeing including indications of future health, development and wellbeing</td>
</tr>
<tr>
<td></td>
<td>School achievement</td>
<td>School achievement and participation including school attendance, learning difficulties and educational stability</td>
</tr>
<tr>
<td></td>
<td>Post compulsory learning</td>
<td>Extent of engagement in learning and achievement outside of the formal primary or secondary environment</td>
</tr>
<tr>
<td></td>
<td>Independent living skills</td>
<td>Ability to function and live independently and whether additional support is required</td>
</tr>
<tr>
<td>Culture and social wellbeing</td>
<td>Family and relationships</td>
<td>Extent of quality relationships including family, cultural and social connections</td>
</tr>
<tr>
<td></td>
<td>Sense of place and belonging</td>
<td>Connectedness and belonging to cultural and spiritual communities including engagement in relevant cultural events and activities</td>
</tr>
<tr>
<td></td>
<td>Social involvement</td>
<td>Extent of involvement in social and recreational activities</td>
</tr>
<tr>
<td>Health</td>
<td>Mental health</td>
<td>Mental health and wellbeing including factors that may affect state of mental health</td>
</tr>
<tr>
<td></td>
<td>Physical health</td>
<td>Physical health and wellbeing including factors that may affect state of physical health</td>
</tr>
<tr>
<td>Safety</td>
<td>Abuse and neglect</td>
<td>Existence and extent of abuse and neglect including child and elder abuse, physical, sexual and financial abuse and neglect</td>
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<tr>
<td></td>
<td>Family violence</td>
<td>Existence and extent of family violence</td>
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<tr>
<td></td>
<td>Injury</td>
<td>Extent of injury including self-harm and physical abuse</td>
</tr>
<tr>
<td></td>
<td>Safe environment</td>
<td>Existence of abuse, bullying, violence, coercion or exploitation inside and outside the home.</td>
</tr>
<tr>
<td>Behaviours</td>
<td>Alcohol and other</td>
<td>Alcohol and drug consumption including impact and risks</td>
</tr>
<tr>
<td>Outcome area</td>
<td>Outcome indicator</td>
<td>What DHHS are trying to capture</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>drug use</td>
<td></td>
<td>of alcohol and drug use</td>
</tr>
<tr>
<td>Sexual risk</td>
<td></td>
<td>Sexual exploitation, sexual assault and abuse including autonomy of decision making and consent</td>
</tr>
<tr>
<td>Financial stability</td>
<td></td>
<td>Level of financial stability and extent of financial security</td>
</tr>
<tr>
<td>Gambling</td>
<td></td>
<td>Extent and impact of gambling</td>
</tr>
<tr>
<td>Offending</td>
<td></td>
<td>Levels and patterns of offending behaviours</td>
</tr>
</tbody>
</table>

Source: DHHS (March 2015) Outcomes Framework: How to track outcomes
### Appendix B  Sample outcome questions

<table>
<thead>
<tr>
<th>Outcome Indicator</th>
<th>Questions for capture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable Housing</td>
<td>Do you currently have enough bedrooms for your household members?</td>
</tr>
<tr>
<td></td>
<td>If you live in a rooming house, aged care facility or other congregate living arrangement other than a family home, do you have access to a private bathroom?</td>
</tr>
<tr>
<td></td>
<td>If there is a person in the house who has additional needs due to health or disability, does your housing have all the required facilities?</td>
</tr>
<tr>
<td></td>
<td>Is your housing well located for your needs?</td>
</tr>
<tr>
<td></td>
<td>Is your housing more expensive than you can reasonably afford?</td>
</tr>
<tr>
<td>Stable Housing</td>
<td>Are you currently homeless?</td>
</tr>
<tr>
<td></td>
<td>If you are currently homeless, which of the following best describes your situation? (If more than one is applicable, select the most recent or relevant).</td>
</tr>
<tr>
<td></td>
<td>Do you have a housing/lease agreement of 12 months or more?</td>
</tr>
<tr>
<td></td>
<td>Can you stay in your current housing for as long as you like?</td>
</tr>
<tr>
<td></td>
<td>How many times have you moved in the last 12 months?</td>
</tr>
<tr>
<td></td>
<td>If you have moved in the last 12 months, in which month was your last move?</td>
</tr>
<tr>
<td></td>
<td>How many weeks of rent do you owe?</td>
</tr>
<tr>
<td></td>
<td>If you owe one or more weeks of rent, what is your weekly rent?</td>
</tr>
<tr>
<td>Engagement in the labour market</td>
<td>What is your employment status?</td>
</tr>
<tr>
<td></td>
<td>Would you prefer to work more than you currently do?</td>
</tr>
<tr>
<td>Engagement in meaningful activity</td>
<td>Which of the following activities do you regularly engage in? (select all that apply)</td>
</tr>
<tr>
<td>Early childhood development</td>
<td>How many times per week are the children in the household read to?</td>
</tr>
<tr>
<td></td>
<td>Does the young person attend a government approved early childhood education and care service?</td>
</tr>
<tr>
<td></td>
<td>Is the young person currently enrolled in school, including Vocational Education and Training (VET)?</td>
</tr>
<tr>
<td></td>
<td>If the young person is currently enrolled in school (including VET), how many days per week does he/she attend?</td>
</tr>
<tr>
<td></td>
<td>During the previous four weeks of school, how many days has the young person been absent for any reason?</td>
</tr>
<tr>
<td></td>
<td>How many reports have been unsatisfactory over the last 12 months?</td>
</tr>
<tr>
<td></td>
<td>Has the young person’s school contacted you with concerns about their</td>
</tr>
<tr>
<td>Outcome Indicator</td>
<td>Questions for capture</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>performance or behaviour in the last 12 months?</td>
</tr>
<tr>
<td></td>
<td>Has the young person had difficulty progressing from one school year to another in the last 12 months?</td>
</tr>
<tr>
<td></td>
<td>If the young person has been excluded from school in the last 12 months, how many times has this occurred?</td>
</tr>
<tr>
<td></td>
<td>Has the young person been excluded from school in the last 12 months?</td>
</tr>
</tbody>
</table>
### Appendix C  Quality review key elements and descriptions

**NB – Indicative responses included for illustrative purposes**

<table>
<thead>
<tr>
<th>Key Element</th>
<th>Descriptor</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1: Desktop review</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>1 Referral pathways to Services Connect allowed for a timely response to the initial referral.</td>
<td>Met/Not Met</td>
<td>Not possible to meet this function as case was created prior to SCIP release 5.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referring program made client aware of the referral.</td>
<td>(Ie Pre SCIP Release 5</td>
<td>Not possible to meet this function as case was created prior to SCIP release 5. No referral details recorded as case was created prior to SCIP release 5. Comprehensive client information is recorded within the referral form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent conversation, or written consent, was recorded in ‘Notes &amp; Docs’.</td>
<td>Met</td>
<td>Consent form attached.</td>
<td></td>
</tr>
<tr>
<td>Medicare number was recorded.</td>
<td>Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrer was advised of acceptance of referral.</td>
<td>Met</td>
<td>Acknowledged the day following. Case accepted within a week of referral and referrer advised.</td>
<td></td>
</tr>
<tr>
<td>All intake actions were reflected clearly in Notes &amp; Docs.</td>
<td>Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenting needs captured clearly, and reflected in relevant ‘Strengths &amp; Challenges’ area.</td>
<td>Pre SCIP Release 5</td>
<td>Not possible to meet this function as case was created prior to SCIP release 5.</td>
<td></td>
</tr>
<tr>
<td><strong>Needs identification</strong></td>
<td>Alerts descriptions are clear and functional</td>
<td>N/A</td>
<td>No alerts recorded. Assumed to be no relevant alerts.</td>
</tr>
<tr>
<td></td>
<td>All relevant case contacts are recorded in ‘Associated People’.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work was undertaken with multiple family members where appropriate</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All other Services involved, any relevant pre-existing plans, and any relevant assessments are recorded in ‘Services &amp; Assessments’</td>
<td>Not Met</td>
<td>School contact and APM performance services should have been recorded in Services and Assessments.</td>
</tr>
<tr>
<td></td>
<td>Any known orders or sentences have been recorded in ‘Orders &amp; Sentences’</td>
<td>Met</td>
<td>No orders or sentences recorded. Assumed to be no relevant orders or sentences.</td>
</tr>
<tr>
<td>Key Element</td>
<td>Descriptor</td>
<td>Response</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Strengths and challenges have been considered individually, and recorded against all individuals in the case.</td>
<td>Met</td>
<td>Extremely comprehensive information recorded on individual needs.</td>
</tr>
<tr>
<td></td>
<td>Strengths and challenges are not described as needs</td>
<td>Met</td>
<td>Extremely comprehensive information recorded on individual needs.</td>
</tr>
<tr>
<td></td>
<td>Individual Needs descriptions are clear and functional</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Case notes contain an accurate record of all contact in the case, and are reflected in a meaningful chronological order of events, written in concise objective language.</td>
<td>Met</td>
<td>Notes are very regular and specific.</td>
</tr>
<tr>
<td></td>
<td>Needs Identification was completed within 2 weeks of the case being allocated</td>
<td>Pre SCIP Release 5</td>
<td>Could not be determined due to this data not being captured pre SCIP release 5. There were many delays in making contact and with many cancelled appointments with the client before engagement was regular and stable.</td>
</tr>
<tr>
<td>Planning</td>
<td>Any existing plans were considered and incorporated into the Services Connect plan</td>
<td>Pre SCIP Release 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Outcomes Star was completed as part of the planning process, and redone during the review of the plan.</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The long term goal reflects the client(s) aspirational hopes in their own words</td>
<td>Met</td>
<td>Written in first person and clearly reflects client goals.</td>
</tr>
<tr>
<td></td>
<td>The short term goals are clearly described, achievable and measurable.</td>
<td>Met</td>
<td>Goals are tangible and specific.</td>
</tr>
<tr>
<td></td>
<td>All actions are attributed to the appropriate individual and clearly outline their responsibility</td>
<td>Met</td>
<td>Actions are clear. Actions are somewhat blended between what the client can take responsibility for and what the worker is responsible for.</td>
</tr>
<tr>
<td></td>
<td>The goals set align with the prioritised needs of the client group</td>
<td>Met</td>
<td>Goals reflect needs priority.</td>
</tr>
<tr>
<td></td>
<td>Potential challenges and strategies to manage challenges identified and recorded</td>
<td>Not Met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan was completed within 30 days of the commencement of the Client Support stage</td>
<td>Not Met</td>
<td>Approximately 3 weeks later than the 30 day period.</td>
</tr>
<tr>
<td>Key Element</td>
<td>Descriptor</td>
<td>Response</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>The client received a copy of the plan</td>
<td>Not Met</td>
<td>Notes reflected that the worker and client discussed the plan but not confirming that the plan was actually provided.</td>
<td></td>
</tr>
<tr>
<td>The plan was reviewed within a 3 month period and subsequent versions reflected any progress made and new goals/actions set</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Closure</strong></td>
<td>Closure summary gives a clear description of the reason for referral, the support provided, and the reasons for closure.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Closure letters were provided to the client and the referrer</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The client was adequately prepared for closure.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reason for closure matches with the recorded outcomes of the case</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Data Collection</strong></td>
<td>The answers to entry and exit measure questions align with other information in the case</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have demographics questions been answered with a value other than 'information not provided'</td>
<td>Not Met</td>
<td>A strategy has been applied to correct this is making available the list of data collection questions that need to be asked. These questions are not always in keeping with the flow and nature of the conversation with the client.</td>
</tr>
</tbody>
</table>

**Section 2: Worker**

<table>
<thead>
<tr>
<th>Practice Principles (to be discussed with worker)</th>
<th>Worker discussed self-management aspirations and planned with the client(s) for greater independence from the outset of the case</th>
<th>Met</th>
<th>Discussions undertaken with client regarding actions, responsibilities, boundaries and preparing for independence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The grouping of clients was both safe and beneficial to all clients in the case</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Worker employed a strengths based approach to their practice</td>
<td>Met</td>
<td>Key Worker is focused on building upon client’s existing strengths &amp; building confidence</td>
</tr>
<tr>
<td></td>
<td>The client(s) were involved in key meetings about decisions and planning whenever possible</td>
<td>Met</td>
<td>Client involved in all decision making</td>
</tr>
<tr>
<td></td>
<td>Strong links were made with community and other support services</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate cultural awareness for</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
## Quality review key elements and descriptions

<table>
<thead>
<tr>
<th>Key Element</th>
<th>Descriptor</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>the client group is demonstrated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant guidelines and materials were accessed</td>
<td></td>
<td>Met</td>
<td><strong>Key Worker referred to relevant practice guidelines and materials</strong></td>
</tr>
<tr>
<td>Vulnerable individuals within the case were given appropriate focus</td>
<td></td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Skill development was considered/offered to build capacity when appropriate</td>
<td></td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>In cases where risk to safety was identified, the ‘restricted client’ function was considered/used</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Do you feel the model is working?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel that Services Connect allows you to work in a different way? If so how?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: DHHS (2015) Partnership G Quality Review October 2015. Please note 5 Quality Reviews were provided to the Evaluators, all of which being from October 2015.