Delivering quality care more efficiently inquiry

Questionnaire response 87

Name: Flinders University

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an organisation that provides or coordinates care services

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Aged care; Disability; Early childhood education and care; Health; Veterans

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   To a great extent

2. What are the reasons for your answer?

   Early Childhood
   Differences in regulatory frameworks across jurisdictions and sectors create complexity for early childhood providers. For example, duplicative requirements for worker screening and inconsistent standards for early intervention services hinder cross-sector (i.e. early childhood education and care, education, health, disability, social services) collaboration. Aligning regulations could streamline compliance and improve service integration, especially for children with complex needs.
   Recommendation: Develop a unified national framework for early childhood care quality standards that aligns with disability and health sectors, enabling smoother transitions for children with developmental delays or disabilities.

   Disability
   The disability sector, particularly under the NDIS, faces significant regulatory fragmentation. Providers often navigate multiple audits and reporting systems, which increases administrative burden and reduces time spent on care. This complexity can deter smaller providers and limit service availability.
   Recommendation: Harmonize provider registration and audit processes across NDIS, aged care, and health sectors. Introduce mutual recognition of compliance credentials to reduce duplication and improve provider flexibility.

   Aged Care
   Aged care providers face overlapping regulations from the Aged Care Quality and Safety Commission and state health departments. This leads to inefficiencies and confusion, particularly for providers offering services across aged care and disability sectors.

Recommendation: Establish a cross-sector regulatory taskforce to align safety and quality standards, focusing on shared workforce screening, incident reporting, and care planning protocols.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

To a great extent

4. What are the reasons for your answer?

Alignment of quality and safety regulations across the different sectors of the Care Economy reflects a growing recognition that fragmentation across early childhood, disability, and health sectors can impede both service effectiveness and user experience. Greater alignment presents an opportunity to improve continuity of care, reduce administrative burden, and ensure equitable standards for safety and quality across services and jurisdictions.
Areas with Potential for Alignment

Workforce Qualifications and Screening
All Care Economy sectors require staff who are skilled, vetted, and safe to work with vulnerable populations. However, different standards and checks (e.g., Working With Children Checks, NDIS Worker Screening, healthcare credentialing) exist. A unified, portable clearance system and shared professional standards for core roles (e.g., care coordinators, support workers) would simplify recruitment and increase workforce mobility.

Incident Reporting and Risk Management
Early childhood, disability, and health services all require systems for reporting incidents and managing risks, yet these are often siloed and sector-specific. A harmonised, tiered reporting framework—integrated into digital case management systems—could streamline oversight and facilitate cross-sector learning about safety events and best practices.

Person-Centred Planning and Outcomes Monitoring
Each sector uses distinct tools and processes to plan, monitor, and evaluate outcomes. Alignment of outcome domains (e.g., wellbeing, participation, development) and standardised use of tools like the WHO ICF framework could help integrate care across settings and enable shared accountability.

Monitoring and Accountability Mechanisms
While policy direction is often nationally coordinated, variation between jurisdictions in resourcing, implementation timelines, and auditing practices leads to inconsistencies in quality and outcomes. There is strong potential to harmonise these mechanisms through the establishment of a national care economy coordination body with responsibility for setting baseline expectations, aligning monitoring tools, and overseeing audit practices across states and sectors. This body could promote standardisation while allowing for local adaptation, helping to reduce duplication and variability in regulatory burden.

Opportunities, Benefits, Costs and Risks
Improved Continuity of Care: Families and individuals who navigate across sectors—such as a child with developmental delay or a parent managing chronic illness—would benefit from consistent expectations and a unified care approach.

Efficiency and Workforce Flexibility: Providers operating across multiple sectors could reduce duplicated training and compliance efforts, while workers could shift roles more easily in response to workforce shortages.
Shared Learning and System Improvement: A common regulatory language would enable better data sharing, benchmarking, and policy development across sectors and jurisdictions.
Implementation Burden: Aligning regulations would require significant consultation, systems upgrades, and transitional support for providers, especially smaller organisations.
Loss of Sector-Specific Nuance: Uniformity risks overlooking the unique needs and contexts of different populations—for instance, the developmental focus of early childhood or the rights-based framing of disability services.

Recommendations:
Establish a National Care Quality Framework with core principles and a modular structure that allows sectors to adapt to relevant policy context and sector specifics while maintaining consistency.
Pilot cross-sector regulatory alignment in integrated service settings (e.g., Child and Family Centres, Local Health Networks) to test and refine shared models.
Invest in interoperable digital systems that support aligned reporting, credentialing, and outcome measurement across sectors.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

Early Childhood
Collaborative commissioning in early childhood is underutilized, possibly based on the assumption that early identification and intervention to support child development primarily sits under community health. To ensure Australian children get a healthy start to life, regular health and development screening that refers seamlessly into early intervention and, where necessary, intensive support requires the mutual responsibility of multiple care economy touchpoints from pregnancy to school entry and beyond. Current siloed funding and governance structures hinder coordinated care. Collaborative commissioning is a mechanism to ensure that most (>80%) of children complete developmental checks across the first 5 years of life. To achieve this reach requires the collective efforts across primary and community health, early childhood, social services, disability.
Recommendation: Pilot collaborative commissioning models involving early childhood education providers, child health services, and family support agencies. Use Primary Health Networks (PHNs) or Community health as conveners to align services around child development outcomes, through a hub and spoke model out to early childhood and education care, preschool as well as disability and social services.

Aged Care
Older Australians often require services across aged care, health, and disability systems. Collaborative commissioning can reduce hospital admissions and improve continuity of care.
Recommendation: Expand integrated care trials that include aged care providers, PHNs, and ACCHOs. Focus on shared care planning, pooled funding, and outcome-based

contracts to support ageing in place.

Health
Mental health service fragmentation is a significant problem in Australia that affects the ability of consumers (and providers) to navigate the system and ensure access to the right care at the right time. Similarly, navigating across health, social and community services is incredibly complex and can lead to over-reliance on medical services for social needs and cascading effects of social determinants of health. Collaborative commissioning can support service integration, avoid service duplication and gaps, and better respond to the holistic care needs of consumers.

2. What are the benefits of pursuing greater collaborative commissioning?

The participant did not respond to this question.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

The need for a shared vision, mutual responsibility between the Commonwealth and jurisdictions, as well as continuity of care across Care Economy Sectors are key barriers to collaborative commissioning.

Lessons from the Education portfolio which has delivered a national curriculum and national joint funding agreement could guide a fit for purpose solution across Care Economy sectors.

Two key issues have emerged in the mental health space: 1) lack of funding specifically for collaboration, and 2) including collaboration/service integration as a KPI for commissioning organisations.

Recommendation: Undertake a rapid review of international examples of success, including in other Government areas (e.g. Education) to identify predictors of success and relevant solutions for application to the Care Economy.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Governments face significant barriers to investing in prevention across the care economy. Prevention programs often take many years to show measurable outcomes, which misaligns with short-term budget cycles and the political preference for visible, immediate results. Additionally, prevention efforts in one sector (like early childhood) may deliver benefits in another (like reduced hospitalisations), making it difficult to attribute value or justify investment within siloed funding systems. In federated systems like Australia's, fragmented responsibilities between federal, state, and local governments further complicate coordinated investment and accountability.

Measurement and evaluation of prevention outcomes—such as reduced disability, delayed institutional care, or increased workforce participation—are hampered by the lack of shared data infrastructure and longitudinal tracking. This makes return on investment difficult to demonstrate. At the same time, funding models prioritise reactive

services over long-term planning, and workforce shortages limit the ability to implement or scale preventive programs. Finally, universal programs may miss those most in need, while targeted ones risk stigma or inefficiency, adding further complexity to the political and policy case for prevention.

Veteran interventions and care largely based upon a medico-legal model that prioritises cure and treatment, not prevention. Narrow view of evidence and preoccupation with objectivist research methods. This is also a lack of methodological diversity.
Recommendation: Expand the remit and investment in the Australian Centre for Disease Control, to reflect an Australian Centre for Disease Control and Prevention, that has reach across both infectious and non-infectious Chronic Disease.

Recommendation: Adopt a whole-of-system and life course perspective to chronic disease prevention, obesity prevention, and to support healthy ageing (e.g. prevention of frailty).
Recommendation: The Public Health and Preventative Health workforce, including researchers, are trained in system-thinking, cross-sectoral partnerships, data- and community-informed decision making. Harness this workforce, as part of central capacity and capability of the Care Economy prevention agenda and reform.

Recommendation: Invest in national longitudinal studies (e.g. repeat the Australian Longitudinal Study of Australin Children through new cohorts) that also link to registry and administrative data. Embed ability to test and evaluate both policy interventions, but also simulate the population impact of prevention programs across different sectors of the Care Economy. This can strengthen the evidence-base for a co-ordinated, consistent, cross care economy sector approach to prevention. Research to build this type of health service and prevention research infrastructure and the evidence base could be achieved in part, through a targeted call via the Medical Research Future Fund.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

4-Year-Old Health Check (Medicare Item 709)

• Who funded and provided the program:
The program was funded by the Australian Government through Medicare and provided by general practitioners (GPs) across Australia. The check was part of the Australian Government's commitment to early childhood health and development, delivered under the Medicare Benefits Schedule (MBS) from 2008. It was supported by the Department of Health and Aged Care and aligned with the Healthy Kids Check (HKC) initiative.

• The outcomes achieved:
The check aimed to identify health, developmental, and behavioural issues in children before they started school. It reportedly increased GP engagement with preventive child health, helped detect issues such as vision, hearing, and developmental delays, and improved referrals to allied health services. Uptake varied across regions, with better reach in areas where services were coordinated with early childhood services.

• Any potential reasons for why it was discontinued:
The MBS item was removed in November 2015. Reasons for discontinuation likely include limited uptake, duplication with other state-based health checks (e.g. through

child and family health nurses), administrative burden for GPs, and mixed evidence of effectiveness. Some stakeholders also noted that universal preschool attendance offered an alternative setting for developmental screening.

• Any evaluations that were conducted:
Evaluations were limited. A 2014 evaluation by the Department of Health noted inconsistent uptake and challenges in implementation. A review by the MBS Review Taskforce in 2015 suggested that while the concept was sound, delivery via Medicare was not the most efficient or equitable approach. Academic studies (e.g. by Goldfeld et al.) also examined early childhood screening in Australia and highlighted systemic gaps in access and coordination.

National Framework for University Child and Family Health and Development Services
The National Framework for Universal Child and Family Health Services, published in 2011 by the Australian Health Ministers' Advisory Council, outlines the core services that all Australian children (from birth to eight years) and families should receive at no financial cost, regardless of their location or how they access healthcare. The framework aims to promote the availability and role of universal child and family health services, ensure consistency across jurisdictions, provide a contemporary evidence base for service improvement, and progress towards national performance monitoring and the compilation of national population health data for comparison across jurisdictions and subpopulations.
Since its publication, the framework has not been formally updated. While the Department of Health and Aged Care last updated the publication date to 18 January 2023, there is no indication of substantive revisions to the framework's content . The lack of updates may be attributed to factors such as shifts in policy priorities, resource constraints, or challenges in coordinating across multiple levels of government. Additionally, the complexity of measuring long-term outcomes and the need for robust intergovernmental mechanisms may have contributed to the framework remaining unchanged since its inception.

Updating the National Framework for Universal Child and Family Health Services would significantly strengthen Australia's prevention agenda by creating a more integrated, contemporary, and equity-focused platform for supporting the health, growth, and development of children. By aligning the framework with current evidence and cross-sectoral priorities, it could embed a broader understanding of child wellbeing that includes physical and mental health, social determinants, and development from birth through early schooling. This would enable more proactive identification and response to developmental, family, and social risks, reducing the likelihood of children entering crisis or high-cost service systems later in life.

An updated framework could also better leverage touch points across the care economy—such as early childhood education, maternal and child health, general practice, disability supports, and family services—by clearly defining their role in universal prevention. For example, routine developmental checks in primary care could be more systematically linked to early learning environments, or social prescribing models in health could more effectively connect families to local parenting support. Strengthened data sharing, joint commissioning, and co-located services could support seamless service pathways and enable timely, targeted responses that reflect children's needs and family context. Ultimately, an updated framework would act as a national

roadmap for integrated child development investment, underpinned by prevention, evidence, and shared accountability.
Recommendation: updated framework could also better leverage touch points across the care economy—such as early childhood education, maternal and child health, general practice, disability supports, and family services—by clearly defining their role in universal prevention.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Early Childhood
Investment in early childhood prevention yields long-term benefits in health, education, and social outcomes. Enhancing prevention efforts to support healthy child growth, health, and development can be achieved through coordinated, cross-sectoral strategies that make the most of existing touchpoints with children and families. Standardising and aligning child health and development checks across sectors—such as health, early childhood education, and family services—using a shared tool and a single entry point can improve consistency, early identification, and coordinated support. Digitising personal health records like the 'blue book' can strengthen navigation and referral pathways, improve transparency for families and providers, and ensure smooth handover between services. Embedding a "Making Every Contact Count" approach and equipping professionals to engage in healthy conversations during routine interactions ensures that every touchpoint becomes an opportunity for prevention, support, and early intervention. However, funding is often short-term and fragmented.
Recommendation: Develop a national early childhood road map to support optimal growth, health and development from pregnancy to school entry and beyond. Include actions such as universal developmental screening, parenting support, and early learning access. Embed long-term evaluation frameworks to demonstrate cross-sectoral benefits.

Disability
Preventive approaches in disability are underfunded, particularly in early intervention and mental health. The long-term benefits of reducing crisis care and institutionalization are well-documented but not adequately measured.
Recommendation: Create a prevention investment framework that includes metrics for quality of life, independence, and reduced service dependency. Fund scalable programs that support transitions (e.g., school to work) and reduce social isolation.

Aged Care
Preventive care in aged care—such as falls prevention, nutrition, and social engagement—can significantly reduce hospitalizations and improve wellbeing. Yet, these programs are often the first to be cut.
Recommendation: Establish a national aged care prevention fund, with co-investment from health and aged care budgets.

Veterans
Integrate stronger lived experience, build develop, and implement a social health/determinants perspective, increase disciplinary and methodological diversity in committees and lead organisations.

Cover sheet: Supporting document #1

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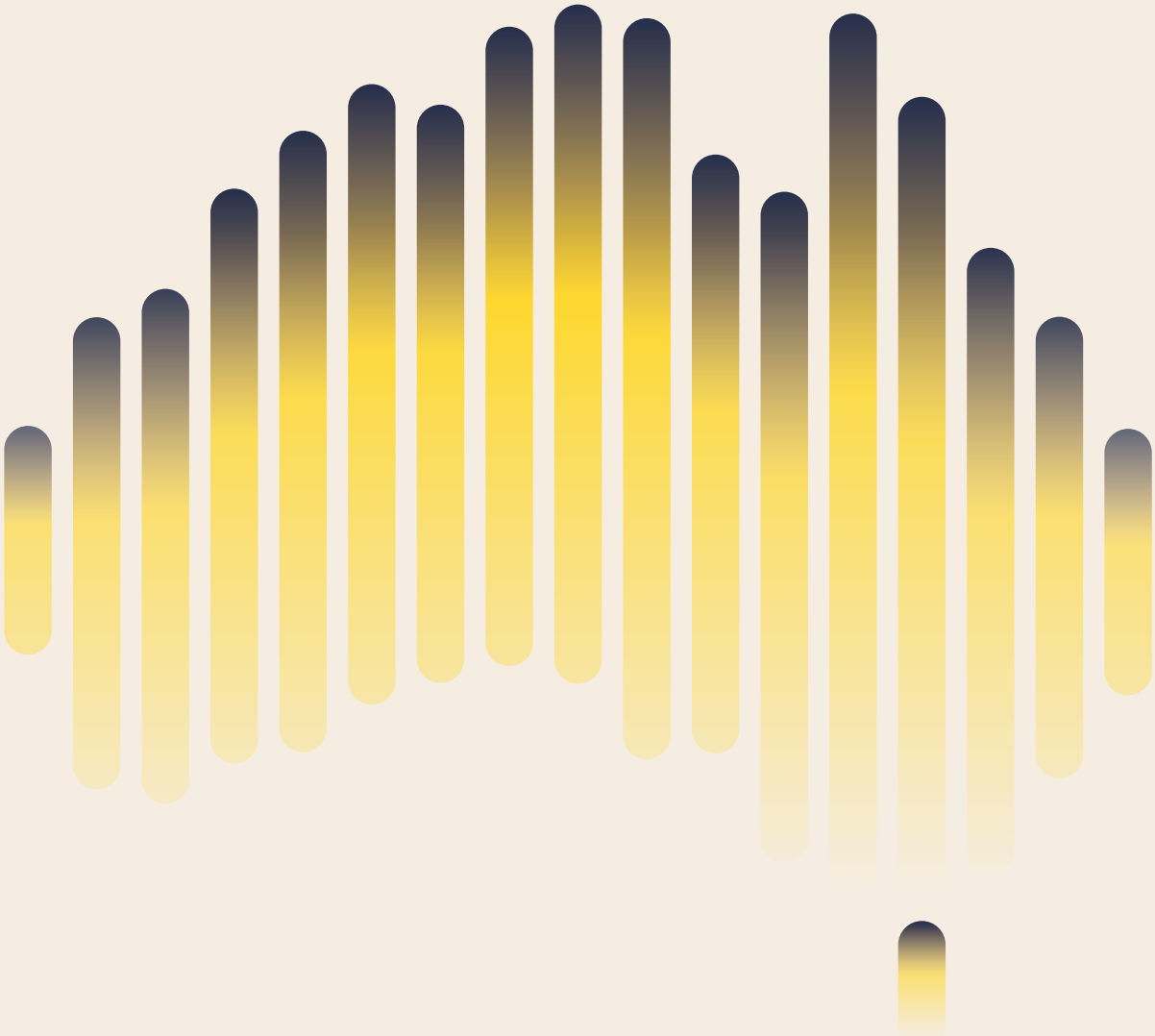

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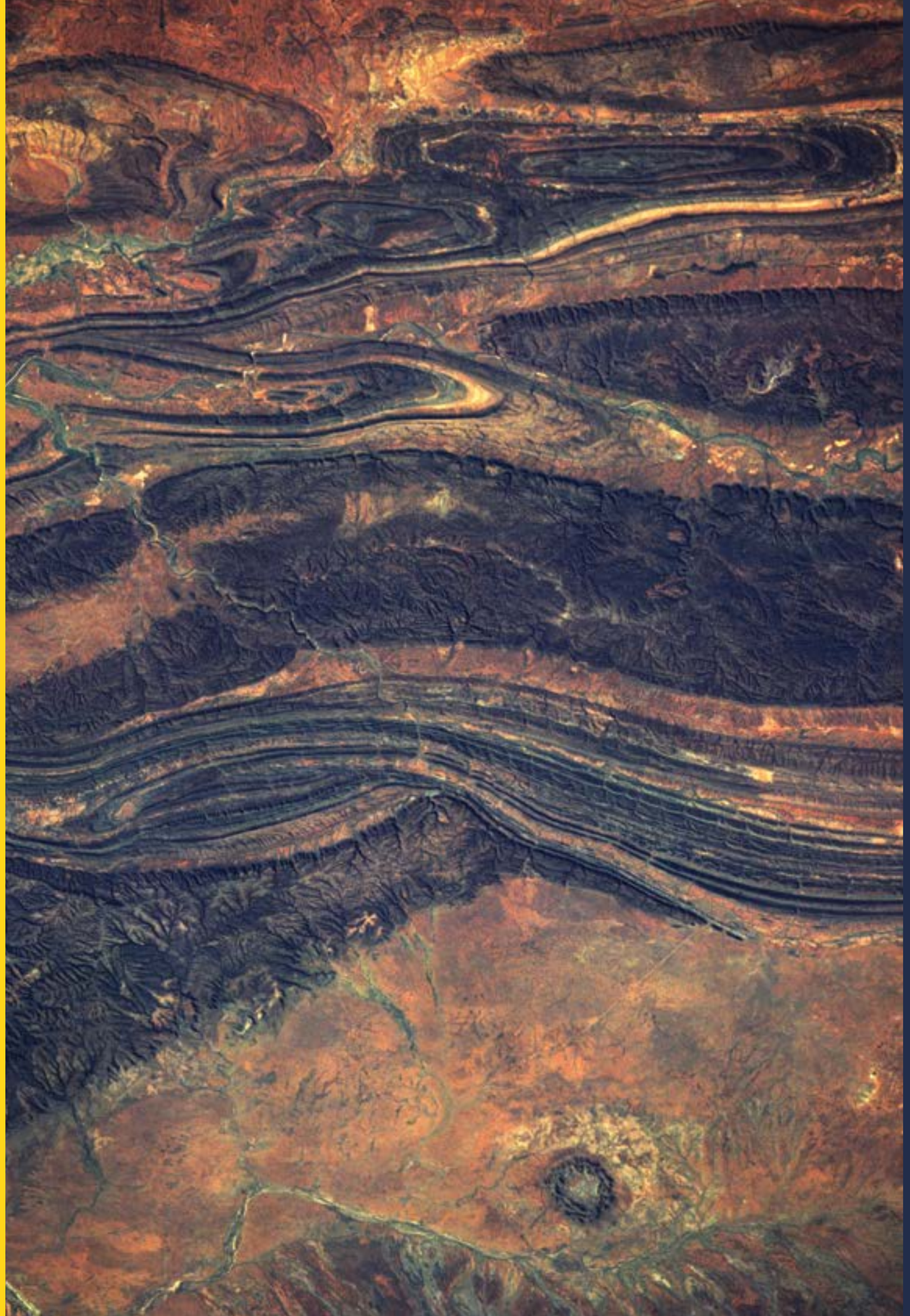
WICKED PROBLEMS REPORT

2025



Flinders University | Wicked Problems

30,000 Australians Have Their Say

At Flinders University we are dedicated to finding solutions to complex challenges with research that matters.

In a groundbreaking initiative, we asked 30,000 Australians from across the nation to voice the problems that matter to them the most in their local communities, resulting in the Flinders Wicked Problems Report.

Wicked problems, such as climate change, healthcare, social inequality, and the cost of living are complicated and unpredictable. These issues don't have clear-cut solutions and can't be solved with simple approaches.

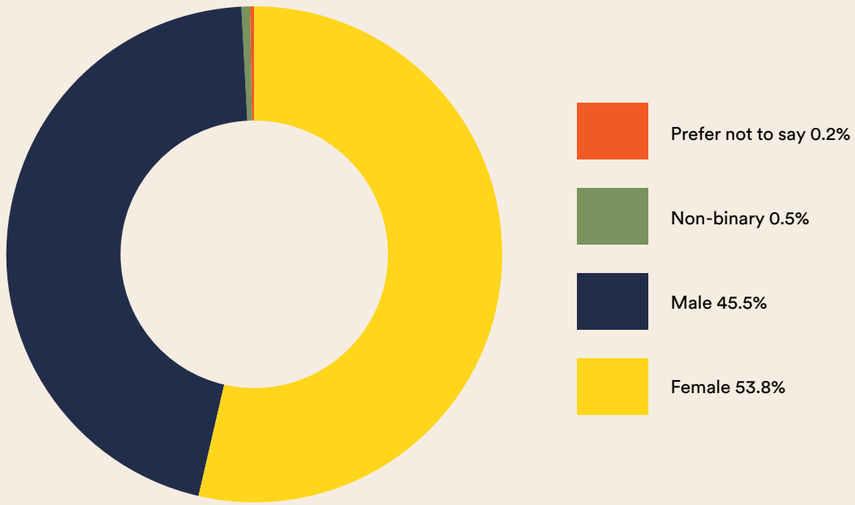
Flinders is bringing together a broad range of expertise, working in collaboration with government, industry and community, creating new knowledge to tackle the problems that Australians care about the most.

Working together to make the world a fairer, healthier and more prosperous place for generations to come.

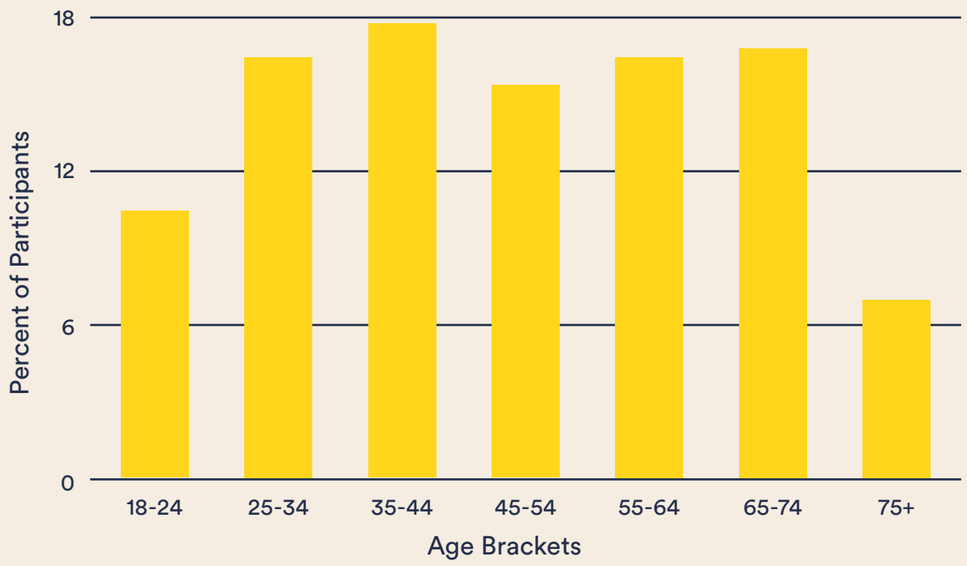
Who Took Part

What is considered to be a wicked problem can vary greatly depending on individual circumstances. We worked hard to ensure a broad spectrum of respondents were able to have their say.

Gender



Age



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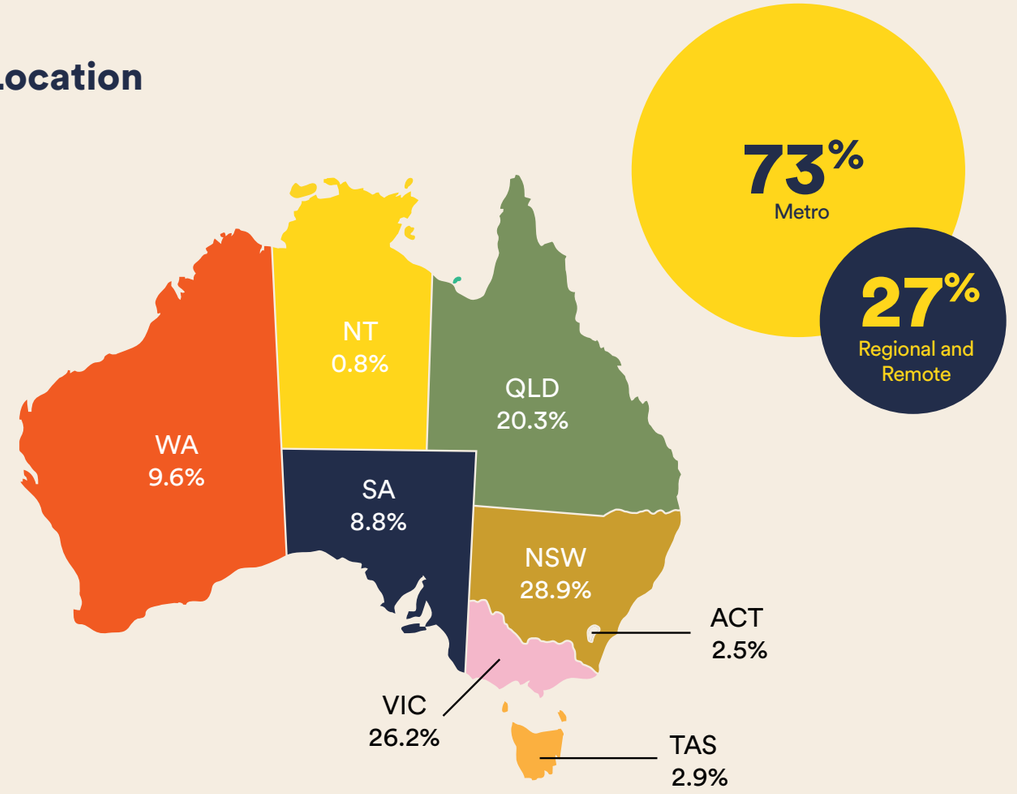

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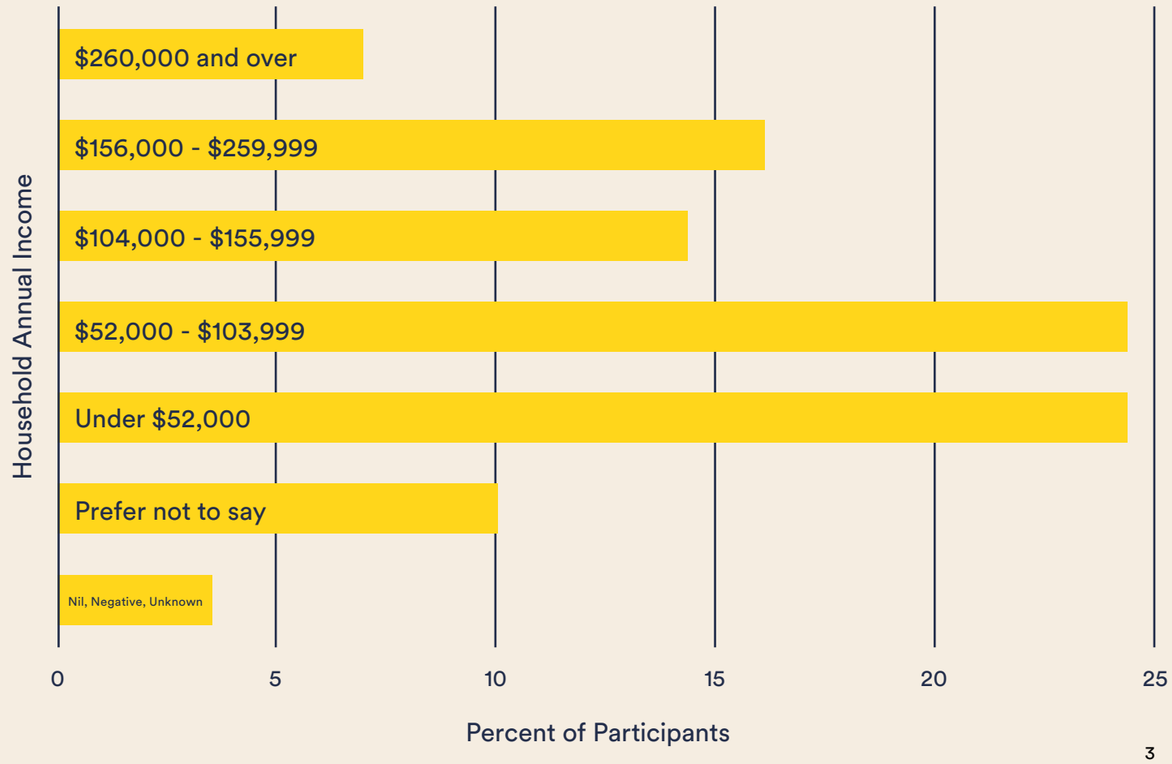


Australia's Top 15 Wicked Problems

The Flinders Wicked Problems Report found that people across Australia share many of the same concerns, but there are some interesting differences depending on who they are and where they live.

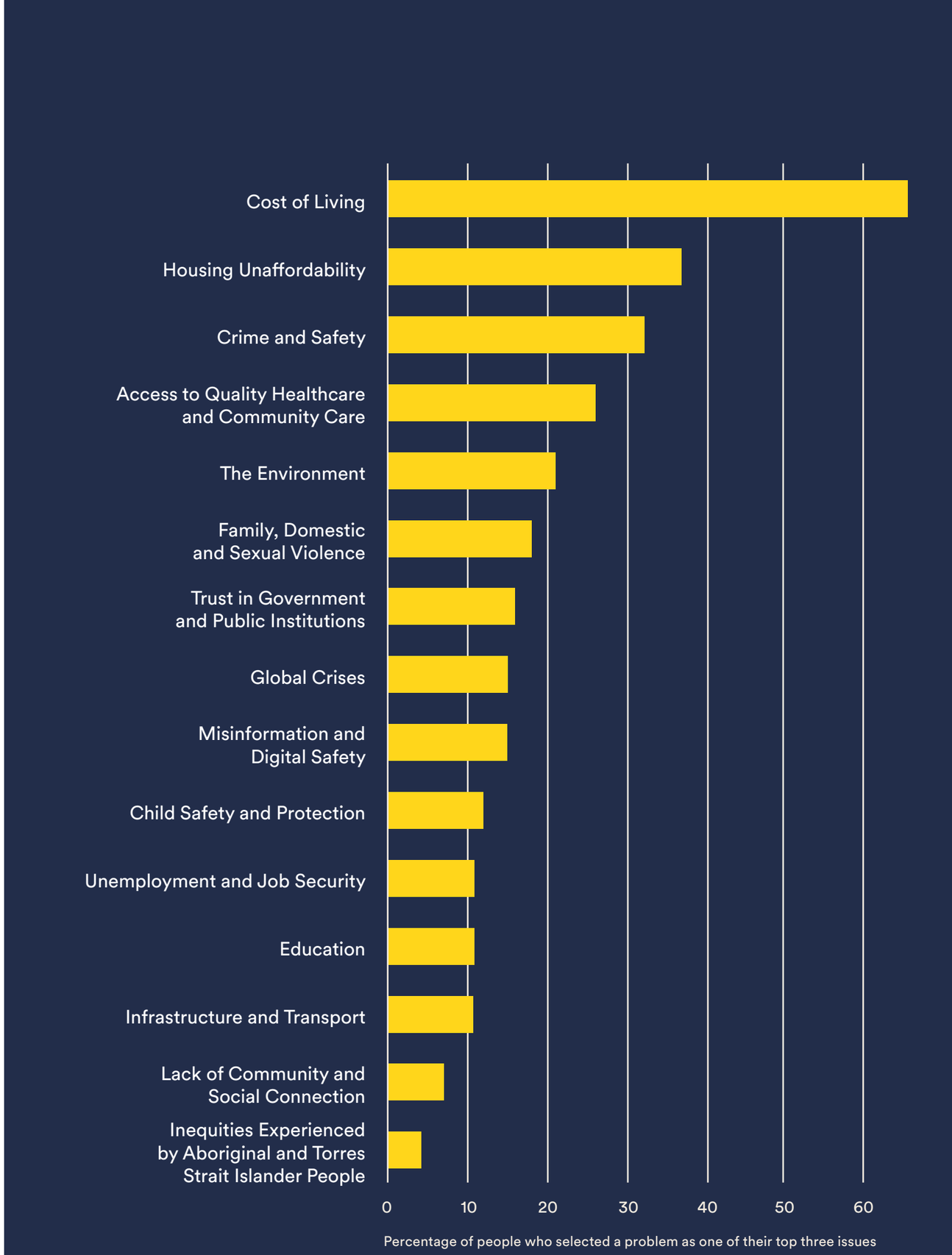
In NT and QLD, crime and safety is one of the major concerns, especially in NT where it's ranked above all other issues. In contrast, NT residents worry much less about housing, cost of living, and healthcare compared to the national average.

People in TAS and SA are more worried about access to health and community care, while NSW and WA residents are more concerned about housing being too expensive. No matter where people live in Australia, the cost of living is a major worry. People in rural areas focus more on crime and healthcare compared to those in cities, who worry more about infrastructure and transport.

Different generations have their own unique concerns. Gen Z is anxious about housing, job security, and domestic violence, while Baby Boomers are more focused on healthcare, the environment, and global issues. Women are particularly worried about the cost of living and domestic violence, whereas men are more concerned with government trust and global crises.

Interestingly, income levels don't make much difference when it comes to worries about the cost of living and housing. Where you live, however, does affect how much you worry about the environment, with ACT residents being the most concerned and Queenslanders the least.

These findings highlight just some of the diverse priorities and concerns across different groups in Australia.



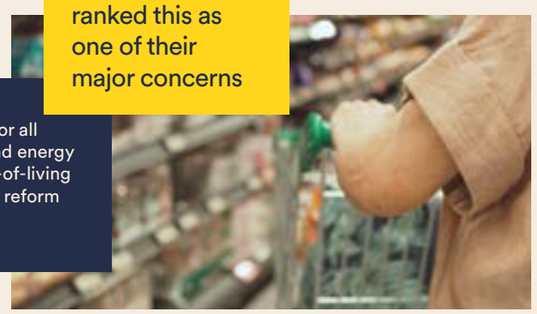
Key Findings

1

Cost of Living

With rising cost of bills, inflation, energy costs and affordable food highlighted as major concerns by respondents, findings highlight a deeper issue: people are not keeping pace with expenses. Fixed expenses like rent and utilities consume household budgets, leaving less for food and essentials, which is concerning in a wealthy food-producing Australia.

65%
of respondents ranked this as one of their major concerns



We must ensure access to services and opportunities for all Australians, through financial assistance, food relief, and energy bill help, whilst focusing on the root causes of the cost-of-living crisis and engaging with the deep economic and social reform needed for a prosperous future.

2

Housing Unaffordability

37%
of respondents ranked this as one of their major concerns

The lack of affordable and appropriate accommodation is the biggest housing worry for respondents, followed by high rent costs and mortgage stress. More people than ever are homeless with services overwhelmed and more working people struggling with housing costs. Home ownership, once seen as achievable and the Australian Dream, is now at a crossroads, impacting household stability and identity. The rental market is out of reach for many, even dual-income households. Social housing is insufficient and can be mismatched to needs.

We need to develop bold policy solutions that address taxation changes, large-scale social housing investment, and policies recognising housing as essential infrastructure and a human right. Investing in diverse housing options and effective policies for tackling homelessness, with rapid response actions is crucial.

3

Crime and Safety

The feeling of being unsafe in their communities and neighbourhoods is the most significant crime and safety issue for people. Other concerns include youth crime, violent crime, crime related to drugs and alcohol, and high rates of imprisonment.

32%
of respondents ranked this as one of their major concerns

To foster safer and more resilient communities, a different approach is needed—one that understands the multiple factors driving crime and incarceration. It is important to understand the complex relationship between fear of crime and actual criminal activity, coupled with innovative thinking in crime prevention and supporting the transition of former prisoners into the community to address rates of imprisonment.

4

Access to Quality Healthcare and Community Care

26%
of respondents ranked this as one of their major concerns

Long waitlists for medical procedures and specialist appointments, limited access to adequate public healthcare including emergency care and mental health services, access to rural and regional services, and access to aged care and social services are the most pressing issues.

New thinking in healthcare delivery models, whole-of-system approaches, and infrastructure improvements is critical to address a health system in crisis. Increased investment in health promotion, primary healthcare, active ageing and innovative models of care is needed, especially for marginalised communities. Links between the health and social care systems need to be enhanced, and strengthening emergency services, addressing workforce challenges, and improving regional access is crucial.

5

The Environment

Australians are concerned about the environment, with climate change being at the top of the list. Apprehensions about natural disasters such as floods, fires, and droughts, as well as the protection of natural resources, were also significant.

21%
of respondents ranked this as one of their major concerns

The health of our communities is tied to the environment, which provides our food, air, and water. Managing these systems is crucial for prosperity. Climate change impacts sectors like agriculture, so collaboration with farmers, communities, and policymakers is essential. Innovative solutions, from green renewables to carbon sequestration are needed.

6

Family, Domestic and Sexual Violence

With respect to different types of violence, the high prevalence of domestic violence was the most critical concern, followed by concerns about women's and children's safety.

18%
of respondents ranked this as one of their major concerns

Domestic violence and child abuse are serious issues, often overlooked until tragedy strikes. These problems stem from power and control, with abusers repeating harmful behaviours. Protecting children means keeping them safe from direct harm and witnessing violence. As long as society remains silent about abuse, exploitation and violence will persist. Teaching young people about healthy relationships and positive masculinities, and increased funding for prevention programs and support services is crucial.

7

Trust in Government and Public Institutions

15%
of respondents ranked this as one of their major concerns

The most significant concern in this area is the lack of confidence in the government's ability to address community issues. Other concerns include lack of action on important issues, declining trust in public institutions, politics, and democracy and disconnection from the political process, highlighting a deeper issue: the erosion of public trust in democratic systems.

We must ensure political institutions like the public service, political parties, and government are open, accessible, and transparent. Effective communication about their actions is crucial to help the public understand their roles. Addressing the root causes of mistrust through these measures can rebuild confidence and strengthen democracy.

8

Global Crises

The impact of war, instability in the international political environment, and human rights violations are highlighted as major concerns by respondents, underscoring a deeper issue: global shifts are affecting local communities.

15%
of respondents ranked this as one of their major concerns

We must acknowledge the transition to an increasingly complex global order and our place within this changing world. Australia can lead regional and international initiatives to address these challenges.

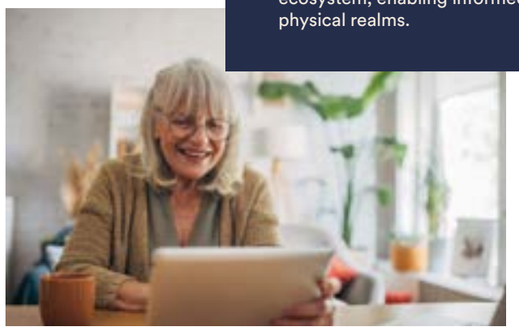
9

Misinformation and Digital Safety

15%
of respondents ranked this as one of their major concerns

It is becoming increasingly difficult to tell the difference between true and false information in the digital age. Online scams are the most significant sub-category, followed closely by the spread of potentially false information and the misuse of artificial intelligence to create misleading content. The ease, reach, and speed at which misinformation can spread is alarming.

We need to develop robust systems to detect and identify false information. Additionally, the general public needs to be equipped with digital literacy and critical thinking – more important now than ever – to recognise credible sources and avoid spreading misinformation themselves. Governments must consider regulatory measures to ensure a safe and reliable information ecosystem, enabling informed decision-making in both the digital and physical realms.



12%
of respondents ranked this as one of their major concerns

10

Child Safety and Protection

The most critical issues identified were child neglect and abuse, followed by bullying, and inadequate information and resources to support child safety and early childhood development. Children and young people have a right to feel safe, and adults have a responsibility to provide safe spaces for them to live, play, and learn. However, many children face neglect, abuse, and bullying, impacting their wellbeing.

Addressing these issues requires valuing children's voices and involving them in creating safer spaces. Transforming schools and adopting a collective approach to child protection as a national priority can help ensure their safety and participation.

11

Unemployment and Job Security

Unemployment, underemployment, and job insecurity can have serious consequences for individual, family and community wellbeing. For many, unemployment means being unable to afford even the most basic necessities such as food, utilities, and housing. The uncertainty associated with insecure employment can disrupt key life decisions like getting married or leaving a relationship, starting a family, and buying a home. Importantly, the negative effects of job insecurity is not limited to workers. Employers also suffer from a lack of employee engagement, lower productivity, and high turnover costs.

11%
of respondents ranked this as one of their major concerns

Addressing these issues requires understanding their causes. For example, is it due to a lack of jobs in the economy, a workforce or skills issue, or a mismatch between the two? Implementing measures such as increasing JobSeeker rates, reconsidering mutual obligations, and strengthening regulations around non-standard employment can help provide economic security for people with precarious employment situations.

12

Education

The most significant concerns centred around the need for the school system to evolve to meet the needs of modern students and society. The traditional school day no longer suits a working family and the ability to leverage new technologies and address diverse learning needs is challenging. Inadequate access to quality schooling and affordable education is also a concern.

11%
of respondents ranked this as one of their major concerns

To address these challenges, the school system should consider school hours to better align with parents' and caregivers' work schedules. This is just part of the rethinking that could be done to better integrate schools with the community. Improving resources in rural schools and reducing school-related costs can help bridge achievement gaps and support better educational outcomes for all students.

11%
of respondents ranked this as one of their major concerns

13

Infrastructure and Transport

Increasing traffic, travel times, and poor road maintenance are the major concerns identified by respondents. Additionally, inadequate public transport options and designs that do not consider the needs of older Australians and people with disabilities is an issue. Efficient transport networks are essential for economic growth, social interaction, and community well-being, enabling access to work, education, shopping, and recreation. When these systems fail, it leads to congestion, delays, and associated safety, environmental, economic, and social impacts.

Regular maintenance to prevent failures, community involvement in planning upgrades, and leveraging technology such as electric vehicles, driverless cars, and e-scooters should be considered to address these issues. Encouraging remote activities like working from home and online shopping, as well as promoting green-powered public transport and sustainable modes like walking and cycling, is crucial. Inclusive infrastructure, such as accessible stations, real-time travel information, and mobile apps for those with disabilities, can enhance transport efficiency and accessibility.

14

Lack of Community and Social Connection

The most pressing issue was the declining sense of community belonging, followed by loneliness and social isolation. These issues have been rising in Australia and globally. Social isolation refers to having few social connections, while loneliness is a subjective feeling of distress due to a lack of connections. Individual circumstances like bereavement, moving, and ill health, as well as broader factors like the Covid-19 pandemic, have exacerbated these issues. Young people and those facing financial difficulties are particularly affected. Social connections are vital for wellbeing, providing emotional support and practical assistance.

7%

of respondents ranked this as one of their major concerns

Policies and initiatives like funding community hubs, promoting age-friendly environments, social prescribing and offering free activities is key to reducing loneliness and building connections. Preventing harmful discussions around topics such as immigration and other forms of marginalisation, and work with schools to foster community engagement is crucial. Celebrating intergenerational connections is also important. We need to better understand and scale successful strategies for these efforts.

15

Inequities Experienced by Aboriginal and Torres Strait Islander People

4%

of respondents ranked this as one of their major concerns

The most significant sub-category was the recognition of Aboriginal and Torres Strait Islander peoples' rights, followed by health outcomes and life expectancy.

These findings emphasise the need for policies that promote equity, self-determination, and the wellbeing of Aboriginal and Torres Strait Islander people and communities, and call for research which is led by those communities which informs culturally appropriate practices and policy.

About the Report

The Flinders Wicked Problems Report are the findings of the first in a longitudinal survey conducted by Flinders University in November 2024 with 30,000 Australians to determine:

(1) What are the complex or 'wicked problems' Australian people and communities face?

(2) Which are the most important wicked problems Australians identify for researchers to work toward solving?

The Flinders Wicked Problems Report will be conducted annually.

Methodology

This study used a mixed-methods approach conducted in two phases:

Phase 1: Data was collected via stakeholder interviews, focus groups, and an online pre-test survey with 442 participants (31 qualitative, 411 online). Findings were synthesised to develop a shortlist of wicked problem categories for Phase 2.

Phase 2: A national survey was conducted through a panel provider (n=29,678) and a public link (n=322). Participants ranked their top three concerns, elaborated on their selections via open text, ranked relevant sub-categories in accordance with their key concerns, and added any missing issues. The survey concluded with demographic questions.

Participation

The Phase 1 focus groups and interview sample had a balanced gender representation, with 16 females and 15 males, ranging in age from 32 to 79. Participants had diverse qualifications, employment types, and income brackets.

The Phase 1 online pre-test survey and the Phase 2 national survey both recruited samples representative of the Australian population by age, gender, and place of residence.

The Flinders Wicked Problems Report is an ethics approved research initiative commissioned by the Deputy Vice Chancellor (Research), Flinders University.
The Research Team declare that this study did not receive any financial support from any external entity. They would like to acknowledge the collective commitment of the Flinders Wicked Problems Project Team and the wider Flinders research community in the development of this important piece of work to understand the issues that are impacting Australians' everyday lives.

Approved by Flinders University's Human Research Ethics Committee (Project 7344).

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Contact us

For further information about this report, and for all media enquiries, including speaking to our experts, please visit

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Australian Health Review

A 'True North Statement for Care': charting the course to better care for all Australians

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ABSTRACT

Objective. To shift the narrative from 'deficit dialogues' in health and social care in Australia, we aimed to generate a series of consensus 'ambition' statements representing what peak care stakeholders in Australia want health and social care to look like in the future. **Methods.** A multiphase co-design study with Australian 'care' stakeholders was undertaken. This consisted of a desk-based audit of Australian health and social care organisations (n = 9) and a pre-forum survey (n = 21 responses) (activity 1), the findings of which informed the national forum activities (activity 2, n = 31 organisations), which became the content for the Delphi survey (activity 3, n = 28 organisations). **Results.** Through this process we distilled five ambition statements and 39 descriptors. These statements are our True North Statement for Better Care, providing a starting point to guide individual, organisation and system redesign across the life span. The statements require action at individual consumer, workforce and system level. **Conclusions.** Creating the True North Statement for Better Care provides a united direction for heterogeneous groups to work together to improve care for consumers, their workforce and the systems they work in. This is an important initiative to change the way we value, talk about, do, own and research care. Further user testing is required to ensure the statements can be translated into action.

Keywords: care, care workforce, health services, person-centred, systems.

Introduction

Health, aged and social care systems worldwide face escalating demands to deliver efficient, safe, high-quality and humane care that meets the complex and diverse needs of individuals and communities.[1–4] Existing systems were not designed to fulfil contemporary care objectives. There is an ingrained culture of conservatism and privileging of the biomedical model. Decision-makers, frontline professionals, communities and individuals are calling for transformative system and policy change to prioritise a human-centred approach.[5,6]

Royal Commissions in Aged Care, Disability and The Early Years have illuminated the flaws in health, aged and social care systems, underscoring immediate need for reform to deliver better care.[7–9] Prior reform responses have been confined within existing structures and mental models. Despite efforts to shift towards an integrated biopsychosocial approach and a focus on person-centred care, our care systems do not yet have the capability to deliver high-quality, consistent, person-centred care that meets peoples' fundamental care needs and expectations.[10,11] Leaders know change is needed and that better systems will deliver better care and outcomes, but the ability to break out of bandaid or incremental change remains elusive.

Engaging with thought leaders in and consumers of care is essential for driving meaningful system change. There is, however, a lack of peer-reviewed literature exploring the

future of care delivery at the individual, organisational and system level, priorities for reform, policy development and practice opportunities from the perspectives of policy, clinical leaders and key stakeholders. Creating a consensus on the future of care within health, social, aged and community contexts in Australia can bring about significant reform in health and care policy, benefiting providers and recipients of care. In other words, our mission is to generate new ways of discussing and tackling old problems.

Flinders Caring Futures Institute hosted the Care Ambition 2030 National Forum to co-design with stakeholders a 'True North Statement' to drive the future of care within our systems, processes and communities. This statement intends to be ambitious and future focused. By fostering a shared energy and ability to identify priorities together, this statement can underpin collective action to shape funding and political decisions. Together, we can chart our paths to deliver transformative change to enhance care systems and improve the care provision and experience of Australians for better health and wellbeing.

Methods

A multiphase co-design study with stakeholders generated a unified statement to drive the future of care (Fig. 1). This research was performed in accordance with the Declaration of Helsinki. Participants provided informed, written consent prior to the National Forum and Delphi survey. Ethics approval was granted by Flinders Human Research Ethics Committee (#5487).

Pre-forum survey

A desk-based audit was undertaken to scope definitions and strategic issues faced by Australian health and social care organisations. Nine national organisations were selected for comprehensive content analysis of their online pages and documents outlining strategic visions, issues and definitions regarding care. Organisations represented medicine, nursing, midwifery, allied health, pharmacy, aged care, carers and multicultural communities. One author (LA) extracted data and two authors (GM, ML) undertook content analysis to identify and theme the relevant content. A pre-forum survey was generated from these findings and sent to all individuals attending the National Forum. In the pre-forum survey, respondents identified their three core issues in care and what a successful transformation of care would look like. Twenty-one individuals responded, representing peak body organisations and professional societies, charity and advocacy groups, government departments and agencies, research centres and organisations in care (see Acknowledgements). GM and ML undertook qualitative content analysis of survey responses and generated three themes where care issues and transformations were most consistently identified; care system (integrated, equitable, patient-centred, sustainable), care workforce (skilled, valued, supported, collaborative) and care consumers (empowered, informed, respected). These themes were used to structure the forum activities.

National Forum

Care Ambition 2030 National Forum was held in September 2022 with representatives from 31 health, care and consumer organisations, including consumers, advocates, practitioners, chief executives and researchers (see Acknowledgements).

To facilitate thinking and information exchange, the World Café process was used.[12] The World Café method involves constructive conversation on designated topics through consecutive rounds, and recording key points through writing, drawing and mapping.[12] Our World Café involved 8–10 participants at tables with a topic area of care workforce, system or consumer and three rounds of conversation: (1) flaws in the Australian care system, (2) changes happening in care nationally and internationally and (3) ideas for the future of care in Australia. Participants then generated their most impactful statements for their designated table topic area, yielding 50 'ambition statements' relevant to Australian care systems. Data from these activities were used to generate Delphi survey items.

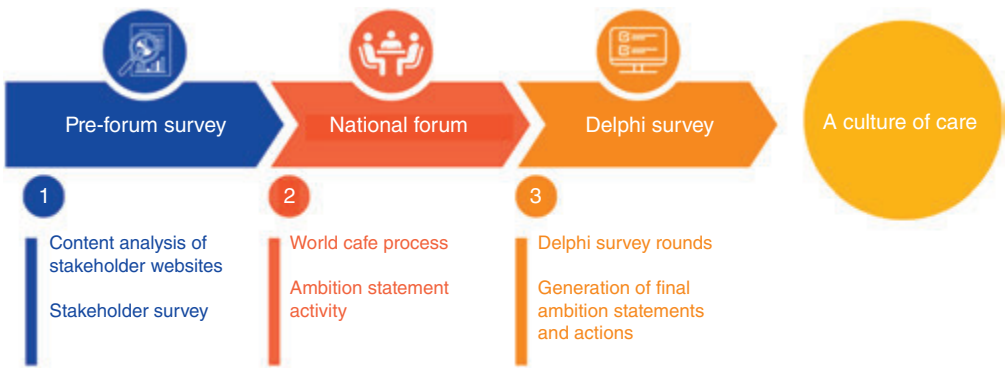

Fig. 1. Stakeholder activities to inform the generation of the Statement for Better Care.

Delphi survey

A modified Delphi survey was used to refine the ambition statements and generate descriptors to inform the True North Statement. The Delphi technique is an iterative, sequential process designed to obtain consensus from experts, termed 'panellists', through multiple survey rounds.[13,14] A traditional Delphi survey provides panellists with open-ended questions to generate ideas in Round 1.[13] We modified this process and provided panellists with statements to rank in Round 1. Forum invitees were our expert panellists and were invited to participate in the Delphi survey. Consensus was set *a priori* at ≥79%.

Item generation for Delphi survey

Forum activity data were used to generate Delphi survey items. The World Café data, captured on butcher's paper, was transcribed to an Microsoft Excel Spreadsheet[15] for analysis. The ambition statement activity data were captured in Slido[16] and transferred to a Microsoft Word Document[17] for analysis.

GM and ML undertook thematic analysis of the ambition statements, categorising them according to their central theme. All statements fit within five main themes. The themed statements were brought to a team meeting where each team member independently generated one statement for each theme, representative of the original statements within that theme. This resulted in 25 statements with considerable overlap, further synthesised into five core statements. These statements were sense-checked against original statements to ensure representation of key ideas. The World Café data were synthesised against these five statements by GM and ML, and used to generate 'descriptors' against each statement by GM and RG. The descriptors represent the requirements for each ambition to be successful. These final ambition statements and descriptors were confirmed by the team before being finalised as Delphi survey items.

Round 1

Round 1 contained five ambition statements, each with five to seven descriptors. Panellists indicated their agreement with each ambition statement and the importance of each descriptor on a five-point Likert scale (strongly disagree to strongly agree). Panellists could provide alternative phrasing or add descriptors.

Round 2

Statements that reached consensus in the first round were not taken through to the second round. Statements and descriptors that had not reached consensus in Round 1, along with panellists' additional descriptors, were presented in Round 2 as above.

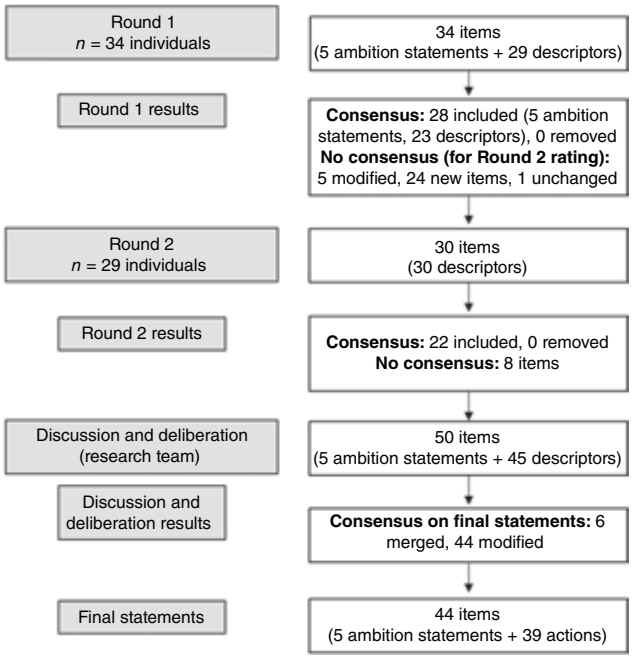

Fig. 2. Flow chart of Delphi process to reach consensus on final statements.

Discussion and deliberation

Results from Round 2 were synthesised and final ambition statements and descriptors were confirmed through team discussion. This process ensured consistent phrasing and terminology. Through this process, descriptors were retermed 'actions'.

Results

Thirty-four individuals participated in Round 1, and 29 in Round 2, representing 28 of the organisations invited to the forum (Fig. 2). Organisations included professional societies, bodies, organisations and boards, research centres, government departments or agencies, charity and advocacy groups, consumers, local health networks and service providers.

Round 1

Of the five ambition statements presented in Round 1, all reached consensus agreement (± modifications). Of the 29 descriptors presented in Round 1, 23 reached consensus agreement (± modifications) and six did not meet consensus (± modifications). Statements and descriptors were refined based on open-ended participant responses. Descriptors that did not meet consensus were modified and carried into Round 2, along with 24 additional descriptors.

Round 2

Of the 30 descriptors presented in Round 2, 22 reached consensus agreement (± modifications) and eight did not. Descriptors were refined based on open-ended participant responses. This was the final Delphi round as we had achieved our study aim of co-designing a consensus True North Statement for the future of care in Australia. Supplementary Table S1 displays the ambition statements and descriptors presented for voting.

Final ambition statements and actions

Two Delphi rounds resulted in consensus agreement of five ambition statements and 45 descriptors for the future and focus of care for Australia. The descriptors were transformed into 39 actions, and the ambition statements were refined according to participant feedback and team discussion (Supplementary Table S2), with a final round of refinement to ensure the statements were accessible for a lay audience. Table 1 presents the final five ambition statements along with the 39 actions. See Fig. 3 for a graphic presentation.

Discussion

The True North Statement for Better Care is a collective call to action driven by a purpose to create value for society. Through this study, the unifying True North Statement was co-designed with stakeholders across health and social care sectors to chart the reform needed within our systems, models of care and communities to deliver a culture of care. Creating the True North Statement for Better Care provides a starting point for a united direction of travel for heterogeneous groups to work together to improve care for consumers, their workforce and the systems they work in.[18–22]

The True North Statement and its ambitions focus on culture, lived experience, workforce, technology and the care ecosystem, setting clear areas for collective action. Shifting towards giving equal weight to compassion and wellness, consumers and supporting the workforce, in addition to current reform priorities, is fundamental. The ambitions articulated align with reasonable expectations but are not uniformly embedded across current care systems. Australia's care landscape is being shaped by significant reform.[7,8] Common across current agendas are strategies aimed at improving access, affordability and quality of care standards, as well as addressing care workforce and funding models or shortages.[7,8,23–25] However, the care preferences of consumers and their care networks, a valued and appropriately renumerated workforce working to their full scope of practice, integrated continuity of care across sectors, integration of digital health and technology innovation and learning care systems informed by multiple evidence sources are largely implied.[26–30]

Addressing Australia's care shortcomings and aligning integrated multiple health and social care systems that work together as a 'care eco-system' that delivers on the overarching ambition of a culture of care, requires action at all levels. Viewing consumers as partners is vital for ensuring that person-centred care drives decision-making. Perspectives such as evidence-based care, risk or system efficiency or the biomedical model cannot be privileged over the care experience.[31] People's voices must be heard and used to drive change. Partnering with advocacy groups can amplify this effort, but change requires action from all sectors involved. Empowered and transformational leadership is crucial, particularly from the care workforce,[32] who have voiced concerns regarding public respect, burn-out, limited agency and inadequate remuneration.[10,11] The fundamental foundation of health and care systems also needs to shift. The call for values based health systems are a step in the right direction.[33] However, without a commitment to care and putting people at the centre of all decisions, there is a risk that the old becomes new. While consumers of care were involved in the development of these statements, further consultation with this key stakeholder group is a critical next step in this work.

Systems thinking and innovative policy planning are necessary to enact these actions nationwide.[34] The World Health Organization's systems thinking framework offers a practical approach to strengthening health systems.[35] The framework encourages collaboration with diverse stakeholders in problem-solving, suggests ways to forecast health system's responses to initiatives and stresses the importance of evaluation. Policies at different levels of government and jurisdiction should be informed by this framework including considerations for (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines and care, (v) financing and (vi) leadership/governance.[35] There are Australian examples emerging at both a state and clinical area level.[31,36–38] It is intended that the generated True North Statement for Better Care developed in this study can be used as a starting point to foster a shared understanding, identify priorities, enhance care systems and chart our paths to deliver transformative change to improve the care provision and experience across health, ageing, early education and social care systems. Focused attention on these priorities from national research funding bodies is required to allocate research funding and prioritise solutions that can bring about care reforms called for by participants in this study.

The statements we refer to as our True North Statement for Better Care are a blueprint to guide individual, organisation and system redesign across the life span. The statements are sequential and require refinement and action at individual consumer, workforce and system levels. Engaging key stakeholders of care was an important first step to getting a heterogeneous group on the same page for a plan for the future of care. Next steps are to take these statements to on-the-ground care workforce and consumers for focus testing to ensure they are (a) reflective of their needs and (b)

Table 1. True North Statement and actions to deliver better care and caring for Australians.

Ambition Statement	Actions
1. A culture of care **Consumers experience a culture of care** where their health and wellbeing are taken care of in a holistic way, with their physical, mental, emotional, spiritual and cultural needs considered. People are seen as experts in their own health, and their friends and family who take care of them are recognised as important partners.	1.1. Create a culture of compassion, kindness and wellness, across health and social care settings that extends across the life course. 1.2. Adopt a strengths-based perspective that is focused on an individual's or community's ability, engagement and enablement as an antidote to exclusion, discrimination and stigma. 1.3. Facilitate connection and communication between health and social care workers and consumers and their chosen carers. 1.4. Respect the unique and diverse needs and experiences of consumers as part of person-responsive health and social care. 1.5. Privilege high-value, person-centred care that uses resources efficiently and achieves optimal results for every person. 1.6. Deliver policy, services, interventions and programs with compassion, kindness and empathy. 1.7. Position agency and self-determination as foundational in each person's care. 1.8. Support health and social care education and literacy across all life stages for consumers, their chosen carers and their care networks. 1.9. Collect health and care data that are exchanged between health and social care partners and networks to support the provision of holistic and integrated care.
2. Consumer experience of health and social care **A consumer experience of health and social care that empowers, informs and respects individuals**, allowing them to easily and equitably access information and services. Consumers should be able to participate in their care according to their preferences, culture and values, provide feedback on their experiences and be involved in co-designing educational and system improvements supported by a comprehensive care team.	2.1. Acknowledge and respect chosen carers as part of the care team, where desired. 2.2. Empower consumers by providing navigation through the health and social care system. 2.3. Keep consumers informed through providing adequate health, care and digital literacy education and support. 2.4. Acknowledge and invest in consumers, and their family and friend carers, as advocates, experts and active participants in their own care in accordance to their preferences, culture and values. 2.5. Integrate consumers and family and friend carers in the design and delivery of healthcare training programs. 2.6. Measure and adequately act upon patient-reported health and care experiences and outcomes. 2.7. Share information with consumers and their family and friend carers through communicating in language, culture and context accessible ways to keep them informed.
3. A caring and cared for health and social care workforce **A care workforce that is skilled, respected and supported**, working to the highest standards. This includes ensuring fair compensation, providing career pathways, strong leadership and support systems.	3.1. Recognise and respect the multiple paid and unpaid workforces for their roles and responsibilities within the health and social care system. 3.2. Adequately fund and remunerate the paid health and social care workforce. 3.3. Facilitate the health and social care workforce to work at full scope of practice with appropriate mechanisms of support, supervision, education and credentialling to deliver excellence. 3.4. Build a culture of care through strong, values driven leadership, including open communication and active collaboration and supporting the health and wellbeing of the workforce. 3.5. Enable the health and social care workforce to innovate and move across the systems, sectors and models of care through purposeful education and training. 3.6. Develop career pathways that recognise and reward demonstrated capability, deliver higher qualifications and incorporate extensive hands-on care experience and leadership skills. 3.7. Support the health and social care workforce to deepen their expertise and interests through professional development opportunities to promote retention in the sector. 3.8. Diversify and optimise existing and new health and social care roles to create more capacity for care, establish clear boundaries and allow all care workers to work at full scope of practice. 3.9. Collect data against mutually agreed indicators to support work performance and ensure quality patient care.

(*Continued on next page*)

Table 1. (*Continued*)

Ambition Statement	Actions
4. Technology to support health and social care **Technology used to support health and social care systems**, to make them more effective and accessible while improving communication and collaboration between providers and consumers.	4.1. Integrate digital systems and technology in a way that facilitates efficient, effective, timely, relevant and safe exchange of information between consumers and care providers. 4.2. Ensure responsible use, lining and protection of consumer data when linking across infrastructures and systems. 4.3. Ensure that digital systems and technology are used to support data-informed and evidence-based change processes, such as quality improvement or service innovation. 4.4. Develop and implement accessible, comprehensive health and social care records that represent a consumer's journey across the whole care system, that can be easily accessed by consumers to increase their control of their care journey. 4.5. Facilitate the human–technology interface through initiative, person-informed design, and empower consumer agency through increasing health and care literacy.
5. Learning health and care systems **Care systems that meet the different needs of communities** by providing care that is tailored, accessible and integrated. These systems should be designed together with the people that use them.	5.1. Design or reform health and social care systems to be responsive to the priorities and preferences of consumers. 5.2. Attend to the cultural, social and commercial determinants of health and wellbeing in the design and operation of health and social care systems. 5.3. Underpin all health and social care systems and models to be inclusive by emphasising the identified needs of priority groups. 5.4. Reduce inequities in access to health and social care services and resources to remove discrimination and stigma in provision of care. 5.5. Enhance access to health and social care by delivering services closer to home, with consumers and their chosen carers having easy and meaningful access to health and social care professionals. 5.6. Provide universal access to designated care workers or technology supports to assist people to navigate health and social care systems when needed. 5.7. Design or redesign an integrated, connected and coordinated health and social care system that connects acute and non-acute services so consumers have improved health and social care service availability, access, awareness and referral. 5.8. Co-design integrated health and social care systems with the influencers, users and beneficiaries of care, particularly consumers. 5.9. Integrate health and psychosocial research to support a holistic and consumer-informed approach to care.

Fig. 3. Graphic representation of the True North Statement for Better Care for all Australians.

implementable within their contexts. Following this process, there are several practical applications of the statements and actions. For example, organisations that work in health or social care could use these statements to inform their strategic plans, research initiatives, education and guideline development. Organisational self-audits could be undertaken to identify current efforts and gaps in addressing and achieving the ambitions. The actions generated against each ambition could be changed into key performance indicators and objectives to track progress in achieving our True North Statement for Better Care across Australia. Timeframes could be set, and cost benefit analyses could be undertaken to evaluate whether organisations embracing the True North Statement for Better Care provide better health, care and wellbeing outcomes for their clients and staff. Multisector collaboration, partnership, inclusion and evaluation will be integral to realising the full impact of our True North Statement for Better Care. In the existing context of workforce burnout, rising costs, ageing and more complex care needs, this is an important initiative to change the way we value, talk about, do, own and research care.

Strengths and limitations

We achieved a high level of consensus across diverse health and social care organisations about what the future of care should look like. These statements embrace individual consumer, employee and system dimensions, which in turn support emerging research and policy shifts to addressing workforce shortages by looking at the psychosocial safety dimensions in the workplace. While this research has involved extensive stakeholder engagement, not all forum participants completed the Delphi surveys, and there was a need for interpretation to transform forum data into Delphi items. Furthermore, while consumers were involved in the co-design process, the statements and actions may not be appropriately articulated to enable their use and implementation. We suggest further market research with diverse consumer groups to ensure the findings from this work are relatable and actionable. These strengths and limitations contribute to the overall blueprint for actionable change and disruptive transformation of self-care, care and caring solutions in Australia.

Conclusion

This series of co-design activities has generated a True North Statement that can serve as a starting point for a shared action-focused vision to transform health and social care in Australia over the next decade. Through an inclusive consultation process with inter-sectorial stakeholders, five ambition statements have been developed to drive the future of care in the country. By actively working towards these ambitions and ensuring their integration across all health and social care systems through continued refinement and articulation, we have the opportunity to redefine the culture of care and use it to chart the future to improve outcomes for individuals, families and communities. This shared purpose will ensure that unique voices and perspectives, including those of consumers, will shape the narrative to inform policy and decision making that impacts care.

Supplementary material

Supplementary material is available online.

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Government of South Australia
Preventive Health SA

Current practice and perspectives for undertaking Child Development Checks within South Australia

Information to support the development of a Universal Child Development Data System

Report for Preventive Health SA
by Flinders Caring Futures Institute
April 2024

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Table of Contents

Executive Summary

Background and Methods

The Royal Commission into Early Childhood Education and Care recommended "legislation for a new Universal Child Development Data System" (Recommendation 4[1]).

To support the development of this data system, Preventive Health SA, Flinders University Caring Futures Institute and the Office for the Early Childhood Development (formerly Office for the Early Years) undertook preliminary research to understand the current practice and perspectives of delivery and data processes for Child Development Checks within the South Australian Early Years System.

To do this, a cross-sectional survey was conducted with individuals who deliver Child Development Checks within the South Australian Early Years System. This survey asked questions to identify who is conducting these checks in the South Australian Early Years System, what check(s) they administer, how they record and manage the information they collect, and their perceptions on centralising Child Development Check information.

Summary of key findings

In total, 68 participants responded to the survey. Overall, this report identified:

- There are many different organisations and providers conducting Child Development Checks in South Australia
- There is diversity in the tools being used to conduct Child Development Checks with no one standardised tool being used.
- Health information is routinely collected as part of Child Development Checks.
- Child Development Check and health information is recorded within organisational based electronic records or hard copy/paper-based records; These records are only available within the organisation or the site unless explicitly referred out.
- Most individuals conducting Child Development Checks are documenting and recording information and results regardless of whether a concern is or is not identified. This information is recorded in patient records, verbally provided to parents, and/or shared externally via referrals.
- Participants responded that a state or national Early Years Data System would be helpful to parents, providers, and children's health.

Introduction and Methods

Introduction and Methods

The Royal Commission into Early Childhood Education and Care recommended "legislation for a new Universal Child Development Data System" (Recommendation 4[2]).

As part of this recommendation, it was outlined that this child development data system should enable:

- Families to have a better experience, not needing to retell their stories or be responsible for information sharing across providers and services.
- Sharing of information across services to support service delivery.
- Sharing of data across services and population level de-identified data to support service planning and evaluation and population level research.
- Data sovereignty for Aboriginal people.

In South Australia, Child and Family Health Service (CaFHS), commissioned services (e.g., State Government funded pilot projects) and primary health care providers offer child health and development checks. However, the full picture of providers offering these checks and the tools being used is unclear. The full reach to South Australian children receiving these checks and the follow-up of the child and family is not known. To maximise the number of South Australian children receiving a quality child health and development check throughout the early years, there is a critical need to better understand the current landscape. This will serve to inform service provision as well as system improvement activities such as the development of a Universal Child Development Data System, as recommended within the Royal Commission.

Aim

Understand the current practice and perspectives of delivery and data processes for Child Development Checks within the South Australian Early Years System.

Study Design

The project team worked collaboratively to develop a cross-sectional survey to capture important and relevant data on the 'who, where, what, why and how' of Child Development Checks in South Australia. The survey was structured into four sections: 1) Demographics, 2) Child Development Checks, 3) Information and Record Keeping, and 4) Centralising Child Development Check Information.

Methods

1. The project team generated a stakeholder recruitment list to ensure adequate sample spread across the range of settings that may deliver Child Development Checks. This list spanned health, education, social and community services, as well as across both the public and private sector.
2. Purposeful sampling from the stakeholder recruitment list was conducted to recruit between 50-100 participants.
3. To ensure a diverse sample, participants were also recruited through advertisement within relevant organisational newsletters and bulletins.

Analysis

Demographic and quantitative survey data were analysed using descriptive statistics and free text qualitative responses were analysed using descriptive analysis[3].

Results

Results

Sixty-eight participants responded to the South Australian Child Development Checks Survey and reported conducting Child Development Checks.

Of these, 45 conduct Child Development Checks as part of their routine service and 15 are currently part of the Child Development Check pilot programs supported by the South Australian Office for the Early Years. Two were both, two reported other and stated their organizational role and four were not sure.

Although only 44 participants completed all questions, other participants responses were included as partial if they responded to any additional questions after demographics.

Results are organised below under the following headings:

1. Demographics;
2. Child Development Checks;
3. Information and Record Keeping; and
4. Centralising Child Development Check Information.

Demographics

This activity is a desk-based review of existing services.

Table 1: Participant Demographics

Characteristic	Staff
Age: (n=68)	
18-30 years old	1
31-40 years old	16
41-50 years old	22
51-60 years old	23
61 years old or older	6
Gender (n=68)	
Man or Male	5
Woman or Female	62
Prefer not to answer	1
Sector (n=68)	
Education	12
Social or Community	11
Health	41
Other	4
Length of time in sector: (n=67)	
Less than 2 years	8
2-less than 5 years	6
5-less than 10 years	5
10-less than 15 years	12
15 years or more	36
Profession (n=67)	
Audiology	-
Early Childhood Education and Care	11
Medical	11
Nursing	19
Nurse Practitioner	2
Occupational Therapy	5
Paediatrics	-
Physiotherapy	1

Characteristic	Staff
Psychology	-
Speech Pathology	5
Social Work	4
Other Allied Health	
– Manager of multi-disciplinary allied health	1
– Family Counsellor	1
Other	
– Executive or management	3
– Language specialist	1
– Public Health	1
– Paediatric Researcher and RN	1

In total, participants spanned the following 31 organisations in South Australia:

- 54 reasons
- Adelaide Health Care
- Aldinga Community Children's Centre
- Child and Family Health Service
- Centacare
- Catholic Education South Australia
- Clovercrest Family Practice
- Department for Health and Wellbeing
- Department for Education
- Eyre and Far North Local Health Network
- Flinders University
- Forhealth
- Gowrie SA
- Hughes Clinic
- Keithcot Farm Children's Centre
- Kudos
- KWY Aboriginal Corporation
- NALHN Children and Families Team
- Nunyara Aboriginal Health Service
- Oakden Medical Centre
- Pangula Mannamurna Aboriginal Corporation
- Playgroups SA
- Port Lincoln Aboriginal health service
- Port Pirie West Childrens Centre
- Refugee Health Service
- Regional Local Health Network
- SA Health
- Uniting Country SA
- Tanunda Medical
- The Benevolent Society
- Torrensville Community Childcare Centre

Child Development Checks

In total, 58 participants completed questions in relation to when they conduct Child Development Checks and what tools they use to complete a Child Development Check. When asked if they select the tool they want to use or if they are required to use a specific tool, most participants responded that they are required to use a specific tool by their organisation (69%). The most used tool is the Ages and Stages Questionnaire (ASQ) or the culturally adapted ASQ-TRAK (65%). Table 2 summarises participant responses on what intervals they conduct checks, the tools they use, and what health information they collect.

Table 2: Child Development Check Intervals and Tools

	Staff (n=58)
Recommended intervals:	
1-4 weeks old	23
8 weeks old	30
6-9 months	34
12 months	36
18-24 months	43
3 years	35
4-5 years	40
Other	18
Required to use a specific tool:	
Yes, my organisation chooses	36
No, I choose	21
Not sure	3
Tools used:	
Ages and Stages Questionnaire (ASQ)	32
Ages and Stages Questionnaire – TRAK (ASQ – TRAK)	7
Brigance Screens	11
Child Development Inventory (CDI)	3
Parents' Evaluation of Development Status (PEDS)	3
Other*	19

*All the other tools are grouped and listed below:

- Health assessment (n=1)
- Bayleys Scale (n=1)
- General aboriginal child health checks (n=1)
- Child Development Review (n=3)
- Beery VMI, Movement ABC, MFUN as well as informal screeners re. milestone (n=1)
- AIMS (n=1)
- Observation (n=1)
- Early Years Learning Framework (n=1)
- Personal knowledge/screening (n=2)
- Clinical History (n=1)
- Blue Book (n=1)
- Discipline specific tools (n=1)

Tool Usability

Participants were asked how user friendly the tools they use are and in general, participants reported the tools they use to be moderately to extremely user friendly, as seen in Table 3.

Table 3: Usability of Child Development Check Tools

	Not user friendly	Slightly user friendly	Moderately user friendly	Very user friendly	Extremely user friendly
Ages and Stages Questionnaire (ASQ) (n=23)	-	-	11	11	6
Brigance Screens (n=10)	-	2	2	3	4
Child Development Inventory (CDI) (n=2)	-	1	2	-	-
Parents' Evaluation of Developmental Status (PEDS) (n=3)	-	-	1	2	-
Other	1	-	6	6	11

Participants also provided qualitative feedback on the advantages and disadvantages of the tools they use. For the ASQ, common reported advantages were around the tool being parent-led, basic, quick, and standardised. Disadvantages of the ASQ were reported as using Americanised language, not digitally available and that parents may make mistakes. For the Brigance Screens, reported advantages were that it was thorough, provides additional assessments and referral information and that it is comprehensive. Disadvantages were that it was time consuming, outdated, and subjective. A full list of advantages and disadvantages as reported by participants can be seen in Appendix 2.

Health Information

In addition to conducting Child Development Checks, we asked participants if they also collected any health information. In total 54 participants responded however six of these participants reported this was not in their scope of practice. The number of the other 48 participants collecting different types of health information can be found in Table 4.

Table 4: Health Information during Child Development Checks

Collection of health information: (n=54)	
Not within scope of practice	6
Physical health	27
Vision	23
Hearing	22
Ear Check	23
Oral health	35
Growth monitoring	34
Health behaviours	39
Immunisation	28
Other	8

Details of the specific information collected within the types of health information are reported below. A complete list of information collected as reported by participants can be seen in Appendix 3.

Physical health

Thirty-seven participants reported collecting physical health information. Qualitative responses on what is collected, includes, but is not limited to, checking for the presence of equal femoral pulses (n=2), hip mobility (Barlow and Ortolani test, Galeazzi test, abduction; n=4), gait/crawling (n=4), Musculo-skeletal assessments (n=8), cardiovascular assessments (n=3), respiratory assessments (n=2), skin assessments (n=7), genitalia assessment (n=2) fontanelles and head shape (n=4), muscle tone and core strength (n=4) and reflexes (n=3).

Vision

Twenty-three participants reported collecting information on vision. Qualitative responses on what is collected, includes, but is not limited to, Kay picture test (n=7), Sheridan-Gardiner Vision Screening (n=1), LEA symbols (n=1), Snellen Chart (n=1), fixation and following (n=4), Red eye Reflex (n=5), Corneal light reflex (n=4), squint (n=2), appearance (n=2), movements (n=2) and pupillary responses (n=1).

Hearing

Twenty-two participants reported collecting information on hearing. Qualitative responses on what is collected, includes, but is not limited to, the Universal Newborn Hearing Screen or Automated Auditory Brainstem Response (AABR) (n=5), audiometry (n=6), turning head towards sound (n=5), response to question/ voice (n=3), Whisper test (n=1), Tympanometry exam (n=1), otoacoustic emissions exam (n=1) and family history (n=1).

Ear Check

Twenty-three participants reported collecting information on ear checks. Qualitative responses on what is collected, includes, but is not limited to, visual inspection of ear canal (n=7), tympanic membrane check (n=7), ear cerumen (wax) check (n=2), ear discharge or evidence of infection (n=3) and other visual abnormalities (n=1).

Oral health

Thirty-five participants reported collecting information on oral health. Qualitative responses on what is collected, includes, but is not limited to, lift the lip (n=11), palate check (n=3), tonsil check (n=3), tooth decay check (n=10), questions about hygiene (n=6) and anatomical variations or abnormalities (n=4).

Growth monitoring

Thirty-four participants reported collecting information on growth monitoring. Qualitative responses on what is collected, includes, but is not limited to, height (n=21), weight (n=21), head circumference (n=18), Body Mass Index (BMI) (n=5), length (n=1), waist circumference (n=1) and vitals (n=1).

Health behaviours

Thirty-nine participants reported collecting information on health behaviours. Qualitative responses on what is collected, includes, but is not limited to, sleep and/or settling (n=17), diet/eating habits (n=15), physical activity/exercise (n=5), social/emotional behaviour and regulation (n=10), toileting (n=5), sedentary behaviour/screen time (n= 3), breastfeeding/bottle feeding/solids (n=3), parenting/parent mental health/supports (n=2), infant mental health (n=2), developmental milestones (n=3) and play (n=2).

Immunisation

Twenty-eight participants reported collecting information on immunisations. Qualitative responses on what is collected, includes, but is not limited to, checking if immunisations are up to date (n=5), providing information on scheduling for immunisations and catch-up services (n=4), record accuracy (n=3) and health promotion around immunisations (n=1) and health promotion around immunisations (n=1).

Other

Eight participants reported collecting 'other' health information. Qualitative responses on what is collected, includes, but is not limited to, allergies (n=1), speech (n=1), ASQ:SE-2 (n=2) and friendships/social wellbeing (n=2).

Information and Record Keeping

Thirty-three participants responded when asked about how they record Child Development Check information. Three participants reported they did not record the information anywhere. The remaining 30 participants reported recording information from the PEDS, ASQ, Brigance Screens, Child Development Inventory scales and other tools somewhere.

Mode of record keeping

Overall, of the 33 participants who reported recording Child Development Check information, most reported using electronic organisational or practice-based system for their record keeping (n=29), followed by hard copy patient records stored within an organisation or practice (n=20). Similarly, other health information collected, most participants reported using electronic organisational or practice-based system for their record keeping (n=33), followed by hard copy patient records stored within an organisation or practice (n=19). Details on the specific organisational record systems used can be found in Appendix 4. Table 5 summarises where participants reported recording Child Development Check information as well as any other health information collected.

Table 5: Mode of record keeping for CDC tools and health information

	Hard copy parent only record	Hard copy patient organisation or practice-based record	Electronic organisational or practice-based record	Wider data system or health record	Other
Parents' Evaluation of Developmental Status (PEDS) (n=2)	1	0	1	0	0
Ages and Stages Qeustionnaire (ASQ) (n=40)	7	12	20	0	1
Brigance Screens (n=19)	3	8	8	0	0
Child Development Inventory (CDI) (n=0)	-	-	-	-	-
Tool total	**11**	**20**	**29**	**0**	**1**
Other (n=37)	6	13	16	0	2
Any health information (n=59)	7	19	33	2	0
Grand total	**24**	**52**	**78**	**2**	**3**

Record Access

Participants were asked who has access to the information collected or the results of the Child Development Checks. Participants reported themselves/the provider and the caregiver (n=30) as well as other staff that work at the same site (n=28) as who most commonly has access to the information. This was followed by other providers across the wider organisation (n=23) and providers who have been referred to (n=26). A few participants listed other organisations across the Early Years System (n=3) as having access and a few participants specifically identified other options which included, the Department for Education's CSSWD[SIC], Early childhood centre directors, external allied health, Playgroup SA and the DEX, DSS[SIC] database. A summary of these responses can be seen in Table 6.

Table 6: Access to Child Development Check Information

Groups	Staff (n=48)
Only myself/the provider	7
Only the caregivers	0
Myself/the provider and the caregiver	30
Other staff at my site	28
Other providers across my organisation	23
Other providers across the Early Years System	3
Providers I have referred to	26
Other	6
I'm not sure	0

Use and Follow-Up of Information

Participants were asked what they do with the information when *no concern is identified* during a Child Development Check, and what they do with the information when *a concern is identified*. The majority reported that they would never or rarely take no action, in either circumstance (n=38 and n=42, respectively). Tables 7 and 8 summarise participant responses.

When *no concern is identified*, almost all participants reported they would often or always document the result in the patient record (n=46). Participants also reported providing a verbal outcome to the caregiver often or always (n=46). With regards to follow ups, most participants reported a follow up appointment was arranged only sometimes (n=21) and quite a few participants reported they often or always organized a follow up despite no concerns identified (n=14). Finally, when asked if they provided a reminder for future action, most participants reported this was done always or often (n=31) with fewer reporting this was never (n=7), rarely (n=6) or sometimes (n=8) done. Qualitative responses to other action taken include, but are not limited to, booking for next routine visit, or supporting access to early childhood care and kindergarten. A complete list of other actions taken when no concern is identified can be seen in Appendix 5.

Table 7: What is done when no concern is identified in a Child Development Check

Staff (n=52)	Never	Rarely	Sometimes	Often	Always
No action	32	6	3	4	7
Result noted in patient record	4	1	1	3	43
Verbal outcome provided to the caregiver	2	2	2	4	42
Follow up appointment arranged	8	9	21	6	8
Reminder for future action	7	6	8	15	16
Other	7	1	1	4	7

When *a concern is identified*, almost all participants reported they would always note the concern in the patients record (n=44) and provide a verbal outcome to the caregiver (n=44). Most reported they would either always or often provide a letter or report to the caregiver (n=34) and arrange a follow up appointment (n=46). Regarding referrals to specialists, participants reported they always (n=17), often (n=13), or sometimes (n=15) provide a verbal recommendation to see another specialist or provider (n=38). Most participants reported often (n=14) or always (n=12) providing an informal referral and often (n=10) or always (n=12) writing a medical letter to another provider or specialist. Finally, most participants reported always (n=20) or often (n=13) providing an intervention at the time of the appointment when a concern was identified. Qualitative responses to other action taken include, but are not limited to, assessing clinical priority/risk, contacting parents, having a conversation with caregivers, ASQ hoke activities and formal referrals. A complete list of other actions taken when a concern is identified can be seen in Appendix 6.

Table 8: What is done when a concern is identified in a Child Development Check

Staff (n=49)	Never	Rarely	Sometimes	Often	Always
No action	42	5	0	0	2
Concern noted in patient record	1	1	0	3	44
Verbal outcome provided to the caregiver	0	0	1	4	44
Letter or report of outcome provided to the caregiver	1	4	10	11	23
Follow up appointment arranged	0	1	4	22	22
Reminder for future action	3	2	3	17	24
Verbal recommendation to see another provider or specialist	3	1	15	13	17
Informal referral to another provider or specialist	4	2	17	14	12
Written medical referral letter to another provider or specialist	0	1	6	10	12
Intervention provided at appointment	1	2	13	13	20
Other	1	0	1	4	10

Centralising Child Development Check information

Participants were asked if they have any prior experience using centralised data systems. Forty-seven responded, with 20 saying yes, 18 saying no, and 8 who were unsure.

Participants were asked their perspectives on centralising the information collected from Child Development Checks. Forty-six participants responded and overall, participants agreed (n=21) and strongly agreed (n=15) that there are benefits in coordinating or centralising the information collected from Child Development checks. Table 9 summarises participants responses to the benefits of centralising information.

Table 9: Perspectives on centralising Child Development Check Information

Staff (n=46)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Question: There are benefits in coordinating or centralising the information collected from Child Development Checks	2	0	8	21	15

Thirty participants provided qualitative responses detailing what they perceive as the benefits of centralising Child Development Check information. These responses include, but are not limited to, tracking children across services, shared information to support families, earlier intervention, ease of communication, continuity of care and less duplications. The complete list of perceived benefits as reported by participants can be seen in Appendix 7.

Only two participants provided perceived challenges to centralising Child Development Check Information. These responses include use in remote communities, ensuring accuracy, focusing only on development and no set pathway or follow up. The complete list of perceived challenges as reported by participants can be found in Appendix 8.

When asked if a state or national based early years data system would be helpful, most participants reported that a state or national system would be very or extremely helpful for providers, parents and for children's health. Only one participant reported that they thought a national system would not be at all helpful for parents or children's health. These results can be seen in Table 10.

Table 10: Helpfulness of a Centralised State or National System

	Not at all helpful	Slightly helpful	Somewhat helpful	Very helpful	Extremely helpful
State based system (n=40)					
Providers	0	1	7	15	24
Parents	0	6	7	16	18
Children's health	0	3	4	17	23
National system (n-37)					
Providers	0	3	10	8	23
Parents	2	4	11	11	16
Children's health	1	3	7	13	20

When asked what would enable setting up a centralised state or national Child Development System, participants reported strong IT support, government will and support, funding, a national agreement, education, time, collaboration, and more staff amongst other reported requirements. The complete list of enablers as reported by participants can be found in Appendix 9.

When asked what a barrier would be to setting up a centralised state or national Child Development System, participants reported confidentiality, funding, coordination, guilds, and professionals who do not want data shared, data ownership, consent, stakeholders, scheduling, glitching and hacking. The complete list of barriers as reported by participants can be found in Appendix 10.

A list of final comments made by participants at the end of the survey in their own language can be found in Appendix 11.

Conclusion

Conclusion

The aim of this survey was to understand the current practice and perspectives of delivery and data processes for Child Development Checks within the South Australian Early Years System, and to generate evidence that can support the development of a Universal Child Development Data System as recommended by the Royal Commission into Early Childhood Education and Care[4].

Overall, this report identified:

- There are many different organisations and providers conducting Child Development Checks in South Australia
- There is diversity in the tools being used to conduct Child Development Checks with no one standardised tool being used.
- Health information is routinely collected as part of Child Development Checks.
- Child Development Check and health information is recorded within organisational based electronic records or hard copy/paper-based records; These are only available within the organisation or the site unless explicitly referred out.
- Most individuals conducting Child Development Checks are documenting and recording information and results regardless of whether a concern is or is not identified. This information is recorded in patient records, verbally provided to parents, and/or shared externally via referrals.
- Participants responded that a state or national Early Years Data System would be helpful to parents, providers, and children's health.

Appendices

Appendix 1

Other tools used during Child Development Checks

- Health Assessment as well
- Internal assessment and Bayleys scale
- ASQ TRAK2
- ASQ Trak Ages & Stages Questionnaire
- General Aboriginal Child Health Checks
- ASQ-TRAK2
- ASQ TRAK 2
- ASQ- SE2, ASQ- Trak
- CDR (organisation selected)
- Standardised assessments as required e.g. beery VMI, Movement ABC, MFUN as well as informal screeners re. milestones
- Child Development Review Checklist
- Speech Pathology and Occupational Therapy discipline specific assessment tools
- Child Development Review (CDR)
- ASQ-TRAK
- AIMS
- Observations
- ASQ-TRAK2
- Early Years Learning Framework
- My own traditional questionnaire
- Clinical history and examination
- Blue book
- General history
- personal knowledge

Appendix 2

Advantages and disadvantages of using the screening tools

	Advantages	Disadvantages
PEDS	-	-
ASQ	> Parent led - parents oftenlearn new things about their child from doing the ASQ > Able to share childs strengths with family. Parents have an esy way to learn about developmental milestones and see some examples of how to encourage their children progress. Consistent tool to use across organisation. > Covers all areas of development from basic perspective , recognised by various agencies as stanadard assessment - ie KUDOS/NDIS Allied health child hood teams as reference for further assessment > Validated screening tool used by CYH for easier referral pathways > Actual assessment with child and parent > Structured approach > Simple, quick > Parent led, supports parents to understand development > Client led, easy to follow, activities provided to support further development, validated and research based > Quick > Activity sheets, Parent completes ahead of time, ease of scoring > Standardised, parent can complete at home over 2 weeks, covers required domains in ASQ-3 and ASQ-Social Emotional > Comprehensive, easy to interpret results > It is a standardised tool, that our child health nurse uses. we use it as a clinician collected tool, rather than parents filling out. It allows a structure assessment and opportunity to discuss parenting and child health. > Can be clinician led and used for direct referral to early intervention services.	> Sometimes parent will score child incorrectly as they arent acknowledging developmental concerns. thisis way it is so improtant to take time to explore and review what you see with the parent as well. > Due to licensing, you cannot email the questionnaire to families. This causes high costs in postage. Some Americanised language throughout it. > American > If rely on parent to complerte may be inaccurately represented as true record of childs development - relies on literacy of parent. WE compelte as conversation with parent so can assess visually child in action and ask for examples as part of conversation , If not completed in person may trigger trauma for parent /care giver , trauma lens needs to be apies when working with vulnerable fammilies who fear Dept Child Protection involvement iof concerns re development are linked to neglect/abuse - expereince required when working with vulnerable families. > American examples (cheerios) and data is stored offshore so we cannot use digital versions > Not always completed before the appointment > Not all professionals are trained in this > Not available digitally yet or in other languages > Too general > Inaccurate answers by parents, not completed, not received, not completed over 2 week timeframe. > Electronic scoring not readily available in Australia > Time taken; hard to get families to bring back > Not validated for refugee population

	Advantages	Disadvantages
Brigance screens	> It is thorough and the results are sent directly to health professionals such as; to Speech Pathologists, Occupational Therapist and Paediatricians and GPs > The advantage of using the Brigance is that it provides the in-depth scores, reports and referrals that are used by Medical and Health professionals. The use of Brigance provides direct referral data from the Nurse Practitioners to Paediatricians, Speech Pathologists, OT, Physios, GPs that they can use and decreases the needs for other appointment, this decreases the barriers for parents to the referral uptake or barriers to health access, and the supports for children with developmental delays or previously undiagnosed and untreated health conditions > Gives percentiles > Provides additional recognised assessment for referral to NDIS. KUDOS /early intervention Allied health teams, Paediatrician. Is a more comprehensive assessment when completed fully that may lead to more follow up with appropitae service/Paediatirican for medical review > Assessor completes the screen, making assessment of a child's strengths, abilities and challenges > It is completed with the child's usual Educator, in the usual child care setting and the RN and NP provides objective assessment and notify the parents if anything found. Brigance also provides direct referral response that are useful to paediatricians, speech pathology and other health professionals creating a bridge between education, parents and health > More comprehensive than ASQ. Can go older.	> Some of the pictures need up dating > Others use an inferior screening tools. You need some training to use it properly. > Subjective > Needs to be explained to parent and more controlled as child has to particpate more in Brigance for accurate record as well as some converation with Parent. May take some time to complete if child not cooperative with process/ parent struggle to particpate due to their own challenges /understanding/ trauma impact/fear of services/ fear of removal of child /fear of DCP involvement > The tool appears outdated and to have an American focus. > It does take time but very comprehensive > Very time consuming. No funding model to use in private bar parent out of pocket costs for report
CDI		
Other	> Measures exactly what we want to review > We are able to confirm reason for referral, pinpoint more accurately intervention needs and understand clinical priorities to formulate clinical responses and further referrals. > Early Intervention > It has been developed and researched specifically for Aboriginal and Torres Strait Islander children and their families. It is a culturally approriate tool to use and encourages referrals to appropriate medical specialists	> We designed it ourselves > None > None found so far > Only a baseline screening/monitoring tool so lacks great depth > More culturally appropriate follow up activities required

	Advantages	Disadvantages
Other (cont'd)	> Culturally safe for Aboriginal and Torres Strait Islander children, play-based, strengths based, practical and short timeframe > Culturally appropriate to use with Aboriginal families > As mentioned above the ASQ- SE2 helps to create a full profile of the child. It gives the parents an opporutnity to consider carefully the child's social and emotional skills and then highlight if this is an area that requires further assessment and support. It also helps with referral pathways as mentioned above it provides a clear picture of challenges that hte child is facing that may not have been apparent in the ASQ 3 if administered on it's own. The ASQ-Trak is a much more culturally safe tool to use with families. It provides visual support for families and walks them through the screen which families have reported to me makes them feel well supported. > Provides standardised information on a child's development > Overall snapshot of delay – informs referrals > Assist with accurate assessment of development against norms and aid in early diagnosis of disability as well as plan appropriate intervention > Quick and informal. Gathers both qualitative and quantitative data. > Culturally appropiate > Observational > The documentation is on hand to review as needed. As the child develops we can check on the progress of the child. > Holistic resource used to guide planning for supporting children's development > Know it well > Patient centred > Easy to use, usually have with them, quick > Quick	> The disadvantage of using the ASQ-SE 2 is that it increases the amount of time to complete the tool. The scoring is described differently to the ASQ- 3 which can be confusing to families if not explained clearly. The latest edition of the ASQ Trak has increased age intervals, which is a positive. The ASQ- Trak does not have the broad questions at the end like the ASQ- 3. It does not ask if there are concerns around hearing? Anything that worries them? Any concern regarding behaviour etc. These open ended questions provide the screener with a great opportunity to get a fuller picture of the child and the challenges that they may be facing. I think this is a negative of the ASQ- Trak. The ASQ- Trak takes about 1 hour to administer, which is very long, but beneficial. > Many children are unable to sit to attend to a formal standardised assessment as well as the time it takes to complete these assessments > Can be inaccurate based on clinician interpretation > None as my team are specifically referred to provide these assessments and early intervention w for children with suspected delay or disability > Milestones are not completely accurate across all domains of a child's development. Less focus on parent-child interaction/attachment > Limited time to complete together > Limited age range > Maybe missing some new modern information > No disadvantage if appropriately trained > Not as comprehensive but good screening tool > Not standardised

Appendix 3

Additional Qualitative Health Data Collected during CDCs by Category

Physical health

- Presence of equal femoral pulses, Hips - Gait. limbs, spine, hands, feet, toes, umbilicus. Genitalia and inguinal area, testes. Check for physical indicators for variations that may suggest genetic abnormalities or things like FASD. Fontanelles plagiocephaly. anatomical variation of ears
- Out of my scope. Cafhs nursing collect all this information
- Physio assessment undertaken by Physio Ears, Eyes, Mouth (shape an function), dental, lungs and heart sounds etc., Height, Weight and head circumference , Hips, gait, core strength
- Collect,
- Cardio sounds, chest sounds, skin
- Movement, skin, any other concerns voiced by carer
- When required for infant health check and new arrival children's screening check
- Age appropriate checks
- Visualised progress, colour, strength
- Gross motor observations/screen
- Fontanelles, Head circ, eyes (tracking), ambylopia assess, ears-tags etc, oral-function, thrush etc, skin, reflexes, hips, genitals, skeletal-spine etc
- Head shape, range of motion, tone, reflexes, skin, capillary refil etc
- Comprehensive health check re tone, muscle strength, femoral pulses, colour, skin turgor etc
- Full developmental assessment
- Head to toe, fontanelle &head shape, symmetry, neck contol and head lag, infant reflexes, limb movement, skin, hip checks, gait, etc per screening tool
- General assessment, depending on findings
- Complete in-depth health assessment and developmental screening

Vision

- Optometry complete these with us
- Corneal light reflex, appearance, fixation/following. distance vision with Kay picture charts
- Out of scope but Cafhs nurses collect all relevant information
- Lea symbols tool
- Visual acuity and red eye reflect
- Visual ascutiy & sheridans
- Kay picture test
- Fixation and following, light reflex, Kays Picture screening
- Kay Picture Chart, fixation and following, apperance, corneal light reflex, distance vision
- Red eye reflex, eye movement, squint, visual acuity screen 4y
- Evidence of visual disturbance, eye movemens, pupillary reflexes, nystagmus, squint etc
- Data on Health and development with the children's educator input and if any issues found the parents are contacted

Hearing

- Under six months - AABR, 4 years- audiometer. information is collected indicating hearing loss and hearing function
- Out of scope but Cafhs nurses collect all relevant information
- Turns head towards sound
- Audiometry, ask question
- Family history, concerns regarding hearing, whether there is a history of middle ear infections, whether child responds to name/noise
- Otoscopic exam, tympanometry, otoacoustic emissions
- UNHS, and audiometry in 4yo
- Newborn and preschool hearing
- Newborn screening (AABR) to 6 months, Audiometry
- Turning head to sound
- Universal screening, 4y audiometry, plus review at all health checks.
- Turning head toward sound, conversational ability

Ear Check

- Ear canal, tympanic membrane check, ear discharge
- Tympanic membrane, infections
- Ear check bilateral TMs
- Ear canal
- Otoscopy
- Any abnormality
- Otoscopic exam
- Check ear canal to look at Tympanic membrane, observing for cone of light, evidence of fluid behind the TM, wax, FB
- Tympanic membrane, wax level, ear infection and need for antibiotics or direct referrals to ent specialists

Oral health

- Teeth, tonsils, gums, etc for signs of deformity or disease
- Lift the lip, palate intact, tongue function and anomalies
- Out of scope but Cafhs nurses collect all relevant information
- Lift the lip, dental
- Teeth, tonsils
- Lift the lip
- Dental check on all children and referral
- Visual check
- Check for dental hygiene
- Train playgroup facilitators to refer to lift the lip program
- Oral motor assessment as part of Speech Pathology consult if needed
- Visual and lift the lip
- Lift the lip and referral
- Lift the Lip, suck, anatomical variation, oral health review
- Visual check and discussion with parent
- All
- Observe dental quality, looking for signs of decay and poor hygiene
- Lift the lip, cleft palate, tooth decay, tonsillitis etc

Growth monitoring

- Yes all
- Height, weight, head circumference, length, BMI
- Out of scope but Cafhs nurses collect all relevant information
- Height, weight, head circumference
- Ht, Wt HC
- Weight, height & head circumference, BMI
- Height, weight, head circumference, baseline vital signs
- Ht, wt, wc, HC
- Height, weight and head circumference is collected and plotted on growth chart.=
- All three and transcribe to WHO growth charts
- All growth measurements
- BMI, height, weight, head circumference, monitor for faltering growth
- Height and weight if apparent issues
- All
- Height, weight, HC
- Height, weight and head circumference measures against blue book growth charts and WHO charts

Health behaviours

- Yes and social behaviours, social-emotional control etc
- Emotional development, sleep, diet, physical activity, behaviours concerning parent
- Out of scope but Cafhs nurses collect all relevant information
- Sleep and physical activity
- Physical activity
- Diet, behaviour, sleep
- Diet review, sleep review when required, behavioural observation and referral when required.
- All mentioned
- Noted behaviours relating eating, sleeping and behaviours

- ASQ-3 -parents are asked open questions about concerns – concerns around diet and sleep are often raised. ASQ:SE2 - parents are specifically asked about their child's eating, sleeping and toileting habits.
- Mealtime information (e.g. food range diary, mealtime behaviours) as well as sleep information (where and how long the child sleeps, night terrors, bed wetting, frequent waking, issues falling or staying asleep)
- Sleeping, eating, toileting, dressing, regulation
- We conduct case history questionnaire, which covers all areas of a child's development
- Depends on what the parent wants to discuss, no data is specifically recorded. Key issues would be sleep, nutrition, toilet training
- Diet, screen time, toilet training, behaviour, sleep, parenting, play, development, community support, mental health, infant mental health, relationships, breastfeeding, feeding, solids etc
- Breastfeeding, feeding, starting solids, family diet, immunisation, play, safety, oral health, behaviour, toilet training, community supports, wellbeing, infant mental health
- Discuss all: sleep, physical activity, sedentary behaviour and diet
- Breastfeeding support, bottle feeding, introducing solids, sleep and settling concerns, movement and gross motor development
- Impulse control, disruptive behaviour, diet, sleep (including snoring which needs immediate ent referrals, ability to meet physical development milestone, social behaviour

Immunisation

- Immunisations completed
- Immunisation status
- Full scheduled and catch up service
- Check AIR, records
- All information is documented regarding immunisations.
- Whether the family are up to date
- Current immunisation status and health promotion re immunisations
- Is child immunisation up to date per schedule
- Immunisation history statement

Other

- Breastfeeding feeding, artificial feeding, solid foods, diet, allergies
- Speech assessment undertaken by Speech Pathologist
- See above response. If there are behaviour concerns then with consent a ASQ- SE2 is completed with the familiy.
- The ASQ:SE-2 is used as an adjunct to the ASQ-3 when indicated
- Information on social wellbeing (friendships, social communication), toileting, sleep, motor development (find and gross motor skills)
- Data is only collected if there is parent or clinician concern

Appendix 4

Organizational Record EMR as reported by participants

- eCHIMS
- eChims and moving to state wide EMR
- CCCME, Health Track, EMR Sunrise
- CCCME, medical file
- We use a research database and provided letters to all parents who consent for their child to be screened. We also ring the parents directly if we find anything of concern that needs a referral.
- Spread sheet
- Microsoft Teams spreadsheet
- Best practice
- Salesforce
- Penelope
- Best practice
- Communicare
- Communicare
- Online Case Management Software
- Have a data system that we keep notes on outcomes of checks for families. Detailed notes, consents, summaries of results and any referrals that have been made are stored securely on the data system.
- Consent forms, ASQ summaries and referral forms are uploaded. Case notes may be entered.
- Sunrise
- Sunrise
- Sunrise
- In-house client record management system
- Sunrise EMR
- eCHIMS

- eCHIMS
- SharePoint
- eCHIMS
- We have a large database, providing comprehensive letters to parents and Centre Directors. also useful information to Health professionals to support children accessing services they need
- Communicare
- Storypark is used for holding children's documentation
- Best practice
- Best Practice
- Best Practice
- Best practice emr
- Best practice software
- Best practice
- Best Practice
- Best practice
- My gov
- Our third party provider software which is used to send information to the DSS
- Playgroup SA records information when facilitating pilot
- Recorded on hard copy and then results uploaded to software case management system Penelope
- Penelope

Appendix 5

Other action taken when no concerns during CDC

- A letter with the results of the devleopmental screening and health check is provided to every parent even if no action is required
- Information is used to inform KPI and progress with how many children are being assessed by CaFHS.
- Refer to community based services for general developmental/parenting input
- All parents receive a letter with scores and a summary of their child's health of how their child was on the day. this letter is also provided to the Educational Centre director to ensure if the child needs support that the educators can provide that while they are waiting for the appointment with Allied Health or Medical professionals
- Reminder for routine dental check ups in all letters to parents
- If no concerns raised will ofer to monitor and review after period of time – not oftne no concerns rasied
- Assist family to enrol at kindergarten or school if appropriate
- Playgroup SA records all information for our families
- If no concerns are identified we have record that a check was completed with a consent form. The family are given the summary sheets for their reference.
- Verbal information provided about how they can access a child development check in the future. Information about next developmental steps may be provided.
- Report data quarterly to DoE Children & Students with Disability Program
- Play activities to support future development
- Provide a written report to the family
- Usual Child educators and centre Director provided with information so they can assist the family
- Seek additional support
- Kept on file for child
- Book for next routine development check
- Support to access early childhood care in mainstream including kindergarten

Appendix 6

Other action taken when concerns noted during CDC

- Data collected to inform service
- Formal referrals completed as needed
- Assess clinical priority/risk and provide follow-up interventions, referrals or place on waitlist with activities provided for families to undertake whilst waiting for further therapy to start. may initiate referral to NDIS, or for medical needs to GP or Paediatrician
- We ring the parents immediately if we find anything of concern.
- Readiness activities provided in letter for childcare/caregivers
- We cannot give direct referral to specialist services, however can refer to allied health support or direct carer/parent to Gp for follow up
- We are a community serivces organisation, not a health provider so we don't have "patients'" and we are not linked ot a health database. We always refer directly to the local Aboriginal Health Service in the first instance, and often complete the checks with a health professional
- When necessary shared with other services - Childcare/Cafhs/Kindergarten so allaware of concersn raised - espicially where parents have vulnerabiliteis engaging with services/literacy levels reduced
- Referral to our Paediatric service
- Playgroup SA collects all information for our families
- If a child is screened as vulnerable then we will discuss possible pathways for families including community supports and formal supports. If the formal supports have a method of formal referral (ie a referral template) then we will complete this and attach any evidence that we have gathered with the parent's consent. We also gather consent from families to keep a copy of the summary record on our files. A written one page summary of results is often given to families to take to their GP if medical concerns were indicated or if they could benefit from referral for particular areas ie. hearing test. Discussion around immediate activites often takes place during the meeting with the family to provide them with some immediate strategies to implement to promote development. Resources are emailed to familes as well as links for online services or other community services. We have recently started offering up to three allied health sessions to families if the child is screened as vulnerable and requiring support with

pathways for further support. These sessions include support to pathways and navigating systems as well as hands on sessions which involve guidance and coaching of parents/caregivers with immediate home based, child centred activities to promote development. We have just started rolling this out.

- Referral forms are often completed with the caregivers.
- Report data qtly to CSSD Program within DoE as part of grant funding obligations
- Conversation regarding recommendations is had with the caregiver. If they consent to referral, a referral is completed
- Centre Director and Educator
- ASQ hoke activities and see again in 3 months if in grey area on screening

Appendix 7

Perceived benefits in coordinating or centralizing the information collected from CDCs

- It provides an ongoing record for the dept of health to identify health interventions, numbers of health professionals required and types to support the community and the waiting time (for CDU these are 3 years) required and for the Dept Edu to understand the levels of developmental vulnerability in the community and identity areas of need where extra supports are required to help the children have the best start to life and school
- Information can be shared to support a family accessing a range of services and organisations
- We would be able to track children across services to provide a complete picture of their development and their health and developmental needs
- Sharing information between providers (access to results and information from previous checks including if referrals were made), allow monitoring of trends in growth and development, facilitate follow-up and clinical governance, tracking of clients to allow reminders for subsequent checks, etc
- Itinerants can be picked up elsewhere
- It is difficult for many of our fmilies to navigate systems, a centralised system would ensure families did not have to remember everything that has been said to them to provide to next provider, but also not have to repeat their story
- Earlier intervention, reduce gaps or children missing out on intervention
- Ease of communication history of assessments completed - ease of sharing inforamtion for chilsren to receive approipaitae support - ease for carers/kinship careds to be able to share inforamtion if children removed/ placed in foster care. Potential for historical assesmsent provided to child in adult life if seeking history due to removal formparents at any stage to suport followup supports in adult life. Simply ease of sharing releveant development assessments across health/education/allied health/NDIS
- Easier access for transfer of care to mainstream organisations
- Early intervention
- National database for transient populations.
- Coorindation, best practice, reduce oversaturation of services, patients repeating their story/information

- Access when families/children transition to other services
- Ensuring that waiting lists for allied health professionals are not too long
- It will allow services to see which checks have taken place in the past and the outcomes, what was recommended and referral pathways made. It will allow you to see if the child has made progress with their development
- The centralising of information would enable more accurate monitoring of a child's development (ie. monitoring can occur even if a child moves from one service provider to another)
- Other organisations can see results and services provided
- Continuity of care
- Accessible data for govement and service providers to identify need and demand for early intervention support
- Coordinated approach to service delivery
- Better access to supports for the child, not needing to repeat assessments and stories etc
- Shared information, open communication, less duplication of referrals, knowing the next steps and who is involved
- Good communication
- Access to all, as appropriate
- Strong follow-up, support for families and less children falling through the gaps in health services
- Prevents children "falling through the gaps"
- Continuity of care between providers, enhancing provision of definitive care and early intervention for children with developmental concerns
- Continuity so we can pick trends in an individual
- Inter practice sharing of info
- More insight as to vulnerability of children form refugee background

Appendix 8

Perceived challenges in coordinating or centralising the information collected from CDCs

- Monitoring data particularly if there are multiple provides undertaking the health and the development checks. Significant issues with collecting data for Aboriginal Children if services provided by ACCHOS or services in very remote communities. significant issues in accurate data collection in regional areas.
- The focus only on development checks and not incoporating a comprehensive health check, holistic approach, caregiver wellbeing etc that all have major impacts on child development, no set referral pathways, recall process or follow up plans

Appendix 9

Enablers to setting up a national data system

- Federal Government and state government will power
- If all children came to CaFHS - just use the sytem CaFSh already have in place and no improvment therefore required. CaFHS can report from their system.
- Have CDC and CHC data collected and reported on separately, children are likley to get lost in the system as they already are. Future proof the data collection/IT system as much as possible, too many iterations means lost data and poorer data recording. Build any system to be as smart as possible and be able to cover easy uploading of hard copy data collection - there are still many organisations/staff in regional areas that are not IT savvy, don't have the mobile devices to input the data or have the bandwidth available. Even our highly skilled Paediatricians can't access electronic/phone in regional areas if they don't have the right data carrier
- Collaboration between Health, Education, CPU, CDU, and the NFP sector
- Collecting data from all participating sites
- Universal System allowing access
- Systems would need to be able to talk to each other, for example we enter data into salesforce that then feeds up to DEX, as an organisation that is tightly funded, having to reenter data into another system would be time consuming
- Local, state and national agreement
- Guidelines re inforation sharing of such data – good IT person! – ease of how works – ie like AIR system for immunisations perhaps?
- Nation data base
- A lot of IT involvement, with health professionals and families.
- Education and a coordinated response
- Funding
- Consistency of approach.
- Government funding and training for all staff across sectors (e.g. health, education, child protection)
- Political appetite, well admisntered network for NGO providers, a single simple system

- Federal government support
- Federal funding and long-term commitment
- A good system that is not slow, everyone has access to
- Federal support and funding and cross state support
- Freedom of information
- Collaboration and ability to record and document all parameters
- Federal government funding and support
- Time, extra staff to allow system to be set up
- Across state agreement
- Based in an app, personalised to the child, accessible to selected providers e.g. consent by parent
- Funding to maintain
- Funding
- Funding and commitment by all relevant agencies

Appendix 10

Biggest Barrier to setting up a national Early Years data system

- Professionals/guilds who want to block sharing information
- It's not just about development it's health as well
- Information sharing guidelines across states
- Not sure what you mean by children's health but our state's have such varied data systems one National data system would be complex to achieve and have accurate/timely data and reporting
- Guilds and Professional barriers. Those who do not want to share
- Funding
- Access
- Confidentiality, costs to access for providers to input and time
- Ownership of information, consistency, confidentiality, data sovereignty
- Historical silo systems /data sharing confidentiality concerns/ownership around data- although ASQ widely used tool – may require a national develpment tool to be advised
- Co-ordination accross states
- Developing a system that is easy to use across the board.
- Education surrounding benefits and consent
- Collecting and managing the data. Different health systems across different states
- Sheer size, confidentiality
- Communication between different providers. Shared responsibility (ie. which provider follows up/sends reminders etc)
- Cost, training for staff
- State based jurisdiction differences, variation in funding for early years intervention and political sensitivity over comparing prevalence, different e-health record systems, wide variety of ngo providers who would need access and training, agreement n screening and assessment tools and establishing a national minimum data set
- Confidentiality

- All organisations signing up to it
- Haha cost and getting all the stakeholders to agree
- Many differences between each state
- Differing health check schedules across all states, differing developmental tools across all states, the focus on development checks alone rather than child and development check
- Huge system which could be prone to glitches and hacking
- Getting all states to agree
- GP and other health professionals who want ultimate control of the system instead of sharing information to benefit children
- Time
- IT issues and finances
- Many patients are currently declining uploads to My Health Record due to concerns about data breaches
- Additional admin burden
- Consistent use by all providers. Access for non-Medicare patients
- Huge amount of data, consent
- Cooperation of all agencies and staff to do the work

Appendix 11

Final comments

- We need to enter 21st century and stop leaving our children behind. Other countries have these systems and these allow federal and state wide planning and responses that follows the child no matter where they live
- There is a a national child health record rolling out - link in with this. There is always a child and someone. Developmental staus of cheildren needs to be considered alongside the parents vulnerabilities as well. you cant just tell a vulnerabily parent to work on development of the child. they need therapeutic support as well
- I think you need to completely separate the development and the health checks it is too bitsy to have sodo the development and some the health checks. Be really clear about what outcome you want from all of this work and effort you are asking organisations and staff to commit to. Make sure you are able to demonstrate outcomes for our efforts and work hard at this simply becoming another administrative exercise
- Australia is behind most devleoped counries who have this informaiton, it is useful for servcie planning, that includes the numbers of Medical, Allied Helath and Nurisng we need to mainaint an responsvie Helth and Education system to meet the needs of children
- No
- This is something our program that focuses on school readiness for early years would have used, as data is not always accurate and difficult to find.
- So many vulnerabel families do not engage with traditional health services/ system due toimpact of trauma/fear of child proctection/judgement – that requires sensitivty when compelting such assessmenet – would hope that those that do not engage with clinic based services woudl be offered option of home based service and trauma responsive assessment completed resepcting the impact of trauma for both parent and child is managed throughout.
- NDIS to be easier to access for families
- Families are reporting that having other ways to complete checks is convenient. More and more families are recognising the value in early intervention and are mostly open to any support that can be provided. When we are screening we need to consider the wait times for families and the risk of stress on families knowing that their child has a potential vulnerability but they have to wait months or years to engage with specialist

providers. Families need to have access to some tools and assistance to support them immediately to help mitigate this. The increased number of screenings has resulted in increased referrals to specialist providers. There is currently a lot of pressure on the allied health system so it is important to consider how this profession can be supported to grow to meet the needs of the community

- As an NGO engaged in early ID and detection of developmental delay in early years non-gov and gov settings there is an enormous and increasing need for earlier ID and funding barriers to responding to provide rapid access to evidence based early intervention.Increasing screening and ID rates will only drive up demand for EBP intervention and cannot be addressed in isolation from access to early intervention. Happy to discuss our role further and keent o be involved in discussions about system reform
- It would be unhelpful to add another level of documentation to an already complex system. A new electronic system would need to replace existing systems not be added on as an extra task
- We need to move forward to aid the 30% of Children who need extra support. for every $1 we spend in the 0-5 years we save $17 in adult care
- NO
- ASQ is routinely done by early childhood educators. A system where education routine does, and clear referral pathway to GP if issues, would be ideal. This would also inform education setting based early intervention strategies
- MHR is not used in SA for paediatric patients. RACGP is recommending a funded 4 year old check. MBS limits funding for screening health checks to ATSI and people with significant intellectual disturbance. Any ideas to do unfunded clinical or administrative work is unhelpful

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Report for Preventive Health SA by Flinders Caring Futures Institute.

Find out more about how Preventive Health SA is leading a dedicated program of prevention work to support the health and wellbeing of all South Australians at **preventivehealth.sa.gov.au**

For more information about the vision of the Caring Futures Institute and the cutting edge research projects already underway or to get involved, visit our website at **flinders.edu.au/caringfuturesinstitute**

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Government of South Australia

Preventive Health SA