ASSESSMENT OF THE ESTABLISHMENT AND EARLY IMPLEMENTATION OF THE CHILDREN'S ACTION PLAN IN HAMILTON

April 2015 to December 2015

Executive Summary

Prepared by Geoff Stone with the Children’s Action Plan Directorate.
Introduction

The Hamilton Children’s Team (HCT) was launched on 1 September 2015. A full Children’s Action Plan (CAP) approach has also been implemented in Hamilton, including a contact centre – the Vulnerable Children’s Hub (The Hub), an inter-agency information sharing agreement – the Approved Information Sharing Agreement (AISA), and a common database/IT platform – the Vulnerable Kids Information System (ViKI). The team was the fifth to be established in New Zealand and the first large scale, urban site.¹

In April 2015, the Ripple Collective was engaged by the Children’s Action Plan Directorate (the Directorate) to undertake an evaluation process that supported the HCT through its planning, development and early implementation phases.

This evaluation ran from April 2015 to December 2015.

A previous assessment of the Children’s Team (CT) demonstration sites by the Social Policy Evaluation and Research Unit (SUPERU) in 2013 identified five design and implementation components. This report is based on the five components and arranged according to each:

- Planning and development
- Partnership
- Implementation
- Systems change
- Scaling up.

¹ A glossary of key terms is provided as Appendix 1.
Planning and Development

For planning and development, the components considered critical for success for the establishment and implementation of the CT were:

- a shared vision and common agenda;
- communication, engagement and change management; and
- fit and alignment with current service provision.

Findings

Shared vision and common agenda

A favourable community climate is an important starting point in progressing a shared vision. We identified that Hamiltonians wanted to do more for vulnerable children. Professionals were well disposed to the idea of a CT and believed it would make a difference to the lives of vulnerable children by enhancing and potentially changing status quo service delivery.

Views differed, however, on how the Children's Action Plan (CAP) should operate in Hamilton. There were different concerns and priorities as well as structural issues at both central government and local levels that slowed the development of the CAP in Hamilton. These differences centred on:

- the local perception that the HCT should work with families / whānau who consented to engage with the process;
- the levels of client risk and need that the HCT should take on; and
- what the Lead Professional (LP) role is and how it should be resourced.

Stakeholders had varied views and the HCT Director needed to negotiate a workable balance between the central government and local level priorities.

There is a growing understanding of the CT's role; sitting between existing service provision and Child, Youth and Family (CYF) statutory intervention.

Communications, engagement and change management

An increased communications effort is crucial to drive and maintain the momentum of the CAP in Hamilton. A key part of that is articulating and refining a clear change model and improving information sharing across sectors without overloading lead professionals.

Moving into a ‘confirmation/expansion phase’ should signal an opportunity to focus on wider systems change. However, this may not happen without active support from the Directorate. What systemic changes need to be made and how can be considered once the HCT is fully established. Further guidance and support is needed from the Directorate to enable the Local Governance Group (LGG) to review Hamilton’s service ecology and engage in service systems design. By mid-2016, it would be opportune for the LGG to focus on community, organisational and workforce change, with the support of the Directorate’s Workforce Programme.

Fit and alignment

It is important to clarify the relationships between initiatives and services in a continuous communications strategy, coupled with concerted efforts to negotiate partnerships. This would not only address any concerns, but also serve to clarify and these concerns.

Understanding of how the HCT fits with other services will take some time. Research, including case studies, will indicate how different groups come into and move out of the HCT and could reveal the patterns of services that were in place before, during and after the HCT’s intervention. This kind of intelligence will help stakeholders engage in local service and systems design.
Insights from Planning and Development

Shared vision and common agenda

Achieving a shared agenda requires the greatest input of resources up front. The level of investment in this phase may need to be increased in order to improve the rate of progress.

Early identification of local views, perspectives and the wider landscape is needed that will affect a shared vision, e.g. previous and current community work for vulnerable children, iwi perspectives and aspirations.

Communications, engagement and change management

Clear and persuasive communications need to focus on:
- the relationship between CTs and CYF and why children end up in one or the other
- the child’s needs as paramount, for example, using the Children’s Commissioner videos and practitioner examples that speak to frontline staff from various disciplines and sectors, and
- information sharing, with assistance from the Office of the Privacy Commissioner, in all new sites to clarify the facts and help practitioners work through their concerns.

Communications need to be tailored to, and actively engage, different stakeholder groups listen to and address their concerns from the earliest moment. Keeping local stakeholders informed of changes and how if possible their concerns have been addressed maintains their support as does enabling them to meet and discuss the implications of changes.

Both National and Local Directors are critical for success. The Directorate provides essential practical support in the early days as well as having an on-going role in building and sharing knowledge, evolving the CAP model based on learning, and maintaining sufficient consistency across sites.

The role of the National Children’s Director is critical in championing the integrity of the CAP model and in securing sufficient resources and inter-agency cooperation at both national and local executive management levels.

The role of the local CT Director is crucial in securing local acceptance and adoption while clearly operating within a nationally established framework.

Expect more effort and longer timeframes for bringing about outcomes for vulnerable children.

Fit and alignment

Clarifying the place of CTs in the overall system may require some more explicit guidance and more general communications that clarify boundaries and points of crossover.

Developing a close working relationship with CYF is critical. It took a while to achieve and has not been without its tensions. It may be opportune to consider how CYF and the CTs might go beyond collaboration and into a more integrative service offering.

Collaboration is resource-intensive and may not be necessary, affordable or sufficiently worthwhile to pursue with some organisations and stakeholder groups (versus seeking informal cooperation or more formal coordination).

It will be important to evaluate the implications and impact on local services and providers of establishing CTs as well as the outcomes for children. Given the timeframe of the Hamilton evaluation, we were unable to explore this issue sufficiently.
Partnership

For partnership, the components considered critical for success for the establishment and implementation of the CT were:

- clear roles supported by strong governance; and
- collective ownership and buy-in.

Findings

Governance

A shared leadership role with the National Children’s Director and LGG Chair is essential for the CT to succeed in the medium to long term. Larger events in Hamilton have provided opportunities to show solidarity between the Directorate and the LGG.

Some LGG members felt confused or conflicted about their governance role. Due to local concerns about securing consent, information sharing and the level of risk of referred children, the HCT Director’s job implementing the CAP was difficult. Some issues, such as information sharing, have been worked through. However, the HCT’s purpose and methods relative to CYF’s remains a point of difference.

To improve its effectiveness the LGG has been reviewing its membership and the Chair has been investigating a regional governance model that may increase local strategic level buy-in and create opportunities for greater collaboration between cross-sector or integrated initiatives. This was encouraged by the Directorate, assuming such a move would increase the sustainability of the HCT. The LGG needs to go further in trying to understand and influence the local service system.

The HCT requires further guidance and support on governance. The Directorate is by default the repository of knowledge about establishing and scaling CTs across the country. Consequently, it is best positioned to provide practical guidance and co-design support for local CAP initiatives.

Working Together

To date, the Hamilton community has only partial ownership of the CT. The HCT is not as widely known about as it should be, although there have been a number of workshops which have been widely communicated to Hamilton based organisations. Hamilton practitioners who know about it support the concept, yet there have been fewer referrals from some sectors than expected and a proportion of referrals come with insufficient useful information.

There has been uneven practical buy-in despite widespread support for the concept and obvious championship among most local leaders. ‘Buy-in’ is inextricably tied up with having a ‘common agenda’. It will take more time and additional Directorate support to advance these aspects.
<table>
<thead>
<tr>
<th>Insights from Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
</tr>
<tr>
<td><strong>The LGG needs to provide a mix of strategic and tactical leadership</strong> based on having a membership comprising regional Vulnerable Children’s Board (VCB) agency managers and executive managers from local organisations.</td>
</tr>
<tr>
<td><strong>The LGG has the greatest potential for promoting referrals</strong> from its own members and associated networks.</td>
</tr>
<tr>
<td><strong>The need for effective LGG members cannot be understated.</strong> LGG members need to make decisions about resources, to identify and delegate tasks, and to more generally shape their respective organisations’ priorities at the local level to improve the CAP’s chances of success.</td>
</tr>
<tr>
<td><strong>Making it worthwhile for local leaders to participate in the LGG</strong>, such as a cross-initiative governance arrangement, might encourage greater participation and membership by those who can effectively influence their agencies and providers.</td>
</tr>
<tr>
<td><strong>Additional support and guidance</strong> is needed for LGGs and CT Directors in large sites. For example, growing and maintaining local commitment is likely to require more Directorate support.</td>
</tr>
<tr>
<td><strong>Working together</strong></td>
</tr>
<tr>
<td><strong>Clarifying boundaries and the respective roles and responsibilities</strong> of agencies and services is essential for effective operations. Multiple integration initiatives targeting the same people or groups create a barrier to implementation for CTs. Resolving this issue is likely to require clarifying goals and boundaries, identifying potential synergies and developing effective working relationships.</td>
</tr>
<tr>
<td><strong>Working with iwi/Māori must be prioritised from the outset</strong> to ensure an integrated and aligned approach that builds on local strengths.</td>
</tr>
</tbody>
</table>
Implementation

For implementation, the components considered critical for success for the establishment and implementation of the CT were:

- national direction and local adaptation;
- a working model;
- structures, tools, guides and processes: referral, assessment, planning;
- a common database / IT platform; and
- a functional team and organisational structure.

Findings

Hamilton now has a functional CT that has been working within expected parameters, i.e. having sufficient LPs to start, working to and within anticipated caseload limits, and receiving referrals that have started to exceed projected levels.

Arguably, Hamilton is in a normal developmental trajectory for managing change of this size and complexity. While implementation has progressed more or less to plan, this has been at some cost to the implementation team – causing strain. A stretched implementation team tends to act under urgency, and effectiveness is compromised in some areas.

As expected for an initiation phase, Hamilton’s early implementation encountered difficulties that put pressure on both local and national implementers, calling for considerable ad-hoc problem solving. The solutions developed showed a capacity and a willingness of both the local CT and Directorate to respond to necessity. However, many were stopgap measures that can temporarily mask problems and/or create new ones. These solutions are not a substitute for a more considered implementation design approach based on feedback and reflection, and which builds in redundancy, or contingency margins.

Hamilton is still running a somewhat inconsistent change model for LPs in terms of deployment, support and accounting for their work. This is problematic and unresolved at the national level. Moving to resolve this issue requires aligned local and national management committed to successful implementation.

The Directorate has established appropriate structures and processes to expand the CAP model in Hamilton. Governance and local management structures are working to a two-year implementation plan. The Directorate has taken more time and deliberation to set this up in Hamilton compared to the demonstration sites. Additional monitoring and learning from experience, including guiding implementation, was supported through evaluation. Local and national consistency has been supported by the publication of the Children’s Team Manual. Directorate support has also been forthcoming with some trouble-shooting, and technical assistance with the different information management systems.

It was too early to assess how the CAP model functions as a whole. The HCT was still in an initiation (and disruptive) phase at the end of the evaluation period, according to the community readiness and change models we have used. Given its unprecedented scale and complexity, it is reasonable to assume that Hamilton is not likely to reach a confirmation/expansion phase until mid-2017.

At this juncture there is typically a performance slump in a project or system, which is to be expected. This means more stable and expansive phases will likely eventuate along with a reduction in tensions between the Directorate and Hamilton stakeholders as the system settles in place after such a big change.
National/Local balance

The nationally determined (prescriptive) nature of the CAP model has attracted some criticism from local stakeholders. This has been prompted by the introduction of new and untested components of the CAP model that promote national consistency, i.e. The Hub and ViKI. These were tested in practice by the HCT and Hamilton community. There is a need to clarify and clearly communicate bottom-line aspects of the CAP model from the start, recognising that the Directorate is still to some extent learning.

There have been instances of give and take, which indicates that a workable equilibrium may be within reach despite some tensions. These include the Directorate's adoption of Hamilton's process flow and information request form, and at the local level the agreement of all key government agencies to share information with the HCT as required by the CAP model.

The Team

The urgency of securing LPs in time for the HCT launch overshadowed the need to select and properly induct the most capable candidates. To get the most capable people – those most open to working differently – it is important to try for an oversupply of willing candidates, and to select the most capable of these. In Hamilton, the capability of LPs has been highly variable. The first tranche of LPs were recruited at the same time, leaving them under-occupied for an extended period while building a caseload. This is unlikely to occur with subsequent tranches of LPs because they can be brought on more gradually or sequentially.

The HCT required additional practical management support from the Directorate in relation to promoting referrals, facilitating access to resources (LPs), leading increased inter-agency collaboration with the HCT and ensuring safety vetting and checking of agency staff.

Getting resourcing levels right requires understanding an appropriate establishment-implementation cost structure (compared with a less intensive maintenance cost structure). This is essential to address initially difficult working conditions which threatened the stability, efficiency and potential effectiveness of the core team.

Infrastructure

During the evaluation period, CAP components were at various stages of development. The most straight-forward and settled components were The Hub, the Children’s Team Panels (Panels) and Navigators. The least developed areas included the training and support of LPs, assessment and planning, local management support across agencies, and ViKI, which had only recently gone live in November 2015.

Improving the effective use of the Tuituia assessment is a top priority, or alternatively, a simpler, easier-to-socialise substitute needs to be found. Access to exemplar child and family assessments and plans is also necessary for LPs and Panel members to build capability and shared understanding. While the HCT Director and Panel members had begun to nominate ‘good examples’, it would be helpful if, drawing on local wisdom, the Directorate began to define and communicate what ‘good’ looks like and why from a national standpoint.

The priority given to resourcing for monitoring and reporting was too low. We gained the impression that reporting progress to the Directorate was experienced as difficult by the HCT core team members. We attribute this to everyday workload pressures combined with too little opportunity to reflect and plan together except under urgency.
Insights from Implementation

National/Local balance

Clarify national bottom-lines from the very beginning in order to create a clear and shared understanding of what the core requirements and essential components of the CAP model are and what constitutes a reasonable range of implementation latitude. This includes considerations such as:

- The proportion of time LPs occupy the role (part-time vs. full time) and ‘tenure’ in the role in the first years of implementation.
- Which sectors/agencies contribute LPs and how they are managed.

Focus more on communication about wider system changes. Stakeholders need to understand the reasons why these changes are important – the likely benefits and implications for them if they are to contribute to the new way of working.

Focus more on building understanding and capability in information sharing and the paramountcy of the child, e.g. providing specific training and support to LGG and Working Group members and specific sectors using the Offices of the Chief Social Worker, Children’s Commissioner and Privacy Commissioner.

The Directorate has a critical role in trouble-shooting and timely guidance which will continue to be important, especially for large sites and those expected to operate regionally. There will be an ongoing need to mediate disagreements, monitor and amend national aspects of the model, evaluate effectiveness and work with central government agencies and local organisations so they can fully play their part.

The Team

The CT Director’s figurehead role is the most important at the establishment and initial implementation stage. To enable the CT Director to focus on this aspect of the role, additional practice and operational support is needed at that stage.

Accord the highest priority to LP selection and training.

It is important to have enough LPs from which to be able to select the most appropriate rather than having to take all on offer. Training and support to LPs needs to be more intensive, fit-for-purpose and integrated with an emphasis on:

- Tuituia – understanding and practice, and collaborative assessment and planning including exiting families (an area that is undeveloped at this point)
- engaging families especially reluctant participants, and using ViKI.

The Infrastructure

Adequate and timely resourcing is needed. The extent of progress in Hamilton reflects the extra lead-in time and dedicated start-up resourcing the Directorate has allocated.

Build in redundancy to anticipate and allocate resources for the 'unexpected'. Fiscal pressures led to resources being tied too tightly to predetermined project steps and defined tasks.

Improve user confidence in ViKI by:

- providing web-based training for individuals and groups, workplace-based training and more intensive group training for key users e.g. CT Coordinators and those providing analytical reports;
- better integration of training, combining the use of ViKI with conducting/recording a Tuituia assessment and creating plans for one or more children and their families; and
- providing dashboard or reporting templates for LPs, Panel members, Coordinators and the CT Director that are suitable to their roles and readily customisable to better meet their purposes.
Systems change and scaling up

For systems change and scaling up, the components considered critical for success for the establishment and implementation of the CT were:

- funding and accountability systems that support collaboration;
- common accountability measures;
- information sharing systems that support collaboration;
- evolved practice;
- workforce safety;
- workforce capability and capacity; and
- changing the current service mix.

Findings

Funding and accountability

While there are service user-level accountability measures through Tuituia and monthly reporting, monitoring the extent and quality of CT’s implementation is still in development.

Government agencies are struggling to prioritise supporting the CT as well as maintaining business-as-usual priorities. Non-government organisations (NGOs) are willing to participate and provide LPs but renegotiating their contracts and making this workable can be complicated.

There is a lack of accountability of the LGG to meet expectations outlined in Terms of Reference, in particular:

- the promotion of the HCT in order to gain referrals;
- workforce safety;
- securing resources – LPs; and
- addressing unmet needs/service gaps (relates to above point).

It is important to note that the requirements for expansion across a large rural area will be very different to those involved in setting up the CT in a relatively compact urban area, not least in resourcing.

Information system that promotes collaboration

An information system is in place that can support collaboration – ViKI (see previous section).

Service mix

It is too early to link any change in service mix to the HCT. There are more medium to long-term goals to be addressed with less priority than some immediate implementation issues.

A regional governance structure that could oversee the HCT and other similar initiatives is being explored. This would provide the chance to address potential programme overlaps and synergies (i.e. with the Family Safety Network, Social Sector Trials and Whānau Ora) and to suitably plan for expansion.
Workforce

Progress with safety checking had been slower than expected up until December 2015, against a backdrop of increasing urgency driven by national regulatory requirements. Partial buy-in from agency managers and the devolved nature of the education and health sectors added further complexity.

LP capability issues were not being addressed effectively by selection, training and clinical support processes (see previous section).

Evolving practice

Evolved (evolving) practice has been added as a new element because we observed trans-disciplinary practice advancing beyond the usual discipline-specific practice. Evolving practice is evident amongst Panel members and some LPs – working in a more trans-disciplinary way and enjoying it.

We identified progress in this area through observing HCT stakeholder interactions and behaviours and through facilitated self-reflection events in which stakeholders identified and evaluated changes in their personal and professional practice (i.e. they were more inclined to see things from another’s standpoint and to change how they might think about or do something at work).
Insights from Systems Change and Scaling Up

Clarifying lines of accountability and leadership for resourcing is important for effective operations (from VCB to local agency to provider and from VCB to CT to LPs).

Designing changes to services and services systems is a complex, long-term and time consuming process. We have already identified that such change does not happen without also creating anxiety for some. Niche groups and service providers fear their familiar programmes or services may be cut or become increasingly unviable.

The Directorate may need to help systems change at the local level. Firstly, beginning with a local assessment process (developing a baseline), and then identifying what motivated stakeholders can reasonably influence by way of direct support and/or in the longer-term, through addressing underlying social conditions that negatively affect vulnerable children and families (e.g. social housing and access to quality early childhood education). Providing realistic and effective examples from similar communities, and facilitating access to community development and service and systems design expertise could prove helpful.

The understanding of VCB agencies about LP capability needs further development, including the support needs of the LP role. The Directorate will need to further engage VCB agencies at the national and local levels to do this.

Taking a more evaluative approach to monitoring might induce more critical local discussion and action in response to trend data.

Examples of practice change and opportunities to discuss challenges and developments in professional practice would be helpful in building effective practice. The make-up of Panels creates a natural community of practice and an incubator for trans-disciplinary learning and professional development.

An online professional development platform and resources that explain and model exemplary practices may make it easier for more professionals involved directly in CTs to reflect and learn, not to mention aiding the wider children’s workforce. This is a common approach to teacher professional development and moderation.

It is important to make the best use of opportunities to conduct experiments to understand any fundamental regional variations in the way that CTs are implemented. This would build evaluation more fundamentally into CAP Directorate planning and local implementation and would build evidence-based practice.

2 MSD’s Social Action Team (which oversees Strategies for Kids, Information for Parents, or SKIP) does programme co-design and provides user-centred design training in a variety of communities, increasingly directed at improving social conditions for younger vulnerable children and their families and whānau.
Conclusion

Overall we found that systems-level change requires:

- concerted and persistent national and local leadership;
- skilled adaptable implementers; and
- time to address complexities and to build necessary levels of trust.\(^3\)

As evaluators, the issues and differences we observed between the Directorate, LGG and Working Group were characterised by three tensions:

- The need for an operating model that has some nationally consistent principles and elements, that is linked to formal evidence and that is acceptable to the VCB agencies and the responsible Minister.
- Local stakeholders’ desire for an independent and locally-developed solution that aligns broadly with the Government’s White Paper.
- Expedient (rather than strategic) solutions proposed by local managers who are primarily concerned about fiscal or workload implications and business-as-usual priorities.

We recommend a user-centred design approach for reconciling some of these tensions.\(^4\) This would focus on vulnerable children and their families but take into consideration the whole service ecology in Hamilton.

Using the SUPERU framework we have identified the areas with greatest progress.

Figure 1: Establishment and implementation assessment framework

<table>
<thead>
<tr>
<th>Planning and development 3.1</th>
<th>Partnership 3.2</th>
<th>Implementation 3.3</th>
<th>Systems change 3.4</th>
<th>Scaling up 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared vision and common agenda</td>
<td>Clear roles supported by strong governance</td>
<td>Prescriptive vs. local adaptation</td>
<td>Funding and accountability systems that support collaboration</td>
<td>Workforce safety</td>
</tr>
<tr>
<td>Communication, engagement and change management</td>
<td>Collective ownership and buy-in</td>
<td>A working model Structures, tools, guides and processes: referral, assessment, planning</td>
<td>Common accountability measures</td>
<td>Workforce capability and capacity</td>
</tr>
<tr>
<td>Fit and alignment with current service provision</td>
<td>Common database / IT platform</td>
<td>Information sharing systems that support collaboration</td>
<td>Changing the current service mix</td>
<td></td>
</tr>
<tr>
<td>Functional team and organisational structure</td>
<td>Evolved practice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY**
- Has been challenging but progress being made
- Will need to be addressed as the model matures
- Most pressing and difficult issues
- Signs of profound change


ASSESSMENT OF THE ESTABLISHMENT AND EARLY IMPLEMENTATION OF THE CHILDREN’S ACTION PLAN IN HAMILTON

April 2015 to December 2015

Full Report

Prepared by Geoff Stone with the Children’s Action Plan Directorate.
Table of Contents

Table of Contents .............................................................................................................................................. 15
1. Background ................................................................................................................................................ 16
2. Evaluation Approach .................................................................................................................................. 18
  2.1 Evaluation scope and methodology ........................................................................................................ 18
  2.2 Evaluation questions ................................................................................................................................ 20
  2.3 Assessment frameworks ........................................................................................................................ 20
3. Findings ...................................................................................................................................................... 22
  3.1 Planning and development ...................................................................................................................... 22
  3.1.1 Progress markers ............................................................................................................................ 24
  3.1.2 What went well .................................................................................................................................. 24
  3.1.3 Key Challenges for Hamilton ............................................................................................................ 26
  3.1.4 Addressing Challenges for Hamilton .................................................................................................. 31
  3.1.5 Insights .............................................................................................................................................. 34
3.2 Partnership .................................................................................................................................................. 36
  3.2.1 Progress markers ............................................................................................................................ 38
  3.2.2 What went well .................................................................................................................................. 39
  3.2.3 Key Challenges for Hamilton ............................................................................................................ 41
  3.2.4 Addressing Challenges for Hamilton ................................................................................................. 44
  3.2.5 Insights .............................................................................................................................................. 45
3.3 Implementation .......................................................................................................................................... 47
  3.3.1 Progress Markers ............................................................................................................................ 49
  3.3.2 What worked well ........................................................................................................................... 49
  3.3.3 Key Challenges for Hamilton ............................................................................................................ 54
  3.3.4 Addressing the Challenges ............................................................................................................... 59
  3.3.5 Insights .............................................................................................................................................. 60
3.4 Systems Change and Scaling Up ............................................................................................................... 66
  3.4.1 Progress markers ............................................................................................................................ 66
  3.4.2 What worked well ........................................................................................................................... 67
  3.4.3 Key Challenges for Hamilton ............................................................................................................ 69
  3.4.4 Addressing the Challenges ............................................................................................................... 71
  3.4.5 Insights .............................................................................................................................................. 73
4. References ................................................................................................................................................... 75
Appendix 1: Glossary of terms ....................................................................................................................... 78
Appendix 2: Children’s Team Entry Criteria Threshold Form ........................................................................ 85
Appendix 3: Different theories of change ...................................................................................................... 90
## 1. Background

The Children’s Action Plan (CAP) is part of the 2012 White Paper for Vulnerable Children and was launched with the aim to better identify, protect and support vulnerable children. Its driving philosophy is that “protecting vulnerable children is everyone’s responsibility” and that “working together we can achieve our goal”.

The components of the CAP model include the following:

**Vulnerable Children’s Act 2014**

This establishes that all Chief Executives responsible for children are jointly responsible for vulnerable children. They must work together to achieve shared goals under a Vulnerable Children’s Plan. The Act also requires standard safety checks for paid staff in the government-funded children’s workforce and government agencies. The other main requirement is that government-funded providers have child protection policies.

**Children’s Team**

A local Children’s Team comprises a Local Governance Group that supports a regional Children’s Team Director and includes support staff and key roles such as Lead Professionals or LPs. LPs act as the principal point of contact for a child and their family and draw together a group of suitable professionals to be a Child’s Action Network for a vulnerable child; working to a single agreed plan to improve the wellbeing of that child; and measuring outcomes through applying multiple assessments.

**Tuituia assessment**

Tuituia is a single holistic assessment for children and young people. The Tuituia assessment records the areas of need, strength and risk for a child or young person, their parents and/or caregivers. The assessment covers three dimensions: Mokopuna Ora (holistic wellbeing of a child or young person); Kaitiaki Mokopuna (capacity of parents or caregivers); Te Ao Hurihuri (wider support networks and family wellbeing). This assessment forms the basis for the Child’s Plan and monitoring progress.

**AISA**

An Approved Information Sharing Agreement (AISA) has been established for the Vulnerable Children’s Hub to clarify information sharing for government agencies. Parties to the AISA can legally share personal information about others without their consent for specific purposes, in this case, in order to help vulnerable children. The parties to the CAP AISA are the Ministries of Education, Health, Social Development, Justice, New Zealand Police and the Children’s Action Plan Directorate.

**The Hub**

The Vulnerable Children’s Hub (The Hub) is a new contact and triage point for professionals and practitioners to raise concerns about a child which they do not think are serious enough for CYF or the Police. The Hub social workers draw on a range of information about the child and their family, initially from the Ministry of Social Development systems, to assess the initial contact and decide whether to refer the case to a Children’s Team, CYF, a non-government organisation (NGO) or a universal service.

**ViKI**

The Vulnerable Kids Information System (ViKI) is an information management system for use in The Hub and by Children’s Teams. It enables professionals and practitioners to record, access and manage information about vulnerable children. It securely stores that information, supports case management and enables reporting on results.

Children’s Teams (CTs) are a central part of the strategy to deliver the plan’s goals through encouraging professionals to work more closely together focused on improving the wellbeing of a vulnerable child, including breaking down barriers to the sharing of information.

The first CT demonstration site was established in 2013 in Rotorua. The Hamilton Children’s Team (HCT), launched in September 2015, was the fifth location to have a CT.
**Hamilton people wanted a Children’s Team**

Hamilton service and agency managers and practitioners came together to make a joint submission on the Government’s Green Paper for Vulnerable Children, after running their own community consultation process. This group had been working to establish a Hamilton CT since 2012. Many from this original group continue to express their commitment through their membership of the HCT Local Governance Group (LGG) or Working Group.

**Hamilton is the first site for implementing the full CAP model**

Hamilton was the first large urban area to have a CT and the first site to also use the AISA, ViKI, and The Hub. In terms of SUPERU’s assessment framework, these new items promoted increasing sophistication across the following components: implementation (particularly the working model) and systems change (information sharing systems and evolved [or evolving] practice).

Modelling assumptions indicated that the HCT will build up to actively work with approximately 1,400 children and young people, as well as their families and whānau, at two years after launch. Local police figures suggest that demand for the service may be considerably higher. Hamilton was one of five locations where the Children’s Action Plan Directorate (the Directorate) had been concurrently establishing CTs. All went live between September 2015 (Hamilton) and February-March 2016 (Counties Manukau).

The implementation of a large city-sized initiative and additional components of the model made Hamilton a complex rolling innovation.

**A combination of local influences shape Hamilton’s implementation of the CAP**

Local influences that impacted on the local operating environment in important ways were:

- a strong historical drive from Hamilton stakeholders to develop their own CT initiative;
- changes in Child, Youth and Family’s (CYF’s) criteria for accepting notifications; and
- the piloting in Hamilton of a potentially nationally significant police-led multi-agency family violence prevention initiative - The Family Safety Network (FSN).
2. Evaluation Approach

The Ripple Collective was commissioned to undertake a utilisation-focused evaluation to help achieve the following aims:

- Optimising the establishment and early implementation of the Hamilton Children’s Team (HCT).
- Identifying the extent to which Hamilton qualifies as a proof of concept for the Children’s Team (CT) at scale. In other words, to assess whether all the components of the Children’s Action Plan (CAP) have come together as an effective whole.
- Identifying any other learning that could benefit the establishment and further development of other CTs.

This evaluation ran from April 2015 to December 2015. Fieldwork for the evaluation was conducted primarily by Geoff Stone in Wellington and Hamilton, and by Ripple associates Ruth Hungerford and Kiri Edge (Momentum Research and Evaluation Limited) based in Hamilton. Angelique Praat from Ripple provided additional quality assurance and advice.

2.1 Evaluation scope and methodology

We scoped the evaluation of the HCT to cover two phases of a three-phase programme development cycle, as we initially saw it. This exercise helped us discern what to look for and roughly when to expect it. The following table shows what was in and out of scope given our timeframe.

Figure 2.1: Scope of the evaluation

<table>
<thead>
<tr>
<th>Phases</th>
<th>Things to look for and anticipated timeframes for change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN SCOPE</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 1. Planning & preparation | From 2014 to at least the end of 2015  
  • Developing systems / specifying processes and creating infrastructure  
  • Securing resources / building organisational capacity, building the CT (referral ready)  
  • Preparing settings - building relationships, promoting the programme |
| 2. Implementation | From September 2015  
  • Delivering services to intended clients, and working within desired parameters  
  • Initial client engagement occurs and clients have a good initial experience? |
| **OUT OF SCOPE** |                                                                                                                         |
| 2. Implementation | From February 2016  
  • Optimising services. This includes seeking to improve client engagement with services - ensuring they get more/better help? |
| 3. Results       | From June 2016  
  • Client changes become apparent, some disengage  
  • Service delivery system begins to change |
|                  | From October 2016  
  • Some changes in the service delivery system become business-as-usual  
  • Some client changes are sufficiently maintained  
  • Population level changes may be identified longer-term? |
It is important to note that our evaluation effort focused on providing ‘real-time feedback’ to the HCT Director and Children’s Action Plan Directorate (Directorate) stakeholders as the HCT initiative unfolded. Consequently, we needed to consider aspects of programme development that were not an explicit part of the SUPERU assessment framework. These included considerations such as: did the HCT in fact become operational as planned, and did clients have a positive initial experience?

Throughout this report we have used the term ‘progress marker’ to specify behaviours or actions that were expected of the programme, and/or appear to be logically linked to longer-term outcomes inferred from stakeholder interviews, programme documents and relevant theoretical literature.

We took a utilisation-focused and developmental evaluation approach as this was agreed as appropriate to the unfolding and unpredictable establishment phase of the HCT. This approach focused on responding to the questions and concerns of evaluation users as the initiative unfolded and was in keeping with the developmental stage of the initiative. The developmental aspect involved operating to some extent as a HCT-Directorate member with responsibility for guiding reflection and providing rapid feedback to support ongoing design and implementation decisions. We used The White Paper for Vulnerable Children (2012), Directorate planning documents and a previous evaluation of CTs as important points of reference. The research methods we used are listed below.

Document review. This involved close reading of formal and informal documentation in order to determine how the CAP was expected to operate, especially in Hamilton. Documents were sourced from the Directorate and the HCT. We have also referenced relevant literature and the previous SUPERU assessment of the CT design and implementation in demonstration sites.

Observations. We periodically attended meetings including HCT staff meetings, Local Governance Group (LGG) and Working Group meetings and meetings of the Executive Management Group (EMG), which made decisions about resourcing Lead Professionals (LPs). We also attended community hui, training events, and community liaison meetings involving local team members and various groups. We regularly attended Children’s Team Panel (Panel) meetings.

Surveying. We developed surveys for the HCT to conduct that provided systematic feedback on various events. We also provided assistance in interpreting and reporting top-line findings from these surveys. We surveyed the level of awareness amongst LGG staff about the plan to establish a HCT. This provided data and analysis for planning future communications and also acted as an intervention by raising awareness.

Interviews. We conducted interviews with key people including individual and group reflection sessions. These were in-person key-stakeholder interviews using a semi-structured interview format, occasionally supplemented by telephone interviews.

Rapid reporting and feedback. We composed emails, short reports and progress matrices that drew on multiple sources of data to provide a picture of progress, issues arising, potential implications, and suggestions for action as appropriate. Regular meetings with the evaluation commissioner and periodically with Directorate managers provided the questions requiring answers as the evaluation proceeded.
2.2 Evaluation questions

This evaluation report covers some of the questions and main issues and developments we observed from our fieldwork.

We compiled a range of questions of interest to the Directorate to guide the evaluation. Questions were grouped under phase 1 and phase 2 of our development framework. We were involved in self-evaluation and feedback activities with the HCT core staff and provided at least fortnightly, and later weekly, feedback to the Directorate on the progress of the HCT.

2.3 Assessment frameworks

For this evaluation report, we drew on a framework previously developed by the Social Policy Evaluation and Research Unit (SUPERU) for assessing the progress of critical design and implementation components for CTs in the two demonstration sites. This report is organised into sections following that framework, as set out in Figure 2.3.1 below.

The table below uses the SUPERU framework to show the pattern of relative progress and challenges that we identified in Hamilton in the first three months of implementation. It should be noted that this is still very early in the CT’s life. The scaling up phase in Hamilton city is not expected to plateau until mid to late 2017.

**Figure 2.3.1 Establishment and implementation assessment framework - components considered critical to success**

<table>
<thead>
<tr>
<th>Planning and development 3.1</th>
<th>Partnership 3.2</th>
<th>Implementation 3.3</th>
<th>Systems change 3.4</th>
<th>Scaling up 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared vision and common agenda</strong></td>
<td><strong>Clear roles supported by strong governance</strong></td>
<td><strong>Prescriptive vs. local adaptation</strong></td>
<td><strong>Funding and accountability systems that support collaboration</strong></td>
<td><strong>Workforce safety</strong></td>
</tr>
<tr>
<td><strong>Communication, engagement and change management</strong></td>
<td><strong>Collective ownership and buy-in</strong></td>
<td><strong>A working model Structures, tools, guides and processes: referral, assessment, planning</strong></td>
<td><strong>Common accountability measures</strong></td>
<td><strong>Workforce capability and capacity</strong></td>
</tr>
<tr>
<td><strong>Fit and alignment with current service provision</strong></td>
<td><strong>Common database / IT platform</strong></td>
<td><strong>Information sharing systems that support collaboration</strong></td>
<td><strong>Changing the current service mix</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Functional team and organisational structure</strong></td>
<td></td>
<td><strong>Evolved practice</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY**
- Has been challenging but progress being made
- Most pressing and difficult issues
- Will need to be addressed as the model matures
- Signs of profound change
Another conceptual framework we found useful is known as the Behaviour Change Ball. We used this to help identify options for improvement in the design and implementation of the CT model, focusing on the challenges observed through our evaluation of the Hamilton CT site. The Behaviour Change Ball includes specific organisational roles, contexts and behaviours that can generate positive change across various policy categories. For example, there are strategic, tactical and operational policy-level vantage points that are associated with important organisational behaviours or functions. These are highly relevant to fully and effectively implementing the CT approach. This framework is recommended to help understand and guide a multi-level, multi-agency intervention seeking to create a broader systems change.

Figure 2.3.2: Interpretation of the Behaviour Change Ball showing all points and options for influencing behaviours

<table>
<thead>
<tr>
<th>Policy categories</th>
<th>Zones of influence</th>
<th>Organisational behaviours</th>
<th>Intervention functions</th>
<th>Behavioural drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Guidelines</td>
<td>• Strategic</td>
<td>• Agenda setting</td>
<td>• Enablement</td>
<td>• Capability</td>
</tr>
<tr>
<td>• Environmental / social planning</td>
<td>• Tactical</td>
<td>• Leadership</td>
<td>• Modelling</td>
<td>• Opportunity</td>
</tr>
<tr>
<td>• Communications / marketing</td>
<td>• Operational</td>
<td>• Policy Formation</td>
<td>• Environmental</td>
<td>• Motivation</td>
</tr>
<tr>
<td>• Legislation</td>
<td></td>
<td>• Operational</td>
<td>• Restructuring</td>
<td></td>
</tr>
<tr>
<td>• Service provision</td>
<td></td>
<td>• Network formation</td>
<td>• Education</td>
<td></td>
</tr>
<tr>
<td>• Regulation</td>
<td></td>
<td>• Innovation</td>
<td>• Persuasion</td>
<td></td>
</tr>
<tr>
<td>• Fiscal measures [funding &amp; contracting]</td>
<td></td>
<td>• Teamwork</td>
<td>• Incentivisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Policy formulation</td>
<td>• Coercion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Implementation</td>
<td>• Training</td>
<td></td>
</tr>
</tbody>
</table>

In summary, we have used the SUPERU assessment framework to help specify what the important ingredients are for the success of the CT approach, while the Behaviour Change Ball provides a means of working out how to have these key ingredients in play and working as they should.

---

5 Hendriks et al. (2013). Proposing a conceptual framework for integrated local public health policy, applied to childhood obesity - the behavior change ball
3. Findings

3.1 Planning and development

<table>
<thead>
<tr>
<th>Planning and development</th>
<th>Partnership 3.2</th>
<th>Implementation 3.3</th>
<th>Systems change 3.4</th>
<th>Scaling up 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared vision and common agenda</td>
<td>Clear roles supported by strong governance</td>
<td>Prescriptive vs. local adaptation</td>
<td>Funding and accountability systems that support collaboration</td>
<td>Workforce safety</td>
</tr>
<tr>
<td>Communication, engagement and change management</td>
<td>Collective ownership and buy-in</td>
<td>A working model Structures, tools, guides and processes: referral, assessment, planning</td>
<td>Common accountability measures</td>
<td>Workforce capability and capacity</td>
</tr>
<tr>
<td>Fit and alignment with current service provision</td>
<td>Common database / IT platform</td>
<td>Information sharing systems that support collaboration</td>
<td>Changing the current service mix</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functional team and organisational structure</td>
<td>Evolved practice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Shared vision and common agenda

The SUPERU report stated that "this element is vital to the success of shared initiatives (Moore 2014, Kania & Kramer 2011). This needs to occur horizontally across the initiative (i.e. within each sector) and vertically through the layers – central, regional and local".6

In the context of rolling out the Children’s Action Plan (CAP) as a central government, multi-site initiative, establishing a shared vision and common agenda in particular communities is a highly aspirational goal. It will always be arguable as to how ‘shared’ such a vision can be. In any event, establishing a shared vision and common agenda takes time. In Hamilton it is still ‘early days’.

We suggest that one way of understanding progress is to draw on a model for assessing community readiness for innovative strategies.7

---

Using this model we propose that a shared vision and common agenda will be sufficiently realised when the CAP has:

- ‘stabilised’ - the model is running as expected, key components are viewed as stable and the community climate is generally favourable; and
- moved into a ‘confirmation/expansion phase’ whereby:
  - standards have been set;
  - users are more comfortable about accessing/using services;
  - monitoring and evaluation has driven learning and development (acknowledging and resolving problems, and seeking to reach more people, those at more risk, and/or different demographic groups);
  - sufficient resources are being sought or committed; and
  - critical community engagement permits challenge while indicating fundamental support.

The SUPERU report highlighted the importance of establishing a vision for the Children’s Teams (CTs) that is widely endorsed across the social sector. This requires that a CT is part of a mutually reinforcing pattern of service delivery and support whereby its “complementarity with existing initiatives and its point of difference and added value are clear”.8

The Human Services Value Curve Model of Integration provides a way of thinking about complementarity, as an integrative state.9

Figure 3.1.2 The stages within the Human Services Value Curve Model of Integration

Communication, engagement and change management

This design element relates to the CAP Directorate’s (Directorate’s) role as a long-term change agent across multiple sectors and physical locations on behalf of vulnerable children.

Our expectations related to facilitating large scale and multi-level cross-sector collaboration and change and we have pragmatically drawn on several sources that are most applicable to the CAP. In the first instance, the Directorate acted like the ‘backbone organisation’10 in what is known as the Collective Impact Model11, which SUPERU referenced in its assessment of demonstration sites.

Acting in this capacity, the Directorate would need to:

- guide the vision and strategy with regard to the CAP;
- support aligned activities (influence or create alignment);
- establish shared measurement practices;
- build public will;
- advance policy; and
- mobilise funding.

---

8 ibid
10 Collaboration for Impact (n.d.) The Backbone Organisation
Fit and alignment

Given that the CAP is a national intervention that has certain regular features, it is inevitably imposed on a pre-existing service landscape, and points of alignment and complementarity are negotiated over time. Given that it is still early days in Hamilton and there has been an emphasis on getting to implementation, we have only two significant progress markers so far.

3.1.1 Progress markers

The following progress markers were identified as contributing to a state of ‘preparedness’. In other words, a level of community receptivity and team planning that was essential to support the initiation phase:

- A shared vision is articulated by stakeholders.
- Community is committed and enthusiastic.
- Communications provide key messages to key audiences.
- Stakeholders can describe the difference between the CT approach compared to others and where the complementarity of initiatives produces better outcomes for children.
- Essential processes and structures ready.
- National expectations clear.
- Roles and functions are understood and supported.
- Partner agencies aligned and committed.

3.1.2 What went well

Shared vision and common agenda

We found a broad acceptance of the concept of child vulnerability in Hamilton and enthusiasm for the establishment of a CT as an appropriate response to child vulnerability. This represented a step-change from demonstration sites where the lack of a strengths-based emphasis in communications had been an issue. Communications from the local Hamilton Children’s Team (HCT) Director and Workforce Lead had strongly emphasised that the HCT will ‘stop vulnerable children falling into the gaps’, between various services and forms of support. This seemed to have struck a chord.

There were high levels of optimism and commitment across a variety of frontline, specialist and some operational management staff. They believed that the HCT would significantly improve the lives of vulnerable children in Hamilton, particularly through improving collaboration, increasingly focusing on the whole child, and having a suitably trained workforce. Many acknowledged, as previously indicated, that it was time to try something else because the status quo wasn’t working as well as people wanted.

Large-scale events such as the Journey of the Child Symposium in June 2015 and the HCT launch on 1 September 2015 were well attended and well received. These occasions provided an important show of solidarity involving the Directorate managers, the HCT (the HCT Director and her team, and the Local Governance Group (LGG) and Working Group members) and various other Hamilton stakeholders. Various feedback about the event indicated stakeholder confidence in the process, and in the likely outcome of establishing a CT. These occasions also allowed people to provide feedback and suggestions.

<table>
<thead>
<tr>
<th>Selected comments from Journey of the Child symposium participants (12 June 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Gained] Clarity around HUB, VIKI how it will be implemented locally. Clarification about supervision and primary accountability to employing agency. Networking and collaboration.</td>
</tr>
<tr>
<td>[Gained] The perspective of other organisations and how all are willing to work as a single group. Everyone is committed to making it work.</td>
</tr>
<tr>
<td>[Ensure] Adequate support for CAT. Don’t get too big too soon.</td>
</tr>
</tbody>
</table>

Communication, engagement and change management

The main avenue for ensuring national expectations are given effect is publishing and explicitly linking training to an operational manual that outlines all the key processes and considerations for implementing the CAP. The Directorate published the first comprehensive manual in August 2015. This was a very important development for core HCT (implementation) staff. The manual reflects a “learn as we go” approach; it is being updated over time as some aspects of the operating model with points of difference are resolved and clarified. It is important that updates are well-publicised so that the CTs know what has changed.

A range of CAP Directors spent time in Hamilton, alongside the local HCT Director, presenting and explaining to local stakeholders what the CAP model entailed. They were well received and their explanations appreciated. The Directorate convened monthly local CT Directors (2-day) meetings. This regular event enabled the CT Directors to share experiences and learn from their peers. These structured events helped to create a supportive organisational culture, build organisational capacity and create supportive feedback mechanisms.

Fit and alignment with current service provision

Regular meetings were used to establish a new working relationship between Child, Youth and Family (CYF) and the CT in Hamilton. These provided a basis for increasing mutual understanding about respective roles, thresholds and criteria for accepting or passing on clients. CT staff were also periodically attending CYF moderation meetings to maintain their understanding of CYF’s threshold for accepting or declining client families, and the different kinds of responses CYF has at its disposal. A protocol was established in mid-December 2015 to govern the referral of prospective or existing CYF clients to the HCT. The perception of some health providers was that the threshold had moved as clients who previously would have been with CYF were now in the HCT.

The ability of professionals and practitioners to identify what the CT could do for vulnerable children in addition to and with existing services was important for understanding its place and role in the community, and for encouraging referrals. This judgment has been most evident among

---

13 At least 84% of the 32 participants who completed feedback forms on the Journey of the Child event were pleased they came and felt the meeting was run in the right kind of way (scoring their experience 8/10 or more on these question items).

education professionals. Before the HCT launch, a variety of educators indicated that they could produce lists of children whose circumstances were highly concerning but who were beneath the threshold for CYF intervention. These professionals clearly felt that the HCT would be positioned to address these concerns, which had not been resolved by usual school-based and community services. After the launch of the HCT, the education sector did provide the highest volume of referrals (with the exception of CYF, from November 2015).

**Feedback mechanisms to improve establishment and implementation**

Ripple Research, Design and Evaluation were engaged by the CAP Directorate to report on, and support the progress of, the HCT. We provided the means to gain feedback from presentations and public events; undertook a stakeholder awareness survey; monitored Children’s Team Panels (Panels); and facilitated self-reflection sessions for Panel members, the Vulnerable Children’s Hub (The Hub) staff, the Executive Management Group, the Lead Professionals (LPs), the HCT Director, and HCT core team members.

We also prototyped a LP capability self-assessment tool, evaluated a pre-launch dry run for The Hub, contributed to the Go Live Approval Report and provided information and advice to the Directorate about workforce development and the measurement of effective workstreams.

The requirement on the HCT to provide monthly reporting on its implementation to the Directorate and the LGG enabled stakeholders and the Vulnerable Children’s Board (VCB) to track the implementation progress.

### 3.1.3 Key Challenges for Hamilton

#### Building a shared vision and common agenda

One of the key challenges was the long road to building a shared vision and common agenda; to securing sufficient local buy-in and acceptance so that the CT becomes an unquestionable part of the Hamilton service landscape. There appeared to be uneven championship of the CT by key Hamilton stakeholders.

As the Directorate had already identified: “Some organisations’ concerns about sharing information and specific ethical beliefs mean that they are not always prioritising the interests of the child”. We agreed that in Hamilton, as elsewhere, this will take time to change.\(^{15}\)

---

**Email communication from Waikato DHB senior paediatrician**

“The issue for Waikato DHB and health providers (primary and secondary) around Children’s Teams had been that we need to get effective engagement from families for effective non statutory outcomes, and this is more likely to get off to a good start if we engage and seek permission. If risk is of a level to share knowledge without knowledge or consent our feeling is that it’s needing direct referral to CYF.”

---

Despite general support for the concept of the CT approach, we identified a fundamental difference of views about which children should be served by local CTSs and which should be served by CYF (perceived as central government). These differences presented an obvious barrier to having a ‘common agenda’ because they reflect the different ways people think that the CT model and CYF

---

\(^{15}\) Children’s Action Plan (2015, December). Progress Report (p10)
should operate in Hamilton. As many local stakeholders saw it, central government has been able to proceed with implementing its version of the vision without adapting to the local view, as set out in the table below. This left some local stakeholders disgruntled and mistrustful, implying that the development of a common agenda is still a work in progress in Hamilton.

Figure 3.1.3 The different positioning of central government and local stakeholders views

<table>
<thead>
<tr>
<th>TARGETING</th>
<th>BOUNDARY IMPLICATIONS</th>
<th>PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYF will target the most vulnerable children</td>
<td>CYF will work with children at imminent risk of harm</td>
<td>CYF and CTs do not share clients&lt;br&gt;The best interests of the child are the paramount consideration&lt;br&gt;If a child is at risk of harm then information should be shared without consent if necessary</td>
</tr>
<tr>
<td>CTs will target highly vulnerable children</td>
<td>CTs will accept referrals from The Hub whether or not family consent has been gained</td>
<td>CTs/LPs will work to gain families' consent (building motivation to engage)&lt;br&gt;LPs will work with families on a consensual basis (building motivation/capability to change, gain support)</td>
</tr>
<tr>
<td><strong>Local views</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYF should target highly vulnerable children</td>
<td>CYF should work with children whose parents have not consented</td>
<td>Perhaps CYF and CTs should work together with higher risk families</td>
</tr>
<tr>
<td>CTs should target moderately vulnerable children</td>
<td>CTs should only accept consenting families&lt;br&gt;LPs should not have to try to gain consent</td>
<td>CTs should work in partnership with families to promote child and whānau wellbeing</td>
</tr>
</tbody>
</table>

The work involved in motivating family/whānau engagement is critical. For some families it could be drawn out, was unwelcome and required considerable skill and fortitude on the part of the LP. It was an area of the CAP model that needs further focus as it is critical to success for most at risk families under CYF’s threshold.

**Communication, engagement and change management**

Initial awareness-raising undertaken by the HCT Director was broadly aimed at the wider Hamilton community to raise the general profile of the HCT in the establishment phase. The Directorate provided a Communications and Engagement Adviser to focus on frontline professionals as the target audience leading up to the launch. Education sector networks and champions proved useful but these were under-developed in other sectors.

Since going live in Hamilton, the availability of the HCT Director to communicate across the children’s workforce was limited. Also, support from a Communications Adviser fell away after the official launch. This left some stakeholders uninformed and uneasy about key issues such as the HCT threshold for accepting referrals relative to CYF’s. This put pressure on the HCT Director to address issues by attending one-on-one meetings to address specific concerns.

It was also plain that some sectors have been slow, or reluctant, to refer children to the HCT, notably the health sector and non-government organisation (NGO) service providers. In the health sector this was largely due to concerns that highly vulnerable non-consenting families and children were being referred to the CT instead of CYF. Understanding the reasons for this and changing awareness and behaviour requires a more concerted and intensively engaging communication
effort. We have identified the role of the HCT Director as critical to coordinating and building an implementation team. This has clearly been achieved. However, the HCT Director was also not well positioned to address or influence organisational behaviours that are determined at an executive level.

A related issue was the uneven quality of information coming to The Hub from referrers. The Hub Team Leader suggested this may be due to practitioners being insufficiently prepared to provide the information in line with the Tuituia assessment used by The Hub. There was also a volume of referrals from statutory agencies that contained minimal information.

Lack of engagement with iwi
The HCT Director identified having an insufficient working relationship with Māori as an issue at the national and local level. We also observed low levels of involvement in the LGG by Waikato Tainui. Furthermore, the Chief Executive of a Māori service provider expressed ambivalence about CTs’ sustainability or likelihood of success. This situation represented a real risk to the credibility and broad acceptance of the CAP initiative in Hamilton, especially as the majority of client families were expected to be of Māori descent.

National-local decision-making
Another factor contributing to local negativity towards central government and the Directorate stemmed from the Directorate’s determination of the timeframe to launch a HCT. This decision was predicated on the Directorate seeking to ensure that Hamilton could be a proof of concept for the CAP at scale (including new operating components such as The Hub and the Vulnerable Kids Information System (ViKI)). This was a low priority consideration for some local stakeholders who wanted an earlier start. Changes to current service practice and focus were ‘disruptive’.

Also, for some stakeholders there was another matter of concern. They expected to be included and/or informed about the process of systems redesign (i.e. the role of CYF relative to CT and other services) and felt that they had been kept in the dark about such changes.

Information sharing and consent
The CT approach has also challenged some long held beliefs about practice. Some LPs (and their home agency managers) did not feel it was their job to convince parents to engage with a CT if they have not previously consented to do so. Some stakeholders pointed out that the demonstration sites do not do this; instead only taking referrals for clients who have consented to share their information and to be referred. Consequently, these stakeholders perceived that Hamilton has departed from the CT model as they understood it.

This situation had resulted from the introduction of The Hub to provide the key referral pathway to the HCT. This included referrals of children whose families may not even know that a referral has been made or have explicitly asked not to be referred. This was consistent with the national position and advice of the Privacy Commissioner, which is that if a child is deemed at risk, there should be no hesitation in referring them or sharing information, even if consent is not, or has not yet been, given.

In such instances, once accepted by a CT, the LP then works to gain parental consent before they can start work. This means that, while not considered ‘best practice’ by many practitioners, CTs that gain referrals from The Hub do not, at least initially, always operate on a consent basis.

For some agencies including health and individual stakeholders, beginning to engage families without their consent (cold calling) is highly undesirable. They wanted the CT to work in a more strengths-based way with an emphasis on having the parents ‘onside’. For some, this also includes taking a systematic kaupapa Māori approach to working with whānau.
Tensions between two theories of change

The most significant change expected of the CT model is to change frontline practice. To date there have been two approaches to bringing about this change that have created tension within the Directorate and some key Hamilton stakeholders.

The Workforce Director in the Directorate, along with some Hamilton agency managers, are focused on change in workforce culture. Hence, their priority is on cultivating an awareness and acceptance of the CAP model across the workforce in the long run. For example, Auckland UniServices was contracted to run a series of ‘transformational’ workshops with various groups – Māori, Pasifika (practitioners and managers) and LGG members. The purpose was to get these stakeholders to consider their part – their responsibility to bring about a wider change in their respective services and communities to prevent child maltreatment.

By contrast, more operationally focused CAP managers and the local HCT Director are primarily concerned with securing sufficient, capable Lead Professionals from various agencies. These people needed to be immediately available to work with children and families in a ‘new way’ as referrals roll in and therefore should be the primary focus for capability development work.

This equated to two somewhat opposed theories of change about what should be done to achieve better outcomes for vulnerable children. A table in Appendix 3 attempts to show how these two camps tend to work against each other in this initiation phase. While longer-term transformational change is important, political and operational drivers and formal evidence prioritise the second ‘instrumental’ scenario to achieve immediate and necessary change. For reasons we explore in more detail further on, the first scenario created early barriers to effective implementation. In turn this could significantly jeopardise the quality of implementation and therefore the effectiveness of, and the support for, the CAP model in the longer term.

There was evident reluctance among some Hamilton stakeholders in acknowledging and addressing issues to do with LP capability (skills) and capacity (time available in the role). Training processes for prospective LPs were complex and at times, at very short notice. There was also some concern that it did not prepare people adequately to be LPs.

The Executive Management Group appeared to have a limited ability to facilitate the resourcing of more full-time LPs as recommended by the Directorate’s Service and Resource Lead, based on their research. This situation is likely to continue while the Directorate gives mixed messages about what the CAP model requires to succeed in this implementation/initiation phase.

Fit and alignment

Role of CYF with CTs

The role of the CT in the vulnerable children’s landscape has effectively disrupted status quo patterns of service delivery in Hamilton and challenged professional and service paradigms. Many local stakeholders expressed concern about recent developments, particularly:

- CYF not accepting referrals of children that practitioners feel need a statutory intervention.
- The CT accepting referrals that Hamilton stakeholders think should go to CYF.
- The CT working with very high-needs families, where the children are perceived to be at high risk.
- The CT being prepared to accept referrals of children whose families have not (yet) consented to share their information.

Some stakeholders wanted to work with children with a lower level of risk, consistent with early local communication and dialogue facilitated by the CT staff. Some agencies that were expected to provide LPs believed their staff are not suitable for the kind of work that is now required of them.
It is apparent to many that HCT is now taking children and families that Hamilton stakeholders would have once felt were justifiably referred to CYF. At the end of 2015, CYF was the largest referrer by far.

Uncertainty and tension remained around the ‘grey boundary’ between CYF’s role (and criteria) for working with vulnerable children and that of the CT. There was initial resistance to accepting some referrals from The Hub because Panel members considered they should go to CYF. This resistance reduced when it became increasingly plain that CYF would not accept such referrals. Several Panel members, however, retained deep misgivings about the CT accepting cases they see as most properly dealt with by CYF. At the very least, some felt there should be CYF oversight in some cases that the CT is obliged to take on. These misgivings also extended to CYF Partnered Response Coordinators who felt under pressure to pass on to the HCT cases that they thought were most properly managed through CYF’s partnered response pathway.

The HCT has ended up working with children with higher needs and complex family situations, and arguably with those at greater risk, than many stakeholders anticipated. Some have strongly opposed what they see as CYF’s retreat into working only with cases where children are at immediate risk of harm. They believe that the HCT has been left to deal with families that actually require a statutory intervention to provide sufficient protection for their children.

Relevantly, many stakeholders were of the view that CYF’s actionable definition of cumulative harm and chronic neglect would apply to children that the HCT is expected to work with:

- **Cumulative harm** is compounded experiences of multiple episodes of abuse or layers of neglect. A constant daily impact on a mokopuna can profoundly diminish their sense of safety, stability and wellbeing.
- **Chronic neglect** is frequently a factor in causing cumulative harm due to its high occurrence and its co-existence with other abuse types. Patterns of low level care, particularly during early development, must be considered in terms of the cumulative harm they may be causing.

It is unclear what the future of CYF’s partnered response will be, and whether in fact the CTs will displace this CYF pathway in locations that have Children’s Teams.

### Lack of clarity about relationship between the CT and other services

There was no attempt to make explicit the differences and inter-relationships between child and family support services and the CT. Many stakeholders were unclear why a child should be referred, for example, to the HCT rather than to Strengthening Families or Whānau Ora. Some service provider staff held the view that they are already doing for children and families what the HCT purports to do. A person from a Māori service provider was still waiting to see how the CT would engage with and support a by Māori, for Māori service response.

The CT’s fit with other significant and overlapping integrated services or service delivery innovations remains uncertain, such as the Police-sponsored Family Safety Network (FSN) in Hamilton and the Social Sector Trials in the Waikato.

### Impact on services/providers

There was a common perception, in line with CAP communications, that CTs would stop vulnerable children falling between the gaps in the existing service landscape. By implication, local stakeholders realised that other services are somehow not sufficient. For example, we spoke to professionals who had been considering referring children to CYF but referred to the HCT instead because they felt CYF was unlikely to take action. Inevitably these families were also involved with existing social services. This situation left room for service providers to feel their core services would become less important or relevant within the community and/or that their services might be under threat (i.e. reallocation of funding and/or staff and general capacity to CTs).

### Service gaps

The implementation of Child’s Plans and the achievement of positive outcomes depends on having enough services, and the right kinds of complementary services available for a CT to work well.
Panel members and the CT Director have identified the following unmet needs and service gaps in Hamilton:

- supply and quality of social housing;
- availability of special education funding and/or support for high-needs children;
- access to adult mental health services (waiting lists); and
- access to counselling services for children and young people.

There was uncertainty about how to address these service gaps. For example, access to adult mental health services needed to be brought to the attention of Waikato DHB.

### 3.1.4 Addressing Challenges for Hamilton

#### Shared vision and common agenda

The HCT Director was able to send out occasional email newsletters, and respond to requests from groups to present on the model and work of the CT. This will need to continue. However, a more concerted, pro-active and continuous communication effort is required to win over the necessary number of ‘hearts and minds’ in Hamilton. This is imperative if Hamilton is to get to scale as planned. The Director needs to focus on senior management in those organisations which fund NGOs as well as public services.

#### Communication, engagement and change management

**Building communications**

We suggest increasing resources dedicated to local communications. This increased resource, whether provided through an external communications adviser and/or comprising additional staff hours to the HCT would address the need to educate and persuade a targeted group of local stakeholders as to the value of CTs. There are three aspects to this work.

1. Seeking to better understand the barriers to stakeholders actively engaging with and supporting the work of the CT. This involves creating communication opportunities and should be focused on leveraging the influence of LGG members.

2. Developing suitable strategies for harder-to-reach practitioners, including messages that communicate a sound value proposition for more reluctant stakeholders. This involves building upon professional networks and cultivating champions to actively promote awareness of the HCT.

3. Gauging changes in awareness of, and support for, the CT.

The preparation of frequently asked questions (FAQs) documents has been a useful response to various stakeholders’ information needs. However, people from different sectors tended to want information specifically related to their work setting. We identified interest in having a website that could host inquiries and provide information tailored to different groups. An actively managed web-based platform could be instrumental in supporting communications work previously listed, as well as being a portal for training or professional development.

**The role of the Hamilton Children’s Team Director**

The HCT Director and her team were best able to elicit buy-in and cooperation through creating and maintaining good networks, through teamwork and encouraging and supporting innovative frontline practice. We saw this happening in the Panels, in interactions with LPs and through attendance of inter-agency meetings. These organisational behaviours elicit results that speak for themselves.
Information sharing and consent

All government agencies are now sharing client information with the HCT where there is a concern about harm to a child, whether or not the family has consented. This development was only achieved through the concerted intervention of the Directorate, discussed in the next section. It had also become clearer to Hamilton stakeholders that the CT was working with more serious cases requiring more sophisticated social work skills. This awareness has grown as Panel members, LPs and their managers became more familiar with the children and families being referred (i.e. the issues they presented with) and CYF’s changed position.

The HCT organised for officials from the Office of the Privacy Commissioner to speak in Hamilton on the protections afforded under the Privacy Act for people to share personal information if they were concerned about harm being done to a child. Privacy Commission staff met with the core team, Panel members and LPs, and then went on (accompanied by the HCT Director and LGG Chair) to speak with Waikato District Health Board (DHB) managers and clinicians. It appeared that a number of people still believed that if there are concerns about a child, and if the family is reluctant to engage, to share their information, or to be referred to a CT, then a call to CYF was the appropriate next step. This belief continues to challenge the new service delivery paradigm in Hamilton and ongoing discussions with the various sectors needs to occur.

The HCT Director and The Hub have respectively sought to reduce ‘dump and run referrals’, instead encouraging referring agencies and some professionals to strive to engage families and to at least inform them of an intention to refer and seek their consent to do so. We were unsure if, or to what extent, this was changing.

Directorate support

The National Children’s Director role was critical in facilitating change at the local level when she stepped in to resolve an impasse between the Waikato DHB, the LGG and the CT about sharing information between agencies. On these matters the local CT Director had little influence; central government intervention enabled the CAP model to be effectively established in Hamilton.

Of similar importance, the National Children’s Director needs to promote the effective implementation of the CAP model by seeking to reduce the constraints on the provision of LPs (i.e. agencies putting forward very part-time LPs or making their availability highly conditional. The public health nurse (PHN) team provided one FTE and had all PHNs trained to enable efficient resource reallocation and the installation of the new way of working across all team members. The inclusion of a supervision and mentoring framework to support practice related to working in the CT model will involve engaging the Vulnerable Children’s Board representatives and some local executive managers, since they ultimately control how service priorities are set and how resources are allocated. A case needs to be built showing why this is important and how it can be achieved given other organisational imperatives. A key capability that needs to be promoted at this high level is adaptive management.

Operational support from the Directorate’s Implementation Manager and her team focused on the more complex aspects of CT practice, such as using the Tuituia assessment and Panel decision-making and guidance.

Local implementers wanted greater access to this kind of information and wanted active guidance earlier. Now in an implementation phase, this kind of operational support is more available to the HCT, extending into important areas such as keeping suitable case records, participatory assessment and planning, and clinical supervision.
Fit and alignment

Service gaps and systems mapping

Because of their multi-agency membership, the Panels enabled ad-hoc monitoring. Further, they provided the opportunity to clarify the fit and alignment of services, and to note unmet needs or service gaps.

The governance and operational advisory structures - the LGG and Working Group - provided a ready means for mapping and negotiating the relationships between various services across sectors. Resourcing and assigning this task is the necessary next step. Up till now these bodies had been focused on supporting the implementation of a CT. Service mapping represents a step into ‘service system design’. This concept had only been hinted at previously, at a workshop on transformational change organised by the Directorate. The LGG will need further guidance, including examples of how this might be done, to support its engagement in this work. In this way the Directorate can enable local innovation.\(^\text{16}\)

The point of undertaking a service systems mapping exercise was as much about gaining buy-in through continuous communication as it was about gaining information for more specific analysis and planning. This was a worthwhile but time-intensive strategy that was beyond what the implementation team can reasonably manage. The HCT Director had advocated for a participatory ‘asset mapping’ approach and was hoping that this could be built into the evaluation. It therefore fell to the Directorate and LGG to initiate.

Seeking alignment through collaboration

The protocol developed for CYF and the HCT (and the fact that CYF advisors sit in on HCT Panels and HCT staff sit in on CYF moderation meetings) will continue to improve alignment.

On the other hand, the HCT had persistently sought to collaborate with FSN to achieve complementarity between these initiatives. There were discussions about co-location when both initiatives were looking for new premises but this did not proceed. According to the literature, co-location (a form of environmental restructuring) is a good strategy for improving lines of communication and therefore complementarity.\(^\text{17}\) Despite setbacks, the HCT Director indicated a strong desire to pursue a collaborative relationship. This prospect had also been taken up by the LGG Chair who has been discussing shared governance of both initiatives with the Police District Commander. The Chair wanted to create efficiencies and improve outcomes through collaboration.

It could be inferred that there is now a contest between new inter-agency initiatives for priority and resources, and resolving this may require some intervention from the National Children’s Director and the LGG. “Multiple integration initiatives targeting the same people or groups” has been identified as a barrier to integrating services.\(^\text{18}\)

\(^{16}\) Snook & DMA (2014) Service Design Principles for Working with the Public Sector

\(^{17}\) Atkinson, M., Jones, M. & Lamont, E. (2007). Multi-agency working and its implications for practice: A review of the literature, p67-68). The review also states that it may be confusing for major new initiatives to be co-located. Such risks could be overcome through physical design.

\(^{18}\) SUPERU (2015, November 10) What Works: Integrated social services for vulnerable people, p13
3.1.5 Insights

Shared vision and common agenda

It is critical to identify and then directly address local views and perspectives that will affect a shared vision and common agenda, e.g. previous work or initiatives for vulnerable children, iwi programmes and aspirations, etc.

Communication, engagement and change management

National key messages need to be clear and persuasive rather than just factual, and focus on:

- the relationship between CTs and CYF;
- the paramountcy principle, for example, using the Children’s Commissioner (courageous conversations video) and practitioner examples that could speak to frontline staff from various disciplines and sectors; and
- information sharing, using the Privacy Commissioner in all new sites to clarify the facts and help practitioners work through their concerns.

Local communications are important from the earliest moment to actively engage different stakeholder groups and address their concerns from the earliest moment. This includes developing tailored messages and identifying willing local champions. Local people need to know what good progress looks like, and need to be able to play their part in feedback loops that improve delivery and results. This includes knowing how to make a referral to The Hub and to being prepared to provide the right kind of information.

Improved communications of changes is required. We suggest that a concerted and regular communication strategy be developed to keep local stakeholders informed of changes in the service provision landscape and the reasons for these changes. This would help reduce the confusion and misunderstanding about the fit and alignment of services.

Ongoing learning forum/feedback loops. Taking this one step further, it would be useful to have a periodic wānanga or learning forum for agency representatives to meet and discuss the implications of these changes, to raise issues and to problem-solve. This would enhance the CT’s and the Directorate’s reputation and provide useful data to support ongoing refinements to programme design and implementation.

Both National and Local Directors are critical for success:

The Directorate provides essential practical support in the early days as well as having an ongoing role in building and sharing knowledge, evolving the CAP model based on learning, and maintaining sufficient consistency across sites.

The role of the National Children’s Director is critical in championing the integrity of the CAP model and in securing sufficient resources and inter-agency cooperation at both national and local executive management levels. This will need to include engaging iwi leaders to heed their perspectives and secure their partnership.

The role of the Local CT Director is crucial in securing local acceptance and adoption while clearly operating within a nationally established framework.

Expect more effort and longer timeframes for bringing about outcomes for vulnerable children. Since the CT is dealing with cases that involve more resistant parents and more entrenched problems, it is likely to require more effort and longer timeframes to obtain desired outcomes than many first thought.
The importance of attending to ‘transformational change’ as CTs ‘stabilise’, i.e. when the model is running more or less as expected, key components are viewed as stable and the community climate is generally favourable. Moving into a ‘confirmation/expansion phase’ should signal an opportunity to focus on wider systems change. However, this may not happen without active Directorate support.

**Fit and alignment**

**Clarifying the place of CTs in the system.** It appeared that the CT’s point of difference from CYF is that it works mainly with families where children experience chronic neglect and emotional abuse, rather than the actuality or serious threat of physical or sexual harm. We suggest that it might be useful for the Directorate to develop with CYF some more explicit guidance (i.e. for the *Children’s Team Manual* and the CYF Assessment and Decision-Making policy) and more general communications that clarify boundaries and points of crossover.

**Developing a close working relationship with CYF is critical.** It took a while to achieve and has not been without its tensions. It may be opportune to consider how CYF and the CTs might go beyond *collaboration* and into a more *integrative* service offering.

**Collaboration is resource-intensive** and may not be necessary, affordable or sufficiently worthwhile to pursue with many organisations and stakeholder groups (versus seeking informal cooperation or more formal coordination).

**Research into the interaction of the HCT children and families with various configurations of services** (before, during and after HCT intervention) will help learning and enable local stakeholders to engage more actively in service and systems design.

**It will be important to evaluate the implications and impact on local services and providers** of establishing CTs, particularly in light of concerns about CTs diminishing or disrupting the provision of important support services to children and families. Given the timeframe of the Hamilton evaluation, we were unable to explore this issue sufficiently.
### 3.2 Partnerships

**Planning and development 3.1**

<table>
<thead>
<tr>
<th>Partnership 3.2</th>
<th>Implementation 3.3</th>
<th>Systems change 3.4</th>
<th>Scaling up 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared vision and common agenda</td>
<td>Clear roles supported by strong governance</td>
<td>Prescriptive vs. local adaptation</td>
<td>Funding and accountability systems that support collaboration</td>
</tr>
<tr>
<td>Communication, engagement and change management</td>
<td>Collective ownership and buy-in</td>
<td>A working model Structures, tools, guides and processes: referral, assessment, planning</td>
<td>Common accountability measures</td>
</tr>
<tr>
<td>Fit and alignment with current service provision</td>
<td>Common database / IT platform</td>
<td>Information sharing systems that support collaboration</td>
<td>Changing the current service mix</td>
</tr>
<tr>
<td>Functional team and organisational structure</td>
<td>Evolved practice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SUPERU’s literature review identified clear roles and responsibilities, and collective ownership of the programme as the main elements underpinning effective partnerships and a “robust and workable integrated service approach”.

### Governance

The SUPERU report guides us to consider the role of governance as follows:

> “Inclusive governance processes with clearly defined responsibilities help build a joint sense of ownership and responsibility for performance and outcomes. Governance provides the structure and mandate for a common agenda to be enacted.”

SUPERU identified that the “Children’s Teams model required establishing governance arrangements centrally across social sector agencies, vertically through the system, and locally including community representation”. They illustrated the scope of governance arrangements that were thought necessary to operate effectively as follows.

---

20 ibid
21 ibid
The central governance level has been well defined and operational for several years. Our particular focus was on the regional governance arrangements. These comprised four clearly specified and distinct groups and functions.

**Figure 3.2.2**  Descriptions of the most relevant governance groups and functions

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAP Directorate</strong></td>
<td>The CAP Directorate’s function is to provide consistent, national-level guidance and support based on experience and evidence from across the sites and wider government initiatives.</td>
</tr>
</tbody>
</table>
| **The Local Governance Group (LGG)**       | “Core governance group members should represent key areas within the Children’s Team local system, be at the right level to make decisions regarding systems, services and resources and participate actively.” The LGG’s responsibility is to “inform and approve an operating model; promote and help resource the Children’s Team; monitor the performance of the HCT and address barriers to success; and promote workforce safety and competency”.  

Hamilton Children’s Team (2014) *Draft Terms of Reference – Children’s Team Local Governance Group* (Draft version 2, 1 July 2014), p1                                                                                                                                                                                                                          |
| **The Working Group (WG)**                 | The WG was established as the operational arm of the Interim Governance Group under the direction of the CAP appointed Children’s Team Lead. It was subsequently chaired by the Hamilton Children’s Team Director. This group effectively formulates inter-agency arrangements that are expected to support the implementation of the HCT. Specifically members advise on, or practically respond to, the requirements of the HCT Director and they implement the decisions of the LGG in their respective organisations. |
| **The Executive Management Group (EMG)**   | The EMG was a time-limited and stand-alone group convened specifically to “manage the process that identifies from where personnel, who would currently be providing services to vulnerable, at risk children, could be assigned to be Lead Professionals for the Hamilton Children’s Team to meet expected volume of referred children for the first 12 months from being launched (go-live), and to submit a proposal to implement the required changes to the Children’s Action Plan Programme Executive (CAPPE)”.  

Hamilton Children’s Team (2015) *Hamilton Executive Management Group Terms of Reference* (ToR: draft 1), February 2015                                                                                                                                                                                                                           |
Working together

As the SUPERU report states, "Shared ownership (along with clear aims and allocated time) is consistently identified in the literature as being essential for the success of both multi-agency working and integrated services, and recognised as being difficult to achieve because it requires culture change at a number of levels" (Everitt 2010; KPMG 2013). This has been born out in both the SUPERU assessment of demonstration sites and our evaluation of the CAP in Hamilton.

We have developed the following framework to help us identify progress in ownership of the CAP in Hamilton. We have encountered few naysayers and consequently have not represented 'no ownership' or 'active rejection'.

Figure 3.2.3  Levels and descriptions of collective ownership

<table>
<thead>
<tr>
<th>Levels</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership is imaginable</td>
<td>There is a broad awareness of the HCT; what it is and how it operates relative to other initiatives and services. Ownership has to start with awareness without commitment.</td>
</tr>
<tr>
<td>Community is favourably disposed</td>
<td>Endorsement of the key concepts of the CT approach. This equates to widespread acceptance but not behavioural change. The community climate is generally favourable.</td>
</tr>
<tr>
<td>Partial ownership</td>
<td>Championship is important to ownership but is not sufficient. This involves spreading the word and encouraging uptake. This does not require wholehearted commitment and may not be accompanied by actions that enable the CAP to progress. At the community level there may only be a few actively committed stakeholders alongside some ambivalent ones. Practitioners are starting to refer and participate in Child's Action Network teams. This may be uneven across sectors.</td>
</tr>
</tbody>
</table>
| Substantial ownership         | A widespread practical commitment by a broad group of stakeholders involving changes in structures and practices. Local agencies and service providers:  

- offer resources to enable the CT to operate adequately, and  
- prioritise CT actions and requests.  

Furthermore a broad range of practitioners make referrals and participate in Child's Action Networks. |

3.2.1  Progress markers

Governance

Since the central governance level had been well defined and operational for several years, our focus was on the regional governance arrangements:

- Interim then permanent LGG established with members from the range of key agencies and organisations.
- LGG Chair appointed.
- LGG approves an operating model.
- LGG promotes and helps resource the CT.
- LGG monitors the performance of the HCT and addresses barriers to success.

Working together

Local ownership started in Hamilton when a number of service and agency managers and practitioners started work on establishing their version of the CAP back in 2012. While this local momentum recommended Hamilton as a good choice for trialling the CAP for a large urban population, this strong sense of local ownership of the original idea had created some challenges for establishing a common agenda and achieving broad buy-in to the CT model. Key progress markers are:

- A strong belief in the potential of the CT concept is evident amongst the children’s workforce and agency and organisation leaders.
- All relevant organisations and agencies are actively engaged in implementing and contributing to the CT approach.
- Agencies ensure provision of sufficient LPs and other resources to meet projected demand.

3.2.2 What went well

Governance

An interim Local Governance Group was constituted in September 2014, following the announcement that Hamilton was to have a CT. Membership has been fairly constant since, and was supplemented by the addition of an independent Chair in May 2015. Members came from the five VCB agencies, Waikato DHB, Waikato Tainui and a number of NGOs.

A Working Group was also established as the operational arm of the Interim LGG.

Specific roles were established by the Directorate to provide secretariat-like functions to the governance structures in Hamilton. These included the following:

- **Children’s Team Lead** founded the LGG, developed an initial Terms of Reference, and orchestrated the appointment of a local CT Director.
- **Service and Resource Lead** negotiated the necessary number of LPs to start with, working in conjunction with the EMG and identified where more LPs were likely to come from. The LGG is tasked, in conjunction with the Directorate, with "ensur[ing] the Children’s Team has sufficient cross-agency and Non-Government (NGO) personnel to meet referrals of vulnerable, at risk children".
- **Community and Stakeholder Engagement Lead** created the communications strategy and resources to encourage practitioner awareness of the HCT, and of The Hub and then ViKI as the referral points. This role practically supports the requirement that the LGG "champion the Children’s Team and promote its profile and reputation".
- **Local Workforce Lead** focused on safety vetting and checking of CT workers, as this is now a blanket requirement. This role practically supported the requirement that the LGG "monitor and support the Children’s Action Team Director to ensure that personnel participating in the Children’s Team are vetted and screened to an appropriate standard", and that the LGG "monitors local agency's implementation of plans to improve vetting and screening practice across their organisation".

---

26 All of these roles had been working across multiple Children’s Team sites at various stages of establishment and implementation. Only the Workforce Development Lead has retained a predominant Hamilton focus.

27 Hamilton Children's Team (2015, June) LGG Terms of Reference Review June 2015 V2 DRAFT, pp2-3
Working Together

Those frontline practitioners who knew about the CT concept and the components of the model (i.e. LPs, the Panels, the Child’s Action Networks (CANs), and the single child-focused and family-centred plan) believed it will make a difference to the lives of vulnerable children. Many also acknowledged that it is time to try something else because the status quo does not work. We therefore inferred that the Hamilton community was definitely favourably disposed.

A legacy of personal commitment is illustrated through the membership of the LGG and related Working Group. These bodies comprised people involved in the very early establishment efforts. The HCT Director was appointed on the back of being a long-time proponent of CTs, as the Chief Executive of one of the main service providers working collectively to bring about change. In that respect, the HCT Director and members of the various governance and operational groups were natural local champions for the larger cause of preventing child maltreatment. As we have previously indicated, there have been differences of opinion about how CTs should operate but there is no equivocation about the need for one.

Specific commitment of resources

The Ministry of Social Development (MSD) has provided the greatest level of agency support, involving a commitment across all its main operational groups, including:

- Work and Income provided free premises, extending to a functional office accommodating all start-up staff, and including access to additional training and meeting rooms. Work and Income also provided significant staffing: a Coordinator and project manager on secondment, one full-time LP, two Panel support roles that also act as Navigators and an LGG member.

- Community Investment funded a further four full-time LPs (making it five MSD-funded LPs of the 6.5 Full-time Equivalents (FTEs) needed to begin).

- CYF also contributed two Panel support roles, who also act as Navigators, an LGG member, and a Working Group member.

Within the first three months, CYF became the most substantial referrer of children to the HCT. Also in this time, CYF worked increasingly closely with the HCT to clarify the boundary between the two kinds of services (or service models) and to share practice insights.

We identified that the education sector has been particularly receptive to hearing about how the CT will operate. Despite the devolved nature of the schooling and early childhood education sector, the Regional Manager for the Ministry of Education has been able to orchestrate a significant number and range of meetings presenting information and enabling queries about the HCT, and the CAP model more generally, to be answered.

Health provided three FTE LPs, one paediatrician for one panel, one psychologist for a panel and a health navigator as well as backfilling LPs who were undertaking training a member for the LGG and secretarial support for the LGG.
3.2.3 Key Challenges for Hamilton

Governance

LGG composition and commitment

The LGG composition and level of commitment has been problematic for a range of reasons. While key government social agencies were at the table, some of their representatives (against the expectations in the LGG's initial Terms of Reference) were not sufficiently influential in their own organisations to represent a strategic view, commit resources, or speak on behalf of their organisation. NGO members were self-nominated and it was not clear how they represent the sector as a whole.

There were ambivalent members and noticeable absences at LGG meetings. Māori organisations in particular have shown their ambivalence about the HCT and the governance role. Concerns raised included the level of government commitment to the CT being insufficient for it to work as expected, and the lack of understanding of, and support for, Māori agencies working holistically with ‘vulnerable’ Māori families. Waikato-Tainui have been mostly absent from LGG meetings in 2015. These absences and variable levels of commitment clearly reduced the potential effectiveness and degree of influence this group was expected to provide.

Confusion about the LGG role

Confusion about governance roles and responsibilities is another barrier to the performance of the LGG. Several members have stated that the way CTs have been established means “there is nothing to govern”. By contrast, the Terms of Reference seems quite clear about governance responsibilities that are actionable and measurable.

The Chair had also indicated that he thought the LGG was inclined to be too operationally focused, e.g. deliberating over aspects of the CT Service Model (the detailed process flow) instead of discussing the strategic questions inherent in the model, sufficiently delegating to Working Group members, and trusting the HCT Director to attend to the detail. Such distinctions have been difficult for the LGG members. Many were strongly opposed to the Directorate's view on how the service model should work and tended to express their concerns by focusing on the operational detail.

Barriers to LGG supporting effective implementation

There is too much onus on the local CT Director having to account for the HCT’s performance against these governance areas (by way of monthly reporting). This perhaps took the focus off each agency clearly stipulating what it would do within its ‘zone of influence’, and outlining progress in relation to these things at LGG meetings.

Some agencies have made the HCT Director’s job more difficult. This occurred through:

- making resources (LPs) available under very specific and limiting conditions;
- under-promoting the HCT within their respective networks (which explains variable awareness of the HCT and uneven referrals to the HCT across sectors);
- not understanding or accepting that LPs will be, and are working with, moderate risk/high-needs clients; and
- generally under-promoting compliance with child workforce safety legislation.

---

28 “Core governance group members should represent key areas within the Children’s Team local system, be at the right level to make decisions regarding systems, services and resources and participate actively.” Draft Terms of Reference – Children’s Team Local Governance Group (Draft version 2, 1 July 2014), p1
Almost all LGG members refused to agree on a local operational model that allowed referrals of non-consenting families, i.e. children referred to the HCT via The Hub whose parents or caregivers did not consent to the referral, or to sharing their personal information. This included disagreement about the level of risk that enabled information sharing without consent under the Privacy Act. This situation compromised the HCT Director, set the LGG against the Directorate, ignored enabling provisions under the Privacy Act, and contravened the formal position of VCB agencies and Government Ministers.

The LGG's advocacy role is still underdeveloped at this stage. The HCT Director has consistently promoted the advocacy role of the LGG to Hamilton stakeholders as an important point of difference between CTs and other initiatives. In its Terms of Reference, one of the LGG’s specific responsibilities is to “monitor, review and report via the National Children’s Director to the Vulnerable Children's Board, on service access, trends, gaps and quality issues each quarter”. The HCT Director has, as yet, been unable to secure a commitment from the LGG as a group to act on, or advocate resolving, important issues that have been raised with them. These issues, which are deemed to limit positive outcomes for HCT children and families, include:

- the inadequate supply and quality of social housing;
- the limited availability of special education funding and/or support for high needs children;
- insufficient access to adult mental health services (waiting lists); and
- insufficient access to counselling services for children and adolescents.

Working together

Devolved sectors make governance and influencing difficult

There are LGG representatives from the education and health sectors. Schools, Childcare Centres and General Practitioner practices have an oblique relationship with the government agencies that fund them. This creates an additional barrier for LGG members in these sectors to promote awareness of the HCT, and workforce safety more generally.

Difficulty overseeing and assuring LP performance

Managing LPs and accounting for their performance was made more difficult by decisions made at the governance level. The VCB decided to accord latitude to agencies about how they chose to provide and manage LPs. This had the flow-on effect, already described, of significantly increasing the number of LPs (many part-timers), most of whom will not be overseen directly by the HCT Director and who may only be available under specific conditions.

Several agencies also challenged the HCT Director’s right to decide on the suitability of these LPs. These agencies variously defended the suitability of their staff to undertake an LP role while also expressing concern about their staff being under-prepared to work with higher risk-high needs families. These agencies had also been at odds with the HCT Director about the amount of LP training the HCT Director was proposing. This situation introduced an unnecessary level of complexity, and too many ‘veto points’ which, taken together, endanger effective implementation. While all LPs report directly to their own agencies for workforce development, safety and performance, this performance risk is ultimately a governance issue for Children’s Teams LGGs.

---

29 Hamilton Children’s Team (2014) Draft Terms of Reference – Children’s Team Local Governance Group (Draft version 2, 1 July 2014), p1
Managerial concern about impact on local service delivery

Some local managers of VCB agencies also indicated that being expected to provide LPs threatened their ability to deliver required services — they felt torn. When requested to provide LPs, one agency responded by saying it had already committed all discretionary staff and resources to a national trial (the FSN), which would also benefit vulnerable children. Several NGOs were also reluctant to provide further LPs because this would likely result in reducing services to its own traditional client base. Consequently, some organisations have embraced changes heralded by the implementation of the CT to varying degrees, while others minimally complied.

Selected comments from the Awareness of Hamilton Children’s Team survey conducted in July 2015

[I have been informed] that staff doing this work will have current work redistributed – this is a concern to me as historically when new work has arrived we have not been able to redistribute existing responsibilities as everyone has waitlists and as there is no existing slack in the system.

Re- allocation of time to this project at expense of other work.

Partial commitment of VCB agencies

In the report on reallocating resources to provide LPs for Hamilton, the EMG identified that there would be sufficient LPs for the first three to six months but possibly not beyond that, based on what agencies were prepared to commit to at that time. It has therefore been difficult for the HCT Director to plan and report with confidence to key stakeholders that there will be sufficient LPs in line with the two-year Local Action Plan. Again this is a governance responsibility.

With some VCB agencies, cooperation in support of the CTs is endangered by operational decisions that favour agencies’ business-as-usual priorities. In Hamilton, we identified that public service managers were anxious about having staff work as LPs, as demonstrated by the above quotes. They expected that the LP work would undermine their ability to deliver the services and targets that are still required of their staff in their regular roles (i.e. as public health nurses, advisors, psychologists, social workers). We concluded that the agency’s executive managers have not been able or willing to modify their usual performance and accountability requirements to accommodate a wholehearted commitment to local CAP initiatives.

These issues, which manifest at both the national and local level, are longstanding. They were highlighted as ‘most pressing and difficult issues’ in the SUPERU report on the design and implementation of CTs demonstration sites. We have tried to show that this lack of buy-in poses a risk to the successful implementation of local CTs and consequently to the potential results and sustainability of the CAP as a whole.

Engagement with Māori

Māori organisations have engaged with the HCT by having formal representation on the LGG and by providing operational support, in particular a Panel member and a Working Group member. A Te Puni Kōkiri representative is also on the LGG but this is a central government mandate. However, the frequent absence of Waikato Tainui at LGG meetings (representing the tribal confederation of Māori in the area), and the ambivalent perspective of a significant Māori leader did not bode well. This situation signalled a risk to the collective ownership of the HCT. If it persists, the relevance and credibility of the HCT is likely to diminish in the eyes of local Māori. In the Waikato, Māori are expected to comprise the highest proportion of referrals to the HCT, and the

---

HCT in turn relies on Māori organisations and workers to support vulnerable children and their whānau. Successfully implementing integrated services involves "working in partnership with people using the services" and employing "approaches that are culturally responsive to Māori", and viewed as more 'by and for Māori'.

**Low and uneven referrals**

The number of referrals to the HCT was initially low and somewhat unpredictable, with 18 in September 2015, 37 in October, 30 in November then 62 in December (and 86 in February 2016). This made it difficult for the team to pace their work effectively.

### 3.2.4 Addressing Challenges for Hamilton

**Governance**

**Cross-initiative regional governance**

A regional governance structure covering a range of social sector initiatives is something that the LGG Chair has been investigating. This may mean that high-level agency managers will be more motivated to participate in regular meetings if they can efficiently deliberate over a range of initiatives operating across the region in the one sitting. Such an arrangement may facilitate important planning and funding decisions that apply to multi-agency regional partnership initiatives such as a CT, the FSN, Strengthening Families, and Social Sector Trials; those with overlapping goals and shared clients and constituencies. The LGG Chair is concerned about high levels of 'duplication'. Whānau Ora will also require special consideration given its special importance to local Māori leaders and its wrap-around nature.

Any change to the governance structure involving the LGG will mean rethinking the Working Group. A new operationally-focused management group would be needed to attend to the more practical aspects of inter-agency collaboration and intervention design, to maintain and further develop the HCT’s service model, and (before too long) a Waikato model as well.

**Further Directorate guidance in support of local governance and leadership**

The above scenario raises some capability issues. It might be helpful if the Directorate provided some specific training and support to enable 'tactical leadership' and 'adaptive management'. In terms of leadership, we are referring to taking an integrated prevention approach to tackling vulnerability that is best achieved through inter-sectoral rather than intra-sectoral collaboration. In other words, officials from different sectors should have the opportunity to jointly lead the process of development and change, and should be supporting operational staff to innovate - to optimise implementation and results (e.g. provide adequate resourcing for the HCT, local workforce development and address service gaps).

By 'adaptive management' we mean day-to-day managers of operational staff working in government agencies and NGOs adopting "an open and learning attitude" and involving people such as researchers and reflective practitioners to evaluate policies and strategies. This may require a different selection of operational managers and advisers whose primary performance accountability relates to supporting a well-functioning and innovative CT.

---


32 Drawing on Hendriks et al. (2013). *Proposing a conceptual framework for integrated local public health policy, applied to childhood obesity - the behavior change ball*, p10

33 Ibid, p10
**LGG membership**

Recently the LGG has been updating its Terms of Reference to do with membership. However, to our knowledge, the LGG hasn’t recently addressed the question of who is missing at the governance level. We suggest that having the Department of Corrections and the Hamilton City Council involved might be helpful for reasons that follow. The Department of Corrections, like Police, CYF and Work and Income, hold a lot of information on, and are in a position to influence, HCT clients. This makes the Department of Corrections an important but unrepresented part of the service ecology of relevance to the HCT.

**Working Together**

**Identifying and addressing unmet needs and service gaps**

Local authority involvement could strengthen the LGG’s capacity to advocate and address service gaps and unmet needs for vulnerable families. Local authorities are well positioned to help undertake or fund ventures such as asset or service mapping. The City Council has a responsibility to its residents to consider and improve liveability, and the lack and quality of social housing has already been identified as an issue in Hamilton. We note that the LGG, at the end of 2015, had started to consider service gaps and issues such as the social housing shortage in Hamilton.

**Working with Māori**

Aside from renewed efforts to improve engagement with Waikato Tainui, it may also be timely to consider how best to approach Māori representation on Waikato-wide governance and operational groups, and to do it well in advance of expanding the HCT.

**Securing sufficient referrals across a broad base**

Greater emphasis needs to be placed on gaining referrals from health professionals, the NGO sectors and justice-related agencies such as the NZ Police and the Department of Corrections. While it is arguable that the HCT Director and staff could do more promotion, the LGG remains the greatest untapped resource for promoting referrals from its members and associated networks.

### 3.2.5 Insights

**Governance**

**Clarify roles**

It is important to maintain communications with stakeholders and clarify the respective roles and relative influence of central government versus local stakeholders.

The LGG has the greatest potential for promoting referrals from its own members and associated networks. The Directorate is best placed to ensure that messages are coherent and aligned, and that strategies are likely to be effective.

The LGG needs to provide a mix of strategic and tactical leadership. This should be based on having a membership comprising regional VCB agency managers and executive managers from local organisations.

It is desirable for the National Children’s Director and the LGG to provide joint leadership of the HCT as the local CTS are inextricably linked to central government decision-making (determined by the Ministers, VCB agency executives and the Directorate Directors).
Effective LGG

The need for effective LGG members cannot be understated. LGG members need to make decisions with their own organisations about resources, to identify and delegate tasks, and to more generally shape their respective organisations’ priorities at the local level to improve the CAP’s chances of success.

Make it worthwhile for local leaders to participate in the LGG

This is where the option of a cross-initiative governance arrangement might help. Such a move could reduce meeting burden and address at least two known barriers to successful implementation of multi-party integrated initiatives:

- complexity of integration processes, funding and relationships; and
- multiple integration initiatives targeting the same people or groups.\(^{34}\) (e.g. HCT, FSN, Whānau Ora, Social Sector Trials).

Additional support and guidance for LGGs and Directors, especially in large sites

Growing and maintaining local commitment is likely to require more Directorate support to experiment with alternative governance arrangements and processes. This might usefully include consideration of an online platform for discussion, task tracking and decision-making to reduce problems associated with non-attendance at monthly meetings. For example, the Hamilton LGG Chair wants an adequate working definition of ‘vulnerability’, including illustrative cases. He also wants more central direction to LGGs across the country, crystallising what a ‘national Vulnerable Children’s Team’ looks like. This would include a view of over-arching governance with national guidelines allowing for some level of local autonomy.

Working Together

Clarifying boundaries

Multiple integration initiatives targeting the same people or groups create a barrier to implementation for CTs.\(^{35}\) Resolving this issue is likely to require clarifying goals and boundaries, identifying potential synergies and developing effective working relationships.

Working with Maori

Prioritise engaging and partnering with iwi/Māori from the outset.

Understand and build from local strengths

Make an early priority of identifying key local assets (services and influencers) and systematically identify and address local challenges. This will establish a policy-level engagement with the situation of vulnerable children in each locality.

\(^{34}\) SuPERU (2015, November 10) *What Works: Integrated social services for vulnerable people*, p13

\(^{35}\) ibid, p13
3.3 Implementation

<table>
<thead>
<tr>
<th>Planning and development 3.1</th>
<th>Partnership 3.2</th>
<th>Implementation 3.3</th>
<th>Systems change 3.4</th>
<th>Scaling up 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared vision and common agenda</td>
<td>Clear roles supported by strong governance</td>
<td>Prescriptive vs. local adaptation</td>
<td>Funding and accountability systems that support collaboration</td>
<td>Workforce safety</td>
</tr>
<tr>
<td>Communication, engagement and change management</td>
<td>Collective ownership and buy-in</td>
<td>A working model (Structures, tools, guides and processes: referral, assessment, planning)</td>
<td>Common accountability measures</td>
<td>Workforce capability and capacity</td>
</tr>
<tr>
<td>Fit and alignment with current service provision</td>
<td>Common database / IT platform</td>
<td>Information sharing systems that support collaboration</td>
<td>Changing the current service mix</td>
<td></td>
</tr>
<tr>
<td>Functional team and organisational structure</td>
<td>Evolved practice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In this section we present key findings related to the implementation process in line with the SUPERU assessment framework. These have been structured into three sub-sections:

1. **National/Local balance** (prescription versus local adaptation)
2. **Team** (functional team and organisational structure)
3. **Infrastructure** (a working model and common database).

Given our understanding of the government and Directorate's intent, and based on SUPERU's analysis of demonstration sites, we expected to see the following:

- Core components of the CT model are implemented faithfully, especially those that support effective and consistent practice. Those components that enable progress are monitored and reported on for accountability, but also for programme improvement.

- An increasingly common agenda among partner agencies, and increasing levels of buy-in from them all over time.

- Signs of local innovation that overcome implementation challenges and capitalise on previously unforeseen opportunities. This gives effect to the principle "build on what's working well in local sites".\(^{36}\)

- Well-reasoned challenges to aspects of the CAP model or its implementation are encouraged, considered and acted upon.

---

The establishment of a working model in Hamilton was complicated both by its sheer size and by the associated rollout of the new information management systems and protocols - The Hub, ViKI and the AISA. Consequently, there were foreseeable points and periods of tension that needed to be worked through, as plausibly predicted by various systems change and organisational growth models including the two below.

Satir's Change Model (Fig. 3.3.1 below) describes the common occurrence of a reasonably chaotic start to complex interventions in which it is difficult to fairly assess performance. If wellimplemented and supported, interventions tend to settle down as the people involved become excited by the possibilities of a transforming idea and move towards intended levels of performance and outcomes.37

Figure 3.3.1  A model of change and its effects on performance over time

Diagram is from Swe, S. 2011, What does change look like over time.38

In Griener's Growth Curve model, each stage of growth or development is accompanied by revolution, wherein the solution that arose from one revolution becomes the reason for the next revolution, and so on. Revolution is therefore to be expected and managed. While formulated with a focus on growth and change in business organisations, Griener's growth curve has a commonsense relevance to the national growth of CTs.39

There are three main foci for assessing the working model, based on the key stakeholder intentions and evaluation questions:

1. Are all the parts implemented, and implementation milestones achieved?
2. To what extent do the CAP components work well in themselves – reflecting formal intentions, and as experienced/perceived by users?
3. Do all the components work together as intended, and as an effective whole, as perceived by key stakeholders?

37 For more information on the model and its stages see Smith, S. (2000) The Satir Change Model
38 Swe, S. 2011, What does change look like over time
There is also the more complex and fundamental question:

4. How well, or to what extent, were problems or barriers to implementation circumnavigated or overcome?

This last question relates to the HCT’s and the Directorate’s respective and conjoint capability to learn and adapt as things unfold. We acknowledge that our reflections on these questions are based primarily on observations and discussions with Hamilton stakeholders. Also, the last question will remain live for quite some time as the HCT continues to scale up.

### 3.3.1 Progress Markers

Progress markers for implementation needed to reflect a range of progressive adaptations and trade-offs, at both the local and national level. By progressive, we mean the appearance of a more sophisticated, actionable, and less fragile working model (based on increasingly clear principles) than might have otherwise occurred with a bottom-up or top-down design.

- Decision making responsibilities clear (at appropriate levels and with appropriate mandate).
- Balance negotiated between national bottom lines and local adaptation.
- Key structures and processes operating effectively.
- Guidance and professional resources/training providing necessary support.
- Process flow operating smoothly.
- The HCT has the appropriate roles and resources to function efficiently and effectively.

### 3.3.2 What worked well

During the evaluation period the most developed and well-functioning CAP components were:

- The Hub – it enabled a clear and consistent pathway into the HCT and sound judgements were made about where referrals should go (the HCT, CYF or universal and/or specialist services).

- The Panels were recognised as having the necessary sector coverage and a good mix of expertise. They increasingly came to grips with CYF’s new position (not accepted by all but better understood), and provided important and considered guidance to LPs about perceived risks and options for the support of children and families.

- Navigators and information sharing protocols – all key agencies were sharing information with the HCT upon request and as expected.

Because creating the conditions for sound implementation improves outcomes, the most important foundational achievement in Hamilton has been to create an implementation team and key processes.

We identified a number of milestones as critically important to implementation success. With all the components in place, as outlined and in the following order, the HCT became fully operational.

---

40 Guba and Lincoln, in the context of evaluation, aspire to have individual understanding become more informed and sophisticated and individuals are moved and empowered to act on insights. Hagel (drawing on Taleb) emphasises the importance of “anti-fragility” whereby elements of a working model are not allowed to become over-stressed.
Figure 3.3.2 Systematically creating the building blocks for the HCT

<table>
<thead>
<tr>
<th>Timing</th>
<th>HCT significant building blocks and milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>The Local Governance Group (interim) was established.</td>
</tr>
<tr>
<td>2015</td>
<td>31 January: HCT Director started in the role.</td>
</tr>
<tr>
<td>April</td>
<td>A functional office was established, sufficient to support the main activities of the HCT core staff. This included being able to access MSD’s Outlook functionality, and shared drive for document storage</td>
</tr>
<tr>
<td>April-July</td>
<td>HCT core staff were appointed (Administrator, Service and Resource Lead, Project Manager, Workforce Lead and a Coordinator (one of two).</td>
</tr>
<tr>
<td>July-August</td>
<td>The Hub and Hamilton Panels (2) were established, and sufficient LPs identified and trained ready for the HCT launch.</td>
</tr>
<tr>
<td>August</td>
<td>The Children’s Team Manual was distributed. Further sections were added in September.</td>
</tr>
<tr>
<td>August 20</td>
<td>A paper based information management system and training were rapidly instituted following the news on 13 August that ViKI would not be available at the time of launch.</td>
</tr>
<tr>
<td>September 1</td>
<td>Official launch of the HCT. The launch was the focus of significant targeted publicity. The first call was made to The Hub that day.</td>
</tr>
<tr>
<td>September 8</td>
<td>The first Panel was convened and child and family allocated</td>
</tr>
<tr>
<td>October 29</td>
<td>The first child and family plan was submitted to a Panel and approved</td>
</tr>
<tr>
<td>November 16</td>
<td>ViKI became available. At this point the full CAP model becomes operational. It would require a few months to fully replace the paper-based system provided as a backup.</td>
</tr>
<tr>
<td>December</td>
<td>All necessary government agency Navigators were operating. Based at the Police, CYF, Work and Income, the Ministry of Education, and the Waikato DHB, they were all providing client information in sufficient time for each Panel.</td>
</tr>
</tbody>
</table>

The Team

The core of the implementation team was formed in April 2015 when the HCT Director was joined in new premises by an Administrator and Resource and Services Lead. This core team grew to six with a mix of more establishment-focused roles (short term appointments and/or those working across sites) and more implementation-focused positions.
Figure 3.3.3  HCT core team members and their areas of responsibility

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCT Director</td>
<td>An implementation team leader, and leadership figure representing the Directorate in Hamilton. Works most closely with senior operational managers and some executives on the LGG and Working Group along with other leadership figures in Hamilton. Facilitates the Panels and oversees the work on the Panels and LPs. (Two year contract.)</td>
</tr>
<tr>
<td>Senior Administration Support</td>
<td>Instrumental in setting up the office. Coordinates activities and communications and provides some administrative support in relation to the Panels. (Short-term contract - reports to the HCT Director.)</td>
</tr>
<tr>
<td>Coordinators (2)</td>
<td>Provides the coordination and administrative support that is critical to the functioning of Panels and LPs. (Short-term extendable secondment from Work and Income, two-year contract - reports to the HCT Director.)</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Did a range of complex tasks in the start-up and early implementation phase and took on training delivery. Effectively took on the role of operations manager. (On short-term secondment from Work and Income - reports to the HCT Director.)</td>
</tr>
<tr>
<td>Resources and Service Lead</td>
<td>Is a start-up role focused to ensure there would be sufficient LPs available to service the demand. Worked with the Executive Management Group, agency funding staff and senior NGO managers. Initially based in Hamilton and then working mainly with South Auckland site. (Short-term contract [extended] - reports to the Directorate.)</td>
</tr>
<tr>
<td>Workforce Lead</td>
<td>Primarily tasks involved promoting compliance with the Vulnerable Children Bill requirements for child protection policies, child workforce safety checking and police vetting. Also promoted collaboration on maltreatment prevention processes between practitioners and organisations. (Reports to the Directorate.)</td>
</tr>
</tbody>
</table>

Overall, the caseload expectations appeared reasonable. The HCT Director said she believed the caseload parameters set by the Directorate of around 30 children, or 10 families, were about right for more experienced full-time LPs. The suitability of this caseload has been discussed a number of times between the HCT Director and the manager of the Public Health Nurse service, which considers this caseload excessive for the 1 FTE LP it provides.

The HCT, with support from the Directorate, demonstrated that it was able to work through barriers and challenges, for example:

- When ViKI was not ready to be rolled out as planned, a workable business continuity solution was rapidly put in place to manage The Hub’s and the CT’s information management requirements.
- HCT core staff filled in to meet perceived gaps and capacity problems, for instance, Coordinators worked longer hours to manage the extra administrative load associated with coordinating Panels and LPs when using the paper-based system.
Similarly, compromises were reached on local/national differences:

- The Directorate adopted the main aspects, and visualisation, of the CT practice model (practice process flow) as formulated by local stakeholders on the Interim LGG and HCT Working Group.
- The Directorate accepted HCT’s request for information protocol. The HCT Director created a Request for Information Form that proved acceptable to the Waikato DHB and the Directorate.

Before winding up, the Executive Management Group succeeded in organising the release of the required 6.8 FTE LPs in advance of the launch. It also supported the production of a Directorate paper (prepared by the Resource and Service Lead) for the Vulnerable Children’s Board. This paper, drafted in May 2015, identified options for how LPs could be made available, and from which key agencies and/or sectors, over the 12 months after the HCT’s launch (up to 20 FTE at the conclusion of the first year).

Panels

The HCT Director compiled two relatively large and diverse Panels, which signals a good level of buy-in at the operational level. The Panels are reliably attended by representatives from all the VCB agencies (except the Ministry of Justice). The Panels are attended by the DHB, a major Public Health organisation and by a range of NGO service providers covering early childhood education and Māori and Pasifika health, family and community services.

Two Panels were formed in time to receive referrals from The Hub. The larger membership of seven to eight worked well despite the Directorate’s view that an optimal size would be five to six. More Panel members allowed the appropriate array of key government agency representatives (from Work and Income, CYF, Ministry of Education, the Police and the DHB) as well as practitioners and/or practice and programme managers from important service providers, particularly giving a Māori and Pacific standpoint. The Panels were organised to ensure timely allocation of referrals to LPs, if accepted, i.e. no more than three to four working days (within the five working day maximum).

The Panel’s decision-making became more streamlined over time. Panel members provided valuable information that could not be otherwise accessed via The Hub. This information informed their decision-making and became available to LPs, along with their advice on allocated cases. Panel members plainly indicated their enjoyment of the process and their belief in its value. With the support of the evaluation team, the HCT Director instituted a moderation process that she and the Panel members found useful and expected to keep using.

The infrastructure

The HCT had well-sited and appointed premises with access to meeting and training rooms, and staff and visitor parking at Work and Income’s Anglesea Street site. Co-location enabled collaboration between key workers and agencies (initially with the Ministry of Education [first site] and then MSD’s operational groups including Work and Income and Community Investment).

New forms, rules, methods and technologies were introduced through the development phases over a short time frame (six months from July to November 2015). Part of the processes included the Directorate’s project management approach to monitoring the progress of the HCT. The requirement for HCT to produce a two-year operational plan was also useful because it clearly established what level of local resources or funding was needed to be reallocated and in what timeframe. In terms of structures, the HCT Director and Directorate established the LGG as the local governance body, one of whose responsibilities was to ensure sufficient LPs would be available to meet projected demand.

The Working Group formulated the CT ‘process flow’, which was later adopted with slight modifications by the Directorate to be applied across the board. It outlines the four phases of CT
practice, as captured in the *Children’s Team Manual*, covering intake, assessment and analysis, planning and implementation, and evaluation of success and exit.\(^{41}\)

By September 2015, upon the launch of the HCT, the LGG had overseen the production of a business plan developed by the HCT Director in conjunction with the Working Group. This mapped out the goals and steps for reaching full scale by August 2017, and provides a basis for measuring progress through regular reviews. After much debate, the LGG also approved the CT Service Model. These were two key LGG responsibilities under its terms of agreement.

The *Children’s Team Manual*, distributed in August 2015, was further supplemented in September. Formalising aspects of the CAP served to reduce confusion and provided the basis for promoting shared understanding and practice consistency. In Hamilton, the Coordinators were particularly relieved to have a manual to guide their work with agency staff and LPs.

**The Hub and ViKI**

The Hub has provided a clear and functional pathway into the HCT for professionals working with children.

The Hub has made consistently appropriate decisions about which children to refer to the HCT versus CYF and universal or specialist services. While we have discussed resistance by some Panel members to some Hub referrals, within three months of operation the HCT Director and almost all Panel members were of the view that referrals from The Hub to the HCT had "landed in the right place".

**Hub workers sought to gain comprehensive information from referrers.** When this was forthcoming, Panel members appeared to appreciate having a more rounded picture of the children and their families.

**The Hub encouraged referrer engagement and support.** The Hub staff managed to gain rich information from phone referrers that could then be accessed by Panel members and LPs. These telephone interviews were appreciated by some referrers, but frustrated some others. The Hub workers sought to get referrers to provide as broad a range of information as they could. On occasion this included asking them to seek further relevant information from other professionals they knew to be working with the same child and in effect preparing these other professionals for a role on a CAN team where feasible.

When ViKI was not available on schedule, the Directorate facilitated the quick provision of a paper-based business continuity solution, derived from one used by the Horowhenua/Ōtaki CT. The paper-based solution did the job, but was a hurriedly introduced and problematic solution. We noted a range of resulting frustrations, including:

- Panel members and LPs had to use secure USB drives for transferring case management information which were incompatible with some agency computer systems;
- The Hub staff had to use an Excel spreadsheet for entering referral information, which they found awkward to use;
- Coordinators had to hand-deliver information packs to individual Panel members prior to meetings; and
- LPs had to travel to the HCT office in order to review files or be allocated cases (this information could not be emailed).

Once ViKI was operational, the Coordinators in particular appreciated what ViKI could do compared to the paper-based system they had been using. One Coordinator estimated that it saved her six hours a week in administrative time. Panel members were also greatly relieved at the time and paper-saving benefits of ViKI, although not all could access it or use it with equal familiarity during the evaluation period.

### 3.3.3 Key Challenges for Hamilton

#### National/Local balance

We note that tension is built into, and arises out of, the Directorate’s CT principles: "ensur[ing] service delivery is community led and customised to suit local settings while enabling national consistency where needed".42

The degree of variation that resulted in the first four CTs was considerable due to local variations and changes in the CAP Directorate's concept of the model. The Directorate has since consolidated its understanding of the evolving CAP model through producing the Children’s Team Manual, first circulated in August 2015. This process of clarification and refinement remains ongoing.

#### Fundamental disagreement about information sharing (a national non-negotiable)

The Directorate’s determination to facilitate information sharing affected the tone and quality of communication and working relationships between the Directorate and Hamilton stakeholders, reducing the sense of shared vision so important to this project. This disagreement proved stressful for the HCT core staff to deal with, impeded the functioning of the CT and created ill-feeling at the local and national level.

#### Insufficient focus on promoting the CT

Due to differences and/or suspicion aimed at the Directorate, the Directorate's Engagement and Communications Lead was diverted from proactively promoting awareness and active support of the CT in Hamilton. Instead it became a priority to strengthen key stakeholder relationships and clarify misunderstandings.

The HCT Director revealed that she had insufficient time in a given week to reflect in order to work in a more proactive and communicative way with local stakeholders. This was reflected in the Working Group, who felt ill-prepared to support the HCT Director in implementation planning and trouble-shooting when they convened.

#### Focus on operations rather than strategic approach

The LGG and associated Working Group were primarily focused on debating and finally agreeing to the implementation of the Directorate's CAP operating model. This meant it was slow to explore how it could bring in additional resources to enhance the functioning of CTs or bring about changes at the community level that improve the child maltreatment prevention system.

---

The initial focus on debating the core operating model, in particular, information sharing, created the following impediments to implementation:

- Hindered information sharing and referrals.
- Insufficient championing of the HCT.
- Unwillingness of the LGG to hold itself to account for ensuring there were sufficient LPs available.
- Slowness to promote and meet safety checking and vetting requirements for staff.
- Slowness to consider potential unmet needs and service gaps that would likely limit outcomes for some HCT children and families.

The Team

Limited time for collective planning and support

Work conditions became increasingly difficult due to the:

- high administrative requirements associated with the paper-based information management;
- steep learning curve and trouble-shooting demands of implementing the CAP model with its new components;
- larger scale compared to previous sites; and
- absence of key roles and functions (the Workforce Lead had a long period of leave and an LP Adviser was not appointed).

These conditions reduced the time and collective capacity to regularly reflect and plan together, and to support each other. Non-urgent but important tasks such as systematically assessing the capability and professional development needs of LPs could not be progressed. Overall this has implications for ‘organisational’ or ‘team culture’, eroding the personal commitment of staff and threatening stability, efficiency and potential effectiveness of the core team.

The difficulty of creating a positive organisational culture without an organisation

The Directorate has been at pains to avoid any impression that CTs are another bureaucratic institution created to sit between CYF and the usual array of universal and specialist support services. This intention, however, creates various emergent difficulties. It introduces a problematic limbo for people working in CTs, including LPs (full-timers). They can no longer rely on having the conditions and routines that organisations put in place to, at least, ensure that people are supported to fulfil the basic requirements of their role, and at best support people who are wholeheartedly committed and capable, and do their respective jobs really well and in a sustained way. There is a lot of literature on organisation culture (and within that team culture) and culture’s importance to performance.

In particular, full-time LPs spoke of having an uncertain professional status. This confused clients who were unsure who LPs worked for. A number indicated that they would rather be co-located – working from the same office. This would provide a stronger sense of team, and alongside peer support, would afford readier access to the Coordinators and the HCT Director.

The complex and demanding nature of the HCT Director's role

Challenges such as role complexity, insufficient resources and ambivalent stakeholders undermined the HCT Director's ability to achieve all that was expected of her. The HCT Director's role is clearly pivotal to the success of the HCT, but such success requires many interlinking factors to be favourable.
We found that the HCT Director was over-stretched. She had to deal with too many operational details that detracted from her ability to be sufficiently outwardly and strategically focused, as the role requires. Ideally, the HCT Director needed the support of an Operations Manager and LP Adviser so she could give more attention to increasing the HCT’s visibility to Hamilton professionals and sufficiently focus on relationship management and some difficult stakeholder dynamics.

**An insufficient process for getting the right Lead Professionals**

To get the HCT up and running, securing a sufficient number of LPs was given priority over selecting the right people for the LP role. The HCT was required to demonstrate how it would have enough LPs to meet projected demand over a two-year period. This resulted in government agencies and NGOs putting forward individuals without a sufficient screening process and the HCT had no basis for accepting or declining candidates based on their readiness for the role.

**Timing of Lead Professionals was initially out of sync**

With a focus on securing sufficient LPs in advance of the HCT launch, not enough attention was paid to the timing and sequencing arrangements for starting LPs. This resulted in too many full-time LPs being brought in at once, having been completely freed from their usual home agency work. Once this had occurred it was untenable for their home agencies to re-allocate work to keep them positively occupied at the times when the LPs were not undertaking training or other HCT activities.

**Orienting and training for LPs was under-developed**

Coordinating the availability of prospective LPs with sufficient and timely training was an early challenge. The initial training of LPs was mismatched to the demands of the role. This was in part due to the Directorate’s lack of clarity about the LP role, and the training provider not having timely access to codified guidelines when designing the training. Nationally contracted training was pitched incorrectly at dealing with clients with lower-level needs and levels of complexity rather than at the care and protection population that has come to predominate.

Training design and provision became an issue between the nationally contracted provider, the Directorate and the HCT Director. Consequently, the orientation and some training was provided by the HCT, and other training was conducted by the national training provider (directed variously at LPs and CAN members).

The length of training was also contested by agencies and providers, with some thinking it too long and others who thought that a shortened version would not be sufficient. These can be seen as teething issues but there is a risk of ongoing problems. This also relates to an earlier point about several VCB agencies providing very part-time or conditionally available LPs.

A lack of clinical support for LPs required the HCT Director to compensate by providing weekly group sessions and one-on-one meetings to review cases and LP practice. This has put additional pressure on the HCT Director making it difficult to cover all other duties. This lack of resource is doubly important because of the variable capability of LPs.

**The infrastructure**

**Start-up frustrations**

LPs have been frustrated by not having access to basic tools they see as appropriate to a mobile workforce. While there is no consensus across LPs about the requirement to have the following items, they were flagged in group meetings with LPs as a constraint on effectively doing their work:

- Mobile computers (i.e. laptops or tablets). At times LPs were using their own devices to get around technical difficulties and to streamline work.

- Cell phones. Not all LPs had cell phones making it awkward for clients or the HCT core team to get in touch with a specific LP.

- Vehicles - at times there were insufficient vehicles to enable timely required visits and meeting attendance.
We also noted delays in the core team accessing MSD’s server to manage email correspondence, MSD’s shared drive to securely store HCT documents, sufficient phones and vehicles.

These experiences alone are frustrating, but when they became overlapping or consecutive issues, they impeded the team’s productivity and their sense of being valued, through having to use their own phones, stationery, and/or vehicles to fulfil their public service role.

Information management processes constantly changing

The information management system for the HCT was in a state of flux throughout the evaluation period. It is reasonable to assume that this will largely settle down over the first quarter of 2016.

Difficulties implementing the whole of child assessment

The introduction of Tuituia as a standard assessment is challenging for those who have not previously used a whole-of-child assessment to identify and monitor children’s needs and progress. Training with, and the use of, the Tuituia assessment has proved to be an area of particular weakness. Many LPs indicated that the training they received with this tool was too short and should have included examples and the chance to practice. This was further compounded by the problems experienced by some LPs during ViKI training specific to Tuituia. Furthermore, many LPs indicated that they would find it too cumbersome to work through the Tuituia assessment with clients and therefore were not using the assessment process in the inclusive way intended. We noted that this led to LPs either completing it by themselves and/or completing plans before finishing the assessment that is expected to underpin a plan. For some, the standardised Tuituia assessment was considered a barrier to strengths-based practice (despite some LPs typically using standardised questionnaires, albeit briefer, in their respective home agencies). The HCT Director also raised concerns about how long Tuituia assessments were taking.

All groups of users were hesitant about scoring the Tuituia assessment (i.e. giving children’s needs a numerical score). Without more training or refinement of the tool, this situation makes its data unreliable for the purposes of impact evaluation.

Engaging unwilling families/whānau

There was a lack of clarity about the point where the CT has made sufficient effort to engage hard-to-reach families/whānau before stopping and when to refer families on to CYF if they resist change or engagement. This also raised a question about the effectiveness of LPs’ motivational skills and strategies and their understanding of their role. The ability of the LPs to note and work with ‘client readiness’ – what in correctional psychology is known as responsivity⁴³ – is critical to their effectiveness. LPs need to be able to understand the fit of the programme to person and person to programme. Locally, stakeholders believed the CT would always accept consenting families/whānau willing to work with a LP and CAN.

Lack of certainty about when exit is appropriate

There was a lack of clarity about when children and their families/whānau have made enough progress to sustain them without the support of the CT, and what happens after exit. For example, is there a formal period of ‘monitoring’ by LPs when all the substantive work with a client family is done by CAN members before a client family finishes with a CT, and how long should this period be in order to provide sufficient confidence that a child really is no longer vulnerable? This would

⁴³ The concept of ‘responsivity’ is potentially useful, it relates to the “appropriate matching of offenders [or targeted individuals or groups] to programs and staff, and the identification of factors that might mediate the effectiveness of treatment services [or interventions]”. From Correctional Service Canada (2015, March 5) Chapter 5 Treatment Responsivity: Reducing Recidivism by Enhancing Treatment Effectiveness in Compendium 2000 on Effective Correctional Programming.
mean thinking about stages of family work along the lines of ‘motivational engagement’, ‘supporting change’ and ‘maintaining change’ (monitoring).

**The Hub initially under-utilised**

An audit of The Hub found variable understanding in organisations about The Hub. One informant indicated that information about The Hub was available but frontline staff were extremely busy and overloaded with other information. This will affect practitioner motivation to refer and their ability to make a well-prepared referral. We identified a need to make well considered Hub referrals part of practitioner ‘standard operating procedures’.

- The Hub had too much capacity until December 2015, when they started receiving referrals for the Canterbury CT and volumes of referrals escalated for Hamilton CT. The Hub had four personnel and a Team Leader waiting to receive referrals, having the capacity between them to process approximately 15 referrals a day under ideal conditions. There were many days over the first two months when no referrals were received.

- The Hub is now taking larger volumes of referrals from Hamilton and is also servicing Canterbury and Counties Manukau.

**Working with evolving tools**

The Hub staff felt hampered in their ability to engage and efficiently process referrals when required to use the business continuity solution introduced in place of ViKI. ViKI also provided its challenges.

The Tuituia assessment used by The Hub, as it was being used at the end of 2015, was considered of questionable value. The Hub Team Leader noticed that Panels were inclined to refer only to the high level summary derived from The Hub’s assessment. A consideration for The Hub is the significant time taken to do an assessment that may not be fully used, as The Hub processes increasing volumes of referrals. It would be valuable to know more about what LPs make of the information entered by The Hub in the various assessment domains.

**Making referrals to The Hub has since been streamlined.** The introduction of ViKI has meant that an online form has become the predominant method of referral, cutting down the time needed to input information.

**ViKI delay and initial teething issues**

ViKI’s delayed availability presented the most significant implementation setback. The business continuity solution that was put in place until ViKI became available proved difficult to use, time consuming and technically problematic. While this was a temporary problem, it had a legacy effect of requiring extra work over several months - inputting data into ViKI when it became available.

Once ViKI became available, some users expressed disappointment at its limited functionality, indicating they had been led to believe it would do more, e.g. providing early, ready access to client data from a variety of agencies. The concept of minimal viable product to market was unfamiliar to many users until they received their first training in ViKI. They did not realise that additional functionality would be added over time, and as financial approvals allowed. Coordinators expressed the hope that in the near future ViKI would include functions that further streamline the administrative tasks associated with Panel meetings.

There were many problems with ViKI training during the evaluation period. There was difficulty promoting awareness of training opportunities and some sessions were poorly attended. The training room offered up by the vendor was considered too small and there was no prospect of training elsewhere. It may have been confusing to some that the ViKI training was offered as a preliminary session covering very basic aspects of functionality, and later on the training was on a more sophisticated level. Various HCT core staff were co-opted into publicising and/or co-delivering training and they felt this requirement increased workloads and their sense of being under pressure.
3.3.4 Addressing the Challenges

National/Local balance

LGG taking more of a leading role

Under the current Chair, the LGG had been updating its membership guidelines (within its terms of reference). Beyond that, an agenda item of the LGG was addressing the unmet needs and insufficient services as notified by the HCT Director. The Chair was also continuing to explore the feasibility of a regional governance structure. These steps nudge the LGG towards a more visionary regional role in line with the national maltreatment prevention aim of the Children’s Action Plan. Such steps would also be recognisable in the Human Services Value Curve Model of Integration as integrative and beyond that generative.44

Appropriate Directorate intervention and support

The most pressing problems in implementation have been overcome through Directorate intervention. Being more structural or systemic in nature, these problems resisted local efforts, for example, increasing referral numbers to the HCT and working with the Waikato DHB to share health information with the HCT through the intervention of the National Children’s Director and the direction of two Cabinet Ministers. This has the makings of a lasting change.

The Team

Local-level problem-solving

The HCT showed an ability to address local issues with local solutions, including:

- The HCT Project Manager took on training design and delivery due to the partial capacity or unavailability of a nationally contracted training provider, making good use of her training background.
- The HCT Director provided clinical oversight and support in the absence of an LP Adviser, making good use of her social work background.
- Communication was ongoing between The Hub and the HCT.

However, while these solutions worked to address issues short term, they are generally just stop-gap measures which require a more permanent and sustainable solution.

Recruiting LPs

The HCT Director wanted to provide more specific guidance for, and introduce greater rigor into, the LP selection process. This could potentially involve something like the capability self-assessment tool we started to develop and/or introducing a probationary period. The latter suggestion would most likely have to involve candidates trying out the role through being paired with an LP who maintains the primary worker-client relationship. It will be important to try to find more suitable men to take up an LP role.

The infrastructure

Information sharing

A practical resolution to the information sharing impasse was reached in late November 2015, facilitated by the Directorate and the direction of the Minister of Health. Local Navigators were identified for each relevant government agency and the Waikato DHB. The DHB also nominated a second Navigator that specialised in making adult mental health information available.

The HCT Director proposed an information consent form that proved acceptable to all stakeholder agencies. This has since become standard operating procedure.

This achievement heralded a new era in inter-agency information sharing, and enabled the trans-disciplinary way of working that we began to see in the Panels.

Information sharing between agencies has shifted gear with all the main parties now organised to routinely respond to information requests from the HCT. By the end of November (three months after launch), Navigators and Panel members were routinely providing timely and comprehensive information to Coordinators or to the Panel on the day.

ViKI

Four weeks after its introduction, some users were still having trouble accessing ViKI and gaining the right technical support, which in turn created workflow problems. For some frequent users, such as The Hub workers and Coordinators, resolving usability issues needed to be an immediate priority. In particular, this meant improving the organisation of screens and hence the ease of navigation, in order to reduce repetitive mouse clicks and potential strain injuries.

ViKI will continue to iterate. Initial teething problems are expected and are expected to be mitigated. Also, new levels of functionality are promised and expected. For example, in late March 2016, the much anticipated capability to upload documents was added (e.g. school reports, clinical assessments, or assessment related evidence). The introduction of ViKI heralded a profound change.

Tuituia

Some additional guidance and support (on assessment in particular) was provided by the National Implementation Manager to Panel members and LPs when it became apparent that there was insufficient training, and Panel members and LPs showed a lack of confidence in using Tuituia (either as a screen or assessment).

Selection and support of LPs

In our role as developmental evaluators we also started to create a LP capability assessment tool for the HCT and the Directorate in the absence of a mechanism for systematically selecting capable LPs and for building LP capability.

3.3.5 Insights

National/Local balance

Clarify national bottom-lines

From the very beginning it is important to have a clear and shared understanding of what the core requirements and essential components of the CAP model are, and what constitutes a reasonable range of implementation latitude.

When establishing new sites, the Directorate's engagement and communication strategy needs to focus on implementation design. This means that local stakeholders are under no illusion that the CAP is a nationally driven systemic change (i.e. impacting on a number of nationally operating services and initiatives) that will inevitably disturb usual service delivery.
Hence, local people will require some persuading that their task is to optimise a national programme - for their own location, and for the whole country. The local design challenge is then framed as learning how to optimally implement a national programme to best advantage local users (user-centred design).\(^{45}\) This should minimise the re-litigation of national bottom lines on philosophical grounds, or for expediency.

**Focus more on communication**

Key stakeholders need more information about wider system changes. They need opportunities to understand the reasons why these changes are important – the likely benefits for them (and manageable implications) if they are to contribute to the new way of working. Key stakeholders need to be listened to and local concerns addressed as soon as possible.

Communications activity in existing sites should be aimed at increasing motivation and local buy-in to change.

**Focus more on building understanding of information sharing and the paramountcy of the child**

We suggest providing specific training and support to LGG and Working Group members, and the medical practitioner community, to help them better understand information privacy legislation, ethics and the principle of the paramountcy of the child, as a set of related concepts. Working alongside the Offices of the Chief Social Worker, the Children’s Commissioner and the Privacy Commissioner may reassure stakeholders who are doubtful about the ethics or concerned about the legal risks associated with information sharing.

**Build in feedback loops**

The opportunity to review the CAP model periodically, including any undesirable effects, will provide an important source of information for improving implementation as well as gaining buy-in. The monthly gathering of CT Directors provides an ideal and regular context for sharing implementation issues and mutually acceptable innovations and workarounds.

There is a need to actively research, and seek to apply what is known about, community readiness, managing complex change, and adaptive organisations and systems. These orienting theories could guide the Directorate’s planning, communication, implementation and evaluation approach. Such research has the potential to provide some unifying concepts and language that help national and local perspectives to mesh.\(^{46}\)

**Build in redundancy**

There is a need to anticipate and allocate resources for the ‘unexpected’, such as working through stakeholder disagreements or logistical glitches to do with the introduction of new technology. Our observations suggest that fiscal pressures have led to resources being tied too tightly (and perhaps justified in terms of perceived efficiency) to predetermined project steps and defined tasks. This situation fails to sufficiently account for the volume and nature of emergent needs and tasks that are identified at the local level as being critical to implementation success. Building in redundancy

---

\(^{45}\) The literature identifies common reasons for intervention failures, which relevantly include “incorrect identification of change objectives” and implementation not being considered a dominant part of the planning and policy process”. See Kok, G. (2014). *A practical guide to effective behaviour change: How to apply theory-and evidence-based behavior change methods in an intervention*, p156, and Hendriks et al (2013). *Proposing a conceptual framework for integrated local public policy, applied to childhood obesity – the behaviour change ball*, p5.

\(^{46}\) Maturity models are a good place to start such as the community readiness example we have used early on in this report. Here is an example focused on an organisation advanced by Morgan, J. (2013, April 11) The Five-Step Maturity Model for Building a Collaborative Organization. From a systems design standpoint, see Jones, P.H. (2014). *Chapter 4, Systemic Design Principles for Complex Social Systems*. 

61
(the allowance for additional roles, hours or budget) can be seen as an anti-fragility or precautionary measure that “expect[s] surprise but reduce[s] uncertainty”.

**Adequate and timely resourcing**

The extent of progress in Hamilton reflects the extra lead-in time and dedicated start-up resourcing the Directorate allocated.

The following quote from a literature review highlights the importance of resourcing to effective multi-agency working:

> Adequate resourcing, in terms of funding, staffing and time, was found to be central to the success of multi-agency working. Whilst financial certainty and equity were as important, inadequate or time-limited funding was identified as problematic.

This research insight was reflected in a range of local problems in Hamilton. These were associated with communications support, training and clinical support for LPs, and the provision of a suitable client management and information sharing system. In addition, high levels of workplace stress could have been moderated through the ability to contract in additional support until a more systemic fix was in place (e.g. administrative data entry support, clinical supervision).

**The Team**

**Prioritise support for effective assessment and planning**

The HCT experience has demonstrated the need to accord the highest priority to selection, training and professional development focused on collaborative assessment and planning. Instituting an LP Adviser would appear vital for ensuring suitable LPs are selected and that there is an acceptable consistency and quality of LP practice. Such a role would logically extend to ensuring the adequate provision of home agency supervision.

Improving the effective use of the Tuituia assessment is a top priority, or alternatively, a simpler, easier-to-socialise substitute needs to be found. A shortened and more visual and interactive assessment methodology may help Tuituia gain greater acceptance and use – this is the impression we gained from talking to LPs.

It is advisable to provide more intensive and integrated training with an emphasis on:

- rehearsed strategies for:
  - engaging family and CAN members, especially those reluctant to be involved
  - undertaking collaborative assessment and planning with family and CAN members
- using ViKI to efficiently record and track developments with client children and families
- LPs and Panel members being able to access exemplar child and family assessments and plans. This is necessary to build capability and shared understanding. While the HCT Director and Panel members had begun to nominate ‘good examples’, it would be helpful if, drawing on local wisdom, the Directorate began to define and communicate what ‘good’ looks like and why from a national standpoint.

---


It may be timely to consider introducing a formal quality assurance process, perhaps along the lines CYF describes in its assessment and decision-making policy.  

It may also be advisable to investigate using a simpler assessment tool that serves multiple purposes. This includes not only monitoring changes, but also serving to increase frontline awareness of risk and protective factors relevant to preventing child maltreatment and thereby attuning practitioners to increasing participation in the work of the CTs, e.g. The Common Approach, as piloted in Australia.  

**Characteristics and capabilities of an effective LP**

Based on our early observations and interviews, the following are some of the characteristics of effective LPs:

- Commitment to the Children’s Team concept, including:
  - promoting or acting in the “best interests of vulnerable children” (applying the paramountcy principle); while
  - showing a steadfast regard for family members. Salient Māori precepts apply including: aroha ki te tangata (a respect for people) and kaua e takahi te mana o te tangata (do not trample over the mana of people).
- Adaptability and a willingness to learn - this is particularly important in terms of using and learning new tools and approaches but also applies to being solution focused.
- Being relatable - having the ability to communicate empathetically with vulnerable children and family members.
- Well-developed engagement skills - particularly an ability to identify problems and opportunities to motivate and support family members to change.
- A calm persistence with reluctant/resistant family members.
- A reliable work habit.
- The ability to form or leverage helpful formal and informal supports around a child and family - this requires a certain mix of confidence and authority, tactical skill, and humility.

Given the very early stages of this initiative in Hamilton, this last capability is the least well developed amongst the LPs we spoke with. Significantly, this is an area where CAP Directorate guidance and training support needs to be focused.

**Children’s Team Director**

The HCT Director is expected to perform many roles, some of which are more important in the initial implementation stage than others. In this stage, the CT Director needs to be able to put more focus on being a figure head through leadership, engagement and communications. To enable this to happen, additional support is required for other functions, e.g. practice-related, operational and administrative support.

The Children’s Team Director role would seem to be best suited to people who have represented the government in the regions at a senior level, and who also have extensive experience in stakeholder engagement. We identified that the role in Hamilton was in fact less autonomous and entrepreneurial than the HCT Director and local stakeholders expected. Appointing staff who are

---

49 Child, Youth and Family (2015, February 13) Assessment & decision making policy
more predominantly government-experienced may prevent the degree of national-local tension that has been evident in Hamilton and other sites.

The other key attributes, skills and experience we identified for a Children’s Team Director included:

- a commitment to vulnerable children;
- an understanding of frontline practice;
- cultural competence and standing in the Māori world; and
- management experience at a senior level.

**Capability building**

Under-utilised workers in The Hub could have been deployed to deliver some training or supervision and support to LPs. We found that some workers in The Hub that we interviewed had formulated a sophisticated idea of family issues and potential strategies based on intake information. Their skills in ‘forensic assessment’ and engaging referrers (potential CAN members) would have provided a useful grounding for LPs who were just beginning to undertake comprehensive child and family assessments.

Finding ways to keep including The Hub standpoint in the work of the Panels and LPs would likely enhance trans-disciplinary practice. We found the perspective of The Hub workers to be different from CYF’s Differential Response Coordinators supporting the Panels. While being highly expert at assessment, The Hub staff we spoke to also revealed useful insights about working with highly ambivalent family members that LPs could potentially benefit from. The Hub workers commented that they were most likely to get feedback on what had become of the clients they had referred from the evaluator. Like HCT members, The Hub staff felt vested in the achieving of good outcomes for the children they pass on.

**The Infrastructure**

**A standard office set-up regime needs to be implemented**

This would involve a checklist and perhaps a dedicated role focused on reducing lag and downtime in setting up a physical office, instituting key workflow processes and having access to essential workforce tools – IT, communications and document storage.

**The invaluable trouble-shooting role of the Directorate**

The CAP Directorate played a critical role in supporting the implementation of the HCT through trouble-shooting and timely guidance when issues arose (as they inevitably do). This will continue to be important, especially for large sites and those expected to operate regionally. There will be an ongoing need to mediate disagreements, monitor and amend national aspects of the model, evaluate effectiveness and work with central government agencies and local organisations.

**Increase the priority given to resourcing monitoring and reporting**

We gained the impression that reporting progress to the Directorate was experienced as difficult by the HCT core team members. We attribute this to everyday workload pressures combined with too little opportunity to reflect and plan together except under urgency. While welcoming the evaluators to the site, it became increasingly obvious that core team members, and after a while LPs, were too busy to engage in evaluative discussions and activities, such as engaging in the LP capability assessment work we began with them.
The Hub

The potential value initially promised by The Hub could be reduced through the introduction of an online referral form. The increasingly common use of online referral removes any relational aspect to the referral process; it becomes more like an e-commerce transaction. In this scenario The Hub workers are no longer positioned to actively elicit the information from referrers, or to motivate them to further engage with and prepare families for working with the CTs.

ViKI

We suggest that user confidence in ViKI would be improved by:

• better integrating training (combining use of ViKI with conducting/recording a Tuituia assessment) and creating plans for one or more children and their families;

• providing dashboard or reporting templates for LPs, Panel members, Coordinators and the HCT Director that are suitable to their roles and readily customisable to better meet their purposes; and

• adequately explaining what a ‘minimum viable product to market’ means. By doing so, users could be reassured about the development potential of ViKI, while understanding that such development is dependent on early user feedback and further resourcing to make prioritised changes.
3.4 Systems Change and Scaling Up

<table>
<thead>
<tr>
<th>Planning and development 3.1</th>
<th>Partnership 3.2</th>
<th>Implementation 3.3</th>
<th>Systems change 3.4</th>
<th>Scaling up 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared vision and common agenda</td>
<td>Clear roles supported by strong governance</td>
<td>Prescriptive vs. local adaptation</td>
<td>Funding and accountability systems that support collaboration</td>
<td>Workforce safety</td>
</tr>
<tr>
<td>Communication, engagement and change management</td>
<td>Collective ownership and buy-in</td>
<td>A working model Structures, tools, guides and processes: referral, assessment, planning</td>
<td>Common accountability measures</td>
<td>Workforce capability and capacity</td>
</tr>
<tr>
<td>Fit and alignment with current service provision</td>
<td>Common database / IT platform</td>
<td>Information sharing systems that support collaboration</td>
<td>Changing the current service mix</td>
<td>Evolved practice</td>
</tr>
</tbody>
</table>

Evolved (evolving) practice has been added as a new element because we observed trans-disciplinary practice advancing beyond the usual discipline-specific practice.

### 3.4.1 Progress markers

**Systems**

Progress markers for systems change include:

- Funding systems support for the effective functioning of the CT.
- Accountability is shared appropriately.
- Consistency of data and of Tuituia use to identify needs, progress and results.
- Agencies sharing personal information appropriately and effectively to get better results for children.
- Organisations share resources and good practice processes with each other i.e. hiring procedures and workplace child safety practices.
Scaling up

‘Scaling up’ progress markers were identified as follows:

- An increasing number of personnel associated with the operation of the CTs have been safety checked and vetted.
- Processes are in place to ensure providers have child protection policies and that the children’s workforce is safe.
- Key characteristics of LPs are identified and used to recruit LPs.
- Professional development and supervision is effective and available to build and maintain the capability of LPs.
- Processes are developed for identifying, reporting and addressing service gaps.
- Some examples of sophisticated LP practice are evident.

3.4.2 What worked well

Funding and accountability

The HCT managed to secure sufficient commitment of LP resources to provide for the first nine months of operations. The Ministry of Social Development, including Community Investment in particular, have been most able to modify their contracts to make LP resources available as has Waikato DHB.

Monthly reporting identifies the contributions of agencies as well as provides for accountability for effective operations and results. CT accountability measures are provided through monthly reporting in relation to key outcome areas, including achieving targets for referrals, timeliness of processes and reporting Tuituia results.

Monthly reports also allow for comparisons across sites on common measures.

Service mix

Some service gaps or issues have been identified and reported up to the LGG and Directorate by the HCT Director. These include:

- the inadequate supply and quality of social housing;
- the limited availability of special education funding and/or support for high needs children;
- insufficient access to adult mental health services (waiting lists); and
- insufficient access to counselling services for children and adolescents.
Workforce

One of the most important developments for the CAP is the legislative requirement that all people working as part of CTs must be safety checked and vetted.

A dedicated role has been created in the HCT focused on ensuring organisations working with children have an acceptable child protection policy in place and that the children’s workforce is safe to work with children. Figure 3.4.1 shows how many people required to be safety checked had been nearly four months after the HCT’s launch.  

Figure 3.4.1 Safety checked individuals in Hamilton as at 22 December 2015

<table>
<thead>
<tr>
<th>Groups requiring safety checking</th>
<th>Number checked vs total</th>
<th>Percentage checked</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Active' Children's Action Network members – those expected to work directly with current HCT children – 27 are ready</td>
<td>27 of 77</td>
<td>35%</td>
</tr>
<tr>
<td>All CAN members identified as likely to work with HCT children – 66 are ready</td>
<td>66 of 107</td>
<td>62%</td>
</tr>
<tr>
<td>All individuals identified as being associated with the HCT (including HCT staff, LGG, panel members, LPs, researchers, and CAN members)</td>
<td>109 of 254</td>
<td>43%</td>
</tr>
</tbody>
</table>

Evolving practice

Trans-disciplinary practice is already advancing beyond the usual discipline-specific practice in Hamilton. This can be seen in two ways:

- The Children’s Team Manual defines a trans-disciplinary response as “being a collaborative response from a group of practitioners who will each contribute their expertise to enable a holistic and comprehensive single assessment incorporating the voice of the child and family which together will inform the development of a Child Plan.”

- Personal/professional changes that result from an educative process that increases a person's sophistication as they engage in trans-disciplinary work - they experience changes (paradigmatic, intellectual and philosophical) that enables better problem solving when engaging in a trans-disciplinary methodology.

We found evidence of trans-disciplinary practice and openness amongst Panel members and LPs. They spoke of learning from one another, including considering issues from another standpoint, acquiring new knowledge of services and an understanding of different approaches, and trying something different in their own practice.

As a testament to this trans-disciplinary approach, the paediatrician on one of the Panels said she believed the CT Panel process was better (which we infer as meaning more comprehensive and solution-focused) than the Gateway assessment process she manages. LPs and several CAN members talked about the enhanced experience of collaboration with other colleagues and services that has been afforded through the HCT.

---

51 From an email from Lance Tebbutt, Hamilton Workforce Lead, 22 December 2015
52 Children’s Action Plan Directorate (2015, September 2) Children’s Team/Child Youth and Family Interface Service Response Guide (p.2)
A further change has been the increased sense of accountability for practice and outcomes enabled under the CT. For example, several part-time LPs reported that in their substantive role they tended to work alone, to focus on a narrow set of child-parent factors, and if they referred a client they would not necessarily know the outcome. Under the CT model they felt they were held accountable in a positive way through working closely with another LP (subject to peer critique), being required to work to a shared plan and to monitor progress across a range of domains responding to all of the child’s substantive needs. They could also hold colleagues and clients to account, which they valued.

The motivational role and practices of some statutory agency workers is potentially unnoticed but may be quite important in enabling highly vulnerable families to get the support they need from the HCT.

While we noted this influencing behaviour among Hub workers prompting referrers, and a CYF Partner Response worker prompting a client, this motivational work could also be conducted by Police, Probation and Work and Income staff.

### 3.4.3 Key Challenges for Hamilton

#### Funding and accountability

Some agencies considered that their own business as usual services and required outputs/outcomes would be compromised, in terms of their capacity to deliver, if they contributed resources (LPs).

A lack of clarity about line management created uncertainty about who was accountable for what, particularly in relation to LPs. The Memorandums of Understanding (MoUs) developed with NGOs were not sufficiently specific to resolve this confusion.

The requirement for accountability falls heavily on the HCT Director with a lack of clarity about the accountability of national level VCB agencies relative to local agencies. This created tensions in relation to the provision of resources and acceptance of responsibility.

The manner in which contracted NGOs were expected to account to funding agencies for the provision of LPs and their performance was unresolved during the period of the evaluation. Several NGOs indicated a degree of confusion and concern about this point. We did not have sufficient engagement with funding specialists to gain their perspective.

The inconsistency and difficulties experienced by some LPs in using Tuituia, along with the initial use of a manual data management system, means that data recorded, especially prior to ViKI, may not be as robust as is desirable for accountability purposes.

We note that monthly reports and the LGG engagement with reporting are not geared to engender cycles of action and reflection from HCT partner agencies. For example, uneven referrals across sectors was commented upon at the LGG, however, there appears to be no expectation that agencies best positioned to promote increased referrals from their quarter will do so in order to see this reflected in changed monthly statistics. We are not making an argument for setting targets but suggest a more evaluative approach to monthly monitoring and to identifying significant trends. It was too early in the HCT’s development to be reporting on outcomes.
Information sharing systems that support collaboration

The limited scope of the AISA (Approved Information Sharing Agreement) meant it only applied to VCB agencies; they agreed to provide information to The Hub. The AISA did not extend to DHBs or to local agencies sharing information in response to requests from CT workers. This meant that the Waikato DHB was able to refuse to release personal information unless a family member gave written consent. The DHB received advice from the Ministry of Health and Cabinet Ministers as to how to address this privacy issue.

While there were moves to increasingly formalise information sharing (with an AISA and the HCT information request form), some professionals indicated that they used to share client information more before the HCT began operating. For example, health, education and CYF frontline staff commonly shared Gateway assessment information when considering a child for whom they had a common professional concern. Several public health nurses indicated that they were now more cautious.

Workforce

We identified some hurdles to ensuring people were appropriately safety checked and vetted:

- Initial capacity and process issues with Police safety checking caused delays.
- Insufficient priority was given to identifying and processing those most likely to be working within the HCT.
- Lack of capacity/contingency. A key staff member was on extended leave and other HCT workers who were expected to fill in found this area of work difficult to manage in addition to their usual duties.
- Organisational non-cooperation with safety checking and vetting.
- Devolved service delivery environment. This was particularly problematic in the Education and Health sectors.

Difficulties with the selection and training of LPs have been discussed in section 3.3.3 Implementation – Key Challenges for Hamilton.

In terms of capability development, professional differences and contracting arrangements made collaboration on training design and delivery difficult. In particular, the Children’s Team Manual was not written in time to inform the initial training design.

Changing the current service mix

As originally stated in The White Paper for Vulnerable Children, and reconfirmed in the SUPERU assessment of demonstration sites, “joint agency planning [is expected] to develop a service response model that provides the right mix and level of services for this group across health, education and social sectors”. This is a complex undertaking in itself that will require structural change to funding practices. How this can be done is yet to be worked through. This remains an area for development in Hamilton as elsewhere.

The LGG had not undertaken any obvious advocacy during the period of the evaluation on service gaps and issues and/or or demonstrated an ability to influence or otherwise support the development of new services (i.e. develop policy, secure funding, allocate staff). As at the end of 2015, no stocktake had been done, as envisaged in the LGG terms of reference.

3.4.4 Addressing the Challenges

Information sharing systems that support collaboration

It took three months for the HCT to get consistently detailed client information from each partner agency in Hamilton. Agencies have now provided navigators to make it easier for the HCT to access specific client information. Dedicated navigators have been identified from:

- The Waikato District Health Board (2).
- The Police.
- Work and Income.
- Ministry of Education.
- Child, Youth and Family.

Workforce

Incentivising safety checking and vetting

In November 2015, national champions for safety checking were identified and they in turn appointed local champions. The expectation was that these local managers would expedite CT-associated staff or sector workers being safety checked, or otherwise indicated on a ‘Get Well Report’, identifying a timeframe for having named individuals safety checked. Within a short time the Get Well Report became an unacceptable response.

It seemed there was little incentive for organisations to safety check staff. There was an implied threat that organisations could lose funding if they did not comply. Several VCB agencies at the local level proved resistant to HCT workers’ requests regarding safety checking of staff, compromising the operation of the CAP model.

More efficient and effective CAP-related practice was supported by:

- streamlined systems to ensure there were no bureaucratic holdups to getting safety checked;
- child protection policy templates being made readily available for organisations to use; and
- the Children’s Team Manual providing direction and guidance to HCT staff, LPs, Panel members and organisations providing LPs and CAN members. Aside from a detailed description of CAP processes, it also included items such as an LP supervision policy and health and safety procedures.

Workforce capability

A workforce effectiveness framework has been developed but had not been operationalised to support selection and professional development of LPs – hence evaluators developed the capability self-assessment tool (a rough prototype that was requested by the HCT Director but has not been developed sufficiently for regular or wider use). Supporting LP capability requires a dedicated role.

Adaptive management provided by the HCT Director dealt with workforce challenges by addressing training issues and gaps, although this is only a stop-gap measure. The appointment of a Lead Practice Adviser would enable capability development to be supported from within the team without placing undue demands on the HCT Director.

Progress in this area requires attention from VCB agencies to enable local workforce and service development, given differing views about how LPs should be managed and how VCB agency professionals are to be engaged with by the HCT.
The HCT was permitted to extend the secondment of its Project Manager (a training specialist) to orchestrate LP training in early 2016. Consequently, we would expect that the next generation of training would be informed by insights gained the first time round.

Preparing LPs is likely to be more straightforward in near future for the following reasons:

- The HCT core team and current pool of LPs will be accustomed to using ViKI, and will therefore be able to better inform the training design and offer support and advice about coming to grips with the system.
- The CAP Directorate has continued to elaborate on parts of the operational Children’s Team Manual, providing more material to draw on for training purposes than was initially available.
- More communications materials have been developed that can be used for training.
- LPs and Panel members will increasingly have access to templates in ViKI and exemplar assessments and plans (derived locally and/or identified by the Directorate).

**Changing the current service mix**

Most likely, enabling local service development changes will have to involve national and local level management, and require policy development and fiscal measures.

The LGG could commission an assessment of relevant local services cross-referenced to the identified needs of HCT clients. This would provide a sound basis for local service planning and development.55

Initiating such a project may require partnering with local organisations not represented on the LGG such as Hamilton City Council, Waikato University and Trust Waikato; other organisations capable of providing funding, research, policy and planning support.

At the right time, and to increase utility, this could be conducted as a participatory mapping and planning exercise. Such an approach is good social marketing that can increase community awareness of the CAP and of child maltreatment more generally, and it could be used to build networks, identify champions, and potentially create lasting alliances.56 Done periodically this mapping provides a rolling baseline for assessing levels of community readiness to effectively prevent child maltreatment.

---

55 A literature review - Atkinson, M., Jones, M. & Lamont, E. (2007). Multi-agency working and its implications for practice, promotes consulting service users on issues and priorities conducting a needs analysis as this assists multiagency working, as was carrying out a needs with more extensive consultation leading to bottom-up development more widespread commitment (p51). “Carrying out a needs analysis and mapping existing provision was also identified as a way of clarifying the purpose of multi-agency groups” (p70, citing Percy Smith, 2006) In addition see Strengthening Non-Profits (n.d.) Conducting a Community Assessment
56 Relevant asset-based and participatory approaches are outlined in publications like the Glasgow Centre for Population Health (2011, October). Asset based approaches for health improvement: redressing the balance
3.4.5 Insights

Clarifying lines of accountability and leadership for resourcing is important for effective operations (from VCB to local agency to provider; and VCB to CT to LPs).

Seek to develop the awareness of VCB agencies about the nature, capability requirements and support needs of the LP role. The Directorate will need to further engage VCB agencies at the national and local level to do this. The purpose of such engagement would be to gain agreement on:

- the attributes (and sufficient of these) to recommend a professional for this role;
- how available an LP should be - the proportion of time performing as an LP relative to their usual role - in order to fulfil the requirements of the role most effectively and sustainably;
- the kind and amount of orientation, training and agency support versus direct Children’s Team support needed to ensure an LP functions at a high level throughout their tenure; and
- consistency of provision of LPs across VCB agencies and clarifying the basis for significant regional exceptions.

This clarifying process would strengthen cross-sector accountability for adequately resourcing/supporting the CAP model.

It is important to make the best use of opportunities to conduct experiments. For example, if very part-time LPs continue to be deployed, then similar locations with different proportions of part-time vs. full-time LPs could be compared. This may reveal potential differences in the quality of LP practice and/or the quality of an LPs experience in the role, or not as the case may be. Using opportunities to experiment is appropriate to understand any fundamental regional variations in the way that CTs are implemented. This would then build evaluation more fundamentally into CAP Directorate planning and local implementation and would build evidence-based practice.

Building practitioner capability in the longer-term - to produce a larger workforce change it may be useful to systematically cycle full-time LPs back into their home agencies after a sufficient period to be replaced by those workers who have exemplified trans-disciplinary practice as CAN members. Incumbent LPs, as part of a regular induction and training process, could assist this transition.

Designing changes to services and services systems is a complex, long-term and time-consuming process. We have already identified that such change does not happen without also creating anxiety for some. Niche groups and service providers fear their familiar programmes or services may be cut or become increasingly unviable.

The Directorate may need to help systems change at the local level. Firstly, beginning with a local assessment process (developing a baseline), and then identifying what motivated stakeholders can reasonably influence by way of direct support and/or in the longer-term, through addressing underlying social conditions that negatively affect vulnerable children and families (e.g. social housing and access to quality early childhood education). Providing realistic and effective examples from similar communities, and facilitating access to community development and service and systems design expertise could prove helpful.57

57 MSD's Social Action Team (which oversees Strategies for Kids, Information for Parents, or SKIP) does programme co-design and provides user-centred design training in a variety of communities, increasingly directed at younger vulnerable children and their families and whānau.
Examples of practice change and opportunities to discuss challenges and developments in professional practice would be helpful in building effective practice. The make-up of Panels creates a natural community of practice and an incubator for trans-disciplinary learning and professional development.

An online professional development platform and resources that explain and model exemplary practices may make it easier for more professionals involved directly in CTs to reflect and learn, not to mention aiding the wider children’s workforce. This is a common approach to teacher professional development and moderation.

Accelerating the pace of workforce safety checking has proved very difficult, especially in relation to workers in the education and health sectors.

Taking a more evaluative approach to monitoring might induce more critical local discussion and action in response to trend data. Monthly reports do not tend to show baselines, trends or benchmarks that might galvanise action from the Directorate and/or local Children’s Teams and their partners. It is important to try to establish what operating within a ‘normal range’ (depending somewhat on location) actually looks like, using a mix of process and outcome indicators. Displaying this information in the most engaging way is important (avoiding pie charts and misleading comparisons, i.e. comparing numbers of LPs rather than FTE by organisation, and diagonal text).

Given the complex nature of the CAP, it might also be advantageous to capture accounts of ‘significant change’ in a structured way. A streamlined version of The Most Significant Change Technique could be helpful. This is starting to be used by MSD’s Social Action Team.

---

58 A streamlined version of The Most Significant Change Technique could be helpful. This is starting to be used by MSD’s Social Action Team.
4. References


## Appendix 1: Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approved Information Sharing Agreement (AISA)</strong></td>
<td>Approved Information Sharing Agreements (AISAs) modify the Privacy Principles in the Privacy Act so that parties to the AISA can legally share personal information about others without their consent for specific purposes, in this case, in order to help vulnerable children. An AISA has been established for the Vulnerable Children’s Hub to clarify information sharing for government agencies. The parties to the Children’s Action Plan AISA are the Ministries of Education, Health, Social Development, Justice, New Zealand Police and the Children’s Action Plan Directorate.</td>
</tr>
</tbody>
</table>
| **Child-centred** | A child-centred, family/whānau focused approach includes a:  
  - primary focus on children’s physical, emotional, cognitive and socio/cultural needs, taking account of their views of themselves, their lives, their future, their family/whānau and community  
  - developmental perspective using age-appropriate engagement and communication, assessment and actions within each child’s family/whānau cultural context  
  - focus on family/whānau as the child’s primary support system, and working together in partnership, where appropriate, at all points of contact with services  
  - focus on community support networks in understanding the importance of connections between children, their family/whānau and their community  
  - focus on children’s rights, advocating to maintain a safe environment and provide active support to children and their families/whānau  
  - commitment to urgency when responding to children’s needs and persistence to achieve outcomes. |
| **Child’s Action Network (CAN)** | The children’s workers providing services to the child and their family/whānau as identified by the Lead Professional to develop and action the Child’s Plan. CAN members who are named in the Plan and have access to shared information on the child and their family/whānau are safety checked prior to becoming involved. This group is fluid and co-ordinated by the Lead Professional depending on the needs and progress of the child. They may never actually meet in person although the members are expected to share information and their knowledge with the others. |
| **Child’s Plan** | A Child’s Plan is a single plan developed by the child’s dedicated Lead Professional with the Child’s Action Network, the child and members of their family/whānau. It sets out what needs to happen to address the child’s unmet needs (including those of their family/whānau if these impact on their wellbeing). It is co-ordinated by the child’s Lead Professional and approved by the Children’s Team Panel. |
| **Children’s Action Plan Directorate** | The Children’s Action Plan Directorate, led by the National Children’s Director, oversees the governance arrangements, accountabilities and reporting mechanisms to support the development and implementation of the Children’s Action Plan and the shared work programme. It leads and oversees the delivery of actions and activities for the whole programme of work, including linkages to the wider social sector programme of work. 

The National Children’s Director is accountable for the achievement of the Children’s Action Plan work programme, including the establishment and operation of Children’s Teams. |
| **Children’s Team** | A Children’s Team comprises the people and infrastructure required to co-ordinate and give effect to the trans-disciplinary approach to assessing and addressing the needs of a vulnerable child referred to the Children’s Team. 

It includes all those directly participating in the operation of the Children’s Team approach, including: 

- Children’s Team Director
- Local Governance Group
- Administrator and Coordinator
- Children’s Team Panel
- Lead Professionals
- Child’s Action Networks
- Service Broker. |
| **Children’s Team Director** | The Children’s Team Director is a local leader who is selected by their community and the Children’s Action Plan Directorate to lead the Children’s Team. |
Children's Team Panel  

The Children’s Team Panel is the group of senior managers, professionals or practitioners convened by the Children’s Team Director and Local Governance Group from across government agencies, non-government organisations (NGOs), iwi and community. They are responsible for:

- determining whether to accept or decline a referral of a child to the Children’s Team
- identifying an appropriate Lead Professional for that child and their family/whānau
- approving, monitoring and reviewing a child’s Tuituia assessment and plan, including safety planning if appropriate, and exit
- providing recommendations to Lead Professionals regarding community resources, and
- working to remove bureaucratic barriers, both collectively and individually, within their field of work.

Children’s workforce  

Children’s workers, or the children’s workforce, are people working with and for children and young people (i.e. those who plan, manage, and deliver services), including volunteers. Collectively these people form the children’s workforce. Only children’s workers in the government-funded workforce are subject to the safety checking requirements of the Vulnerable Children Act 2014.

Children’s workers  

The total estimated number of paid children’s workers in the government-funded workforce (who will need to be safety checked) is about 282,000. This includes:

- 147,000 people in the education workforce (registered teachers, teacher aides, non-teaching school staff)
- 86,000 people in the health workforce (doctors and nurses, non-regulated workers, allied and technical workers)
- 27,000 people in the social development workforce (Child, Youth and Family staff, Out of School Care and Recreation (OSCAR) providers and other Ministry of Social Development staff), and
- 22,000 people in the justice sector (Police officers, other justice sector staff and contractors).

Expert Advisory Panel  

This is the independent panel of experts appointed by the Minister for Social Development to lead the development and implementation of a new operating model to modernise Child, Youth and Family. The Expert Advisory Panel produced a final report in December 2015.


Lead Professional  

The Lead Professional is a professional or practitioner assigned to a vulnerable child when the child is accepted by the Children’s Team Panel. They are the advocate for that child and their family/whānau and are responsible for gathering of information that will enable completion of the...
whole of child assessment and developing the Child’s Plan ensuring that all relevant parties including the child, their family/whānau, and professionals and practitioners contribute.

The Lead Professional is the main point of contact for the vulnerable child and their family/whānau, as well as for the professionals and practitioners addressing their unmet needs.

The Lead Professional is responsible for ensuring access to the necessary services for the child and their family/whānau. They make sure that the Child’s Plan stays on track, and monitor and review the Plan to ensure it is effective in getting better results for the child. The Lead Professional reports back to the Children’s Team Panel on progress or to seek advice.

Local Governance Group (LGG) The Local Governance Group (LGG) comprises leading members of the local community who are involved with vulnerable children, such as the Director of Education, iwi representative, or chairperson of a local non-government organisation (NGO). The LGG ensures the Children’s Team Director has the resources necessary to address the needs of the vulnerable children and their family/whānau in their communities.

Non-government organisation (NGO) A non-government organisation (NGO) is any organisation that is independent of government (either central or local) although it may receive financial and/or other support from government. It is also:

- self-governing – controls its own activities and is not under the effective control of any other body
- non-compulsory – although membership might be necessary to practise a profession (for example, the New Zealand Law Society), and
- non-profit making – does not exist to produce profits for itself and is not chiefly guided by commercial goals and considerations.


Service Broker The Service Broker supports the contribution of their sector (e.g. education or health) by working with Lead Professionals and gathering information to inform and build a Child’s Plan. They also help secure services for a child and their family/whānau from their own sector. This is achieved by having a full understanding of the service provision landscape and brokering the required services to support plans and ensure services are being delivered on time and to the required standard.

Social Sector Board Deputy Chief Executives (SSB DCEs) SSB DCEs provides assurance to the Vulnerable Children’s Board (VCB) and undertakes decision-making as delegated by VCB.

Chair: Social Sector DCE, Ministry of Social Development

Members: Deputy Chief Executives from the Ministries of Social Development, Health, Justice, Education and NZ
Police, and the National Children’s Director.

SUPERU

SUPERU or the Social Policy Evaluation and Research Unit works across the social sector to:

- promote informed debate on key social issues for New Zealand, its families and whānau, and increase awareness about what works
- grow the quality, relevance and quantity of evidence in priority areas, and
- facilitate the use of evidence by sharing it and supporting its use in decision-making.

Read more at: http://www.superu.govt.nz/

Trans-disciplinary approach

The trans-disciplinary philosophy is that complex needs cannot be understood or addressed from a singular perspective. Trans-disciplinary teams involve a team of practitioners who work collaboratively and share the responsibilities of evaluating, planning and implementing services to children and their families. One professional acts as the lead and ensures the child and their family receives coordinated care, involve the child and family in all decisions, and acts as the point of contact for the family, team and services. Children and their families/whānau are central members of a trans-disciplinary network.

Tuituia

Tuituia is the whole of child, common assessment framework used by Children’s Teams and Child, Youth and Family (CYF).

CYF developed Tuituia as a whole of child assessment framework for vulnerable children based on international evidence and best practice, e.g. see The White Paper for Vulnerable Children Volume II, Chapter 5 p.85. Since the White Paper proposed having a consistent assessment framework across all children’s services, it was agreed to use Tuituia as the whole of child assessment for the Children’s Action Plan.

Tuituia includes all aspects of a child’s wellbeing (domains) and also parenting capability and environmental factors. The Tuituia assessment framework is used for assessing a child’s unmet needs and strengths, and for measuring their progress at planned points in time as follows:

- at notification to the Vulnerable Children’s Hub (basic information entered where possible)
- on acceptance by a Children’s Team (comprehensive information gathered and assessed)
- periodically to review every three months to track progress while with the Children’s Team, and
- on exit.

The Lead Professional undertakes the Tuituia assessment by bringing together information from a wide range of sources, including from existing databases, the child and members of their family/whānau, and professionals and practitioners currently working with the child. This information is
summarised under the domains of the Tuituia assessment framework to enable the Lead Professional to draw conclusions about the degree to which the child’s needs are met. This is used to track progress and identify results.

The child and their family/whānau also contribute to the Tuituia assessment through a self-assessment process.

Vulnerable children are children who are at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs.

Child, Youth and Family is responsible for children who have, or are suspected to have, been physically or sexually abused or neglected and are at immediate risk of harm. Children’s Teams are responsible for vulnerable children where there is a significant, but not immediate, risk of harm.

The Vulnerable Children's Board (VCB) are jointly accountable Chief Executives who oversee, amongst other things, the implementation of the Vulnerable Children Act 2014 and the Children’s Action Plan 2012. Under the Act they are required to work together to support vulnerable children and develop and give effect to the Vulnerable Children’s Plan.

NB the VCB is to be reconstituted as a result of the report of the Expert Panel on modernising Child, Youth and Family.

As of December 2015:

Chair: Chief Executive of the Ministry of Social Development

Members: Five jointly accountable Chief Executives (Ministries of Health, Education, Social Development and Justice, and the Police Commissioner, with Chief Executives of Corrections and Te Puni Kōkiri).

The Vulnerable Children's Hub (The Hub) was implemented initially for Hamilton professionals and practitioners only, as a new contact and triage point for people to raise concerns about a child which they do not think are serious enough for Child, Youth and Family (CYF) or the Police.

The Hub leverages CYF National Contact centre facilities and resources, including some of its staff who are specifically trained to work in The Hub. The Hub has its own brand identity and phone number (0800 FOR OURKIDS) so there is clear separation between The Hub and CYF.

The Hub social workers draw on a range of information, initially from the Ministry of Social Development systems, to assess the initial contact and decide whether to refer the case to a Children's Team, CYF, a non-government organisation (NGO) or a universal service. The Hub uses the Vulnerable Kids Information System (ViKI) to manage this process. The Approved Information Sharing Agreement (AISA) between partner agencies supports the necessary information sharing
Vulnerable Children’s Plan

Since the development of the first Children’s Action Plan, the Vulnerable Children Act 2014 (the Act) was passed which specifies that a ‘vulnerable children’s plan’ should be developed.

The responsible Minister first sets Government priorities for improving the wellbeing of vulnerable children, after consulting with the other children’s Ministers. The Chief Executives of the children’s agencies (VCB) then work together to develop the draft vulnerable children’s plan.

The Vulnerable Children’s Plan must contribute to:

- promoting the best interests of vulnerable children (having regard to the whole of their lives), including (without limitation) taking measures aimed at: protecting them from abuse and neglect
- improving their physical and mental health and their cultural and emotional wellbeing
- improving their education and training and their participation in recreation and cultural activities
- strengthening their connection to their families, whānau, hapū, and iwi, or other culturally recognised family group
- increasing their participation in decision making about them, and their contribution to society, and
- improving their social and economic wellbeing.

Vulnerable Kids Information System (ViKI)

The Vulnerable Kids Information System (ViKI) is an information management system for use in The Hub and by Children’s Teams. It enables professionals and practitioners to record, access and manage information about vulnerable children. It securely stores that information, supports case management and enables reporting on results.
Appendix 2: Children’s Team Entry Criteria Threshold Form

Role of Children’s Teams
Children’s Teams deliver a co-ordinated multi-agency response to ensure intensive, timely and effective support is provided to vulnerable children. The intention is to act early and plan preventative actions before a statutory response is needed.

Children’s Team Entry Threshold
Children vulnerable to neglect and abuse with multiple and interrelated needs requiring comprehensive assessment and access to a range of services to meet their needs.

Definition of Vulnerability
Vulnerable children are children who are at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community.

Determining entry to a Children's Team
Professional judgement will need to be applied when deciding whether or not a referral meets the Children’s Teams entry threshold. It is critical that the best response is identified for the child:

- Review the referral information
- Assess the child’s needs using the Tuituia Vulnerability Checklist as a guide (pages 2-4)
- Document the team’s decision as to whether the child and family/whānau require support from the Children’s Team on the Referral Form.

Tuituia Checklist
Use the Checklist prompt questions to guide your decision making.

The prompts have been written based on the ideal state of a child’s needs being met. For each domain, prompts have been listed to determine the extent to which the need is met.

Each prompt needs to be considered by the team and a team agreed rating needs to be assigned. Circle the applicable box to indicate the agreed response. A rating scale number can be applied, in or above the circle, if the Panel wishes to use the Tuituia scaling.

---

60 Ibid.
# Mokopuna Ora

*Applicable to child/young person 0-17 years of age*

<table>
<thead>
<tr>
<th>Domain</th>
<th>Prompts to consider</th>
<th>Don’t Know</th>
<th>Not Applicable</th>
<th>Unmet need (1-4)</th>
<th>Need beginning to be met (5-6)</th>
<th>Need being met in sustainable way</th>
<th>Need fully met (10)</th>
</tr>
</thead>
</table>
| Attachment      | • Has a consistent, responsive, warm and secure relationship with parent(s)/caregiver(s).  
• Has a consistent, responsive, warm and secure, relationship with other significant adults and/or siblings/non-adults.                                     |            |                |                  |                               |                                  |                     |
| Health          | • Has access to regular health care and receives health care when unwell.  
• Has diagnosed medical condition(s) and adheres to care plan.  
• Physical growth and development is within normal range for age.  
• Mental-emotional development is within normal range for age.                                           |            |                |                  |                               |                                  |                     |
| Identity & Culture | • Has a positive sense of identity and culture.  
• Has a strong sense of self-belief and has hopes, dreams and wishes for their future.                                                                      |            |                |                  |                               |                                  |                     |
| Behaviour       | • Demonstrates positive pro-social behaviours with no evidence of harmful behaviours (such as, substance use of criminal).                                                                                         |            |                |                  |                               |                                  |                     |
| Friendships     | • Demonstrates empathy & respect for friends and peers.                                                                                                                                                             |            |                |                  |                               |                                  |                     |
| Learning & Achieving | • Cognitive development is within normal range for age.  
• Demonstrates interests and has goals and aspirations.  
• Self-care and independence/life skills are age appropriate.                                               |            |                |                  |                               |                                  |                     |
| Education       | • Participates in formal education (ECE/School) or vocational training employment.  
• Is achieving academically within normal range for age.                                                        |            |                |                  |                               |                                  |                     |
### Domain | Prompts to consider | Don’t Know | Not Applicable | Unmet need (1-4) | Need beginning to be met (5-6) | Need being met in sustainable way (7-9) | Need fully met (10)
--- | --- | --- | --- | --- | --- | --- | ---
**Network of Support**  
• Young person has strong networks of support – community/social/cultural.  
• Community services are available and accessible to young person. | | | | | | | ![Progress](progress.png)
**Resources**  
• Young person’s financial and housing needs are fully met. | | | | | | | ![Progress](progress.png)
**Family/whānau / hapū/iwi**  
• Young person has knowledge and connections to own family/whānau/ hapū/iwi that provide safe, stable and positive guidance and support.  
• Young person has a stable base to call home and follows a routine. | | | | | | ![Progress](progress.png)
Kaitiaki Mokopuna
Caregiver capacity to nurture the wellbeing of the child

<table>
<thead>
<tr>
<th>Domain</th>
<th>Prompts to consider</th>
<th>Don’t Know</th>
<th>Not Applicable</th>
<th>Unmet need (1-4)</th>
<th>Need beginning to be met (5-6)</th>
<th>Need being met in sustainable way</th>
<th>Need fully met (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe parenting</td>
<td>• Is physically and mentally healthy with no evidence of substance abuse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is resilient with no history of offending.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Has no history with child protection agencies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety &amp; Basic Care</td>
<td>• Meets the basic care needs of the child and ensures the child is protected from harm and risks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship with child/young person</td>
<td>• Has positive relationships with household members and there is no evidence of disharmony or violence.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Parent/caregiver and child have a reciprocal positive, respectful and warm relationship that is consistent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills &amp; Knowledge</td>
<td>• Has parenting knowledge and skills to support mokopuna’s learning and development and has the capacity to adapt and change as required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidance &amp; Supervision</td>
<td>• Endeavours to be a positive role model and guides and sets boundaries and consequences which are appropriate to the age of the child/young person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Parent/caregiver is supportive of the child’s learning and achieving.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Te Ao Hurihuri

*Whānau, social, cultural and environmental influences surrounding the child*

<table>
<thead>
<tr>
<th>Domain</th>
<th>Prompts to consider</th>
<th>Don’t Know</th>
<th>Not Applicable</th>
<th>Unmet need (1-4)</th>
<th>Need beginning to be met (5-6)</th>
<th>Need being met in sustainable way (7-9)</th>
<th>Need fully met (10)</th>
</tr>
</thead>
</table>
| **Networks of Support** | - Household members participate in social and community networks.  
- Household members are culturally connected and has cultural and/or faith based values.  
- Household members access community services and resources proactively to meet their needs.                                                                 | ![Networks of Support](image) |               |                   |                                |                                          |                   |
| **Resources**    | - There is enough financial resources to meet the family’s needs and maintain a basic quality of life.  
- Family have lived at the same address for 12 months or more.  
- Home environment is adequate for family size and composition and the number of people in the home is stable. | ![Resources](image)                      |               |                   |                                |                                          |                   |
| **Family/whānau/hapū/iwi** | - Parent/caregiver is well connected and receives positive support from extended family/whānau and/or the community.  
- Family/whānau has a history of positive family functioning.                                                                                          | ![Family/whānau/hapū/iwi](image)       |               |                   |                                |                                          |                   |
Appendix 3: Different theories of change – creating tension

<table>
<thead>
<tr>
<th>Creating wholesale and long-term ('transformational') change in frontline practice</th>
<th>Creating an immediate ('instrumental') change in practitioner approach and results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE WORK OF LPs</strong></td>
<td>Should not be particularly different from what many in the children’s workforce do now. What is different is the chance to work more holistically and collaboratively.</td>
</tr>
<tr>
<td>Should be quite different - working with complex and resistant families who have not benefitted from the usual approaches (including CYF intervention, or even the work of the LPs own agency). This requires LPs to be able to work in a more sophisticated way (more ‘joined up’ and motivating) than they may have been doing in their usual roles.</td>
<td></td>
</tr>
<tr>
<td><strong>PRIOR RELATIONSHIP OF LP TO CHILD</strong></td>
<td>Very important. The prior history that a worker (who becomes an LP) has with a child and their family provides a level of trust that is most likely to support change.</td>
</tr>
<tr>
<td>Not so important. One or more CAN members should have a good enough relationship with the child and their family (having established trust). It is more important that an LP have the capability to work in a different (more joined-up and motivating) way and leverage pre-existing relationships that CAN members have with referred children and families.</td>
<td></td>
</tr>
<tr>
<td><strong>WORKFORCE CAPABILITY</strong></td>
<td>Is not such an issue. Under the right circumstances any child worker should be able to be an LP. Emphasis is on getting agencies to buy-in and support their worker’s participation.</td>
</tr>
<tr>
<td>Is an issue. Many in the children’s workforce do not currently have the capability to be LPs. As well as more sophisticated engagement and motivational skills with families, the role requires an ability to work in a highly participatory way with other agency workers to create a functional CAN team.</td>
<td></td>
</tr>
<tr>
<td><strong>TIME IN THE LP ROLE</strong></td>
<td>Can and should be limited (part-time) in order that the workers continue to focus on their primary role within their home agency.</td>
</tr>
<tr>
<td>Should be at least half-time if not full-time in order to adequately come to grips with the role. Ideally LPs would be co-located to build their practice together, undistracted by the usual requirements and politics of their home agency role. Their home agency colleagues learn about the role through being CAN members and through connections maintained by their LPs.</td>
<td></td>
</tr>
<tr>
<td><strong>HOW THE CAP MODEL IS TO BE SOCIALISED</strong></td>
<td>Everyone gets to be an LP if they have a suitable client or have the capacity. They learn about the role by doing it, as well as from colleagues and through participating as CAN members.</td>
</tr>
<tr>
<td>Everyone gets to be a CAN member and LPs are selected based on their capability and motivational skills. Potential LPs are cultivated into the LP role through participation as CAN members.</td>
<td></td>
</tr>
<tr>
<td><strong>SUPPORT AND ACCOUNTABILITY</strong></td>
<td>Comes mainly from home agency managers and supervisors with some reinforcement and limited oversight from the local Director and team. In practice, accountability for the performance of LPs in this scenario is unclear.</td>
</tr>
<tr>
<td>Comes mainly from the local Director and local team with reinforcement from home agency managers and supervisors. Ideally, the Director or Operations Manager has direct oversight and quality assures the work of LPs, and is answerable to the LGG and Directorate for the performance of LPs and to some extent the CAN members.</td>
<td></td>
</tr>
<tr>
<td><strong>HOW THE CAP MODEL IS SUSTAINED</strong></td>
<td>Through maintaining business-as-usual services. Some home agencies are only able to support the CAP in Hamilton through providing very part-time LPs, and thereby minimising disruption to their usual services and targets.</td>
</tr>
<tr>
<td>Rests initially on the quality of LP practice, i.e. achieving good engagement with children and families, and achieving early results that distinguish the CAP model from the previous service delivery paradigm.</td>
<td></td>
</tr>
</tbody>
</table>