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Giving Victorian children the best start in life

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Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *Giving Victorian children the best start in life.*

Yours faithfully

DDR PEARSON
Auditor-General

2 May 2007

Foreword

Children are our future. Research indicates that when government invests in their first 8 years, children's health, educational prospects and self-confidence are all enhanced. This is particularly the case for children from vulnerable families who usually need to overcome greater health and social disadvantages.

To improve access to, and participation in, maternal and child services and kindergarten, the Department of Human Services (DHS) has implemented 3 initiatives: municipal early years plans, Best Start and children's centres. A feature of these initiatives is their attention to vulnerable families and their children.

This audit examined whether the 3 initiatives have been successful.

On the positive side, qualitative evidence indicates that the initiatives have contributed to improved access and increased participation in maternal and child health services and kindergarten services. There is, however, insufficient quantitative data to confirm a direct contribution to increased participation in these services. It is also difficult to establish whether participation by vulnerable children and families had increased.

In its efforts to establish the causal links which will demonstrate the effectiveness of its initiatives, DHS has indicated that it will improve its performance measurement and evaluation frameworks, and its targeting and monitoring of vulnerable clients.

DDR PEARSON
Auditor-General

2 May 2007

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1 Executive summary

1.1 Introduction

Early childhood services aim to meet the care, health, education and development needs of children. They broadly consist of universal services, which are for the whole population (maternal and child health services [MCHS], childcare, kindergartens and school nursing); and secondary and tertiary, which are for children and families with special needs.

Research shows that investing in children during their early years increases their self-confidence, health and educational prospects. It is also important for children and families who, because of their circumstances (e.g. drug and alcohol problems, disability), are considered vulnerable. This investment reduces the need for remedial, "patch-up" and crisis intervention programs at later stages of life.

Since 2002, the government's policies outline its commitment to invest in early years services for all children and families, especially those considered vulnerable.

The Department of Human Services (DHS) is responsible for overseeing early years services and in 2005-06 allocated $250.7 million for this program. In 2004, DHS identified a small but significant minority of families, including those in disadvantaged areas that under-use some or all universal services. DHS also identified that access can be a problem and that integration and coordination between service providers could be improved. In recent years, DHS has implemented 3 major initiatives described below:

- Best Start is focused on forging a partnership at local levels between service providers, service users and other stakeholders to collectively identify and better meet local service needs. In the 2002-03 Budget, the government allocated $7.6 million over 3 years, which resulted in the establishment of 13 demonstration sites in disadvantaged communities, including 2 Aboriginal-specific sites. In 2005-06, a further $10.8 million was allocated over 4 years to establish a further 15 sites and support the initial sites.

- Municipal early years plans (MEYPs) are prepared by councils and are designed to provide a strategic direction for the development and coordination of educational, care and health programs, activities and other local developments that impact on children aged 0-6 years within a municipality. DHS provided $135 000 in 2003-04 to Municipal Association of Victoria (MAV) to develop a framework that councils could use to develop their own MEYP. At February 2006, 63 of the state's 79 councils had prepared a MEYP.
- Children's centres provide a single point of access to services by locating them in a single or in connected buildings. At October 2006, 18 centres were operational and funding of $16 million (at June 2006) had been allocated by DHS.

The 3 initiatives are aimed at improving outcomes for all Victorian children through better service and infrastructure planning, improved service access and integration, and service innovation. These initiatives also aim to improve vulnerable families' engagement with early childhood services.

1.2 Audit objective

The objective of the audit was to assess whether the 3 initiatives have resulted in improved access to, and participation in, universal services for children and families, including vulnerable families.

The audit did not extend to assessing the extent of referrals to secondary or tertiary services, nor the quality of early childhood services.

1.3 Audit conclusion

Some evidence, which was primarily qualitative, indicated that where successfully implemented, Best Start, MEYPs and children's centres contributed to improved access and participation.

However, except for 2 Best Start sites, there was insufficient quantitative data at the local level that showed the initiatives directly contributed to increased participation in maternal child health and kindergarten services.

Targeting and monitoring vulnerable clients can be improved

While all 3 initiatives had a focus on identifying and engaging with vulnerable children and families, it is difficult to establish whether participation by all vulnerable families and children has increased. This is, in part, due to:

- the inconsistent way vulnerable clients are classified
- existing systems not being designed to maintain a record of their existence (although one group, Aboriginal children and families attending MCHS has been recorded since 2000. In 2005, data collection was extended to record the attendance of Aboriginal children at the 10 key age and stage consultations. Kindergartens also record Aboriginal attendance and cultural status).

Currently, 3 different IT systems collect information about the same child (at different stages of their life). The same data is entered repeatedly as it is transferred from paper systems, to local government systems, to DHS regional offices and finally to DHS central office. This is inefficient and increases the risk of transcription errors.

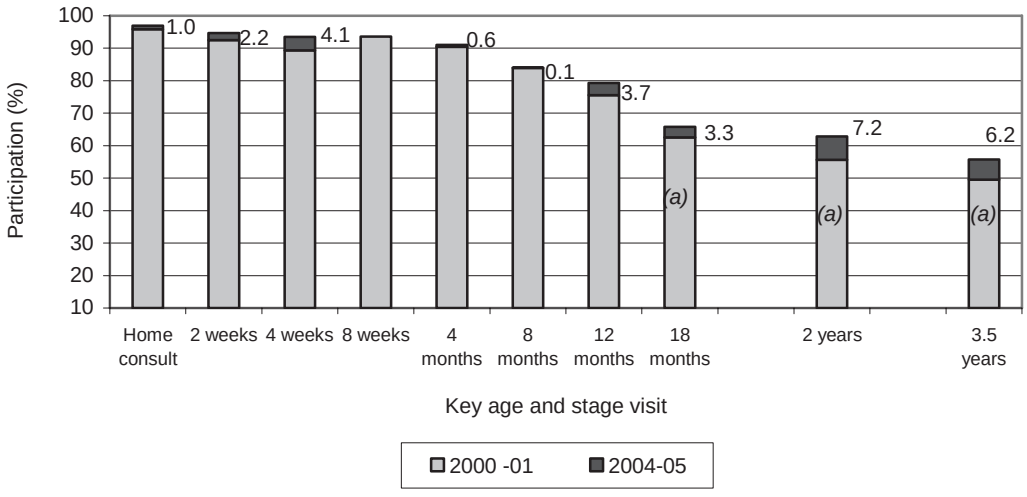
A single statewide database for universal services would facilitate the recording, monitoring and reporting on the success of the initiatives, including their impact on vulnerable children.

Access and participation is good

Over the 5-year period to June 2005, enrolments (i.e. a maternal child health nurse has examined a child) in MCHS by all eligible 0-1 year old children have been high with the annual target of 98 per cent met or substantially met. This indicates access to these services is good.

Participation (i.e. attendance at the first 6 key age and stage visits) by 0-1 year olds has been high averaging around 89 per cent over the 5-year period and generally met DHS's target of an annual increase. The participation rates of children aged 18 months, 2 years and 3.5 years over this period, while lower, are trending upwards. This trend is in line with meeting DHS' target of an increase on the 2002-03 rates by 2006-07 (see Figure 1A).

Figure 1A
Participation, maternal and child health services



(a) In 2002-03, participation rates for the 18 months, 2 years and 3.5 years age groups were 62.5, 56.2 and 47.4 per cent, respectively. DHS set a target to increase these rates by 8 per cent by 2006-07.

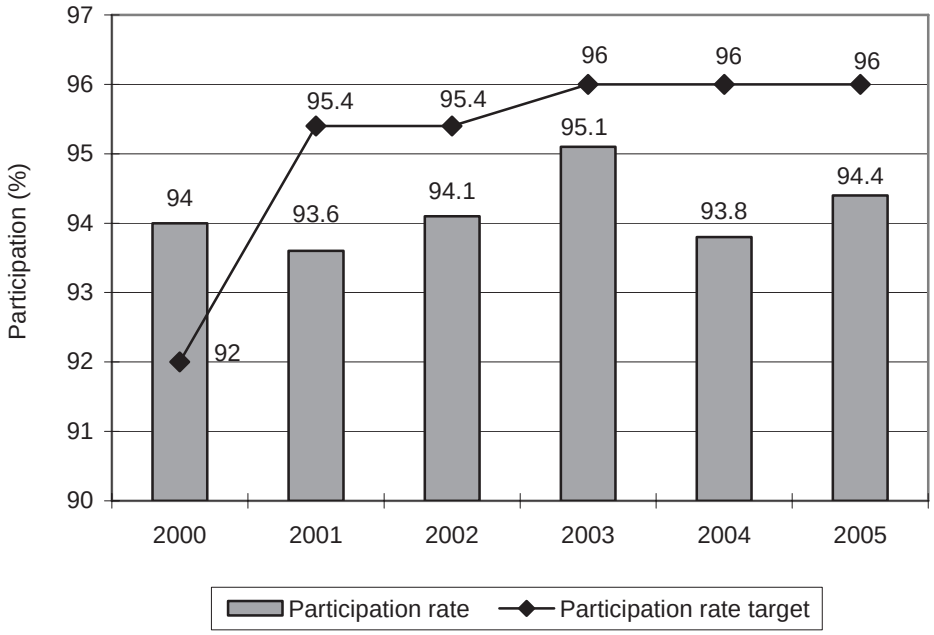
Source: Victorian Auditor-General's Office, from Department of Human Services' data.

Figure 1A shows that for each age group (except 8 weeks) there has been a net increase in participation rates between 2000-01 and 2004-05.

DHS' participation target for the enhanced MCHS has been met from 2001-02 to 2003-04 and substantially met in 2004-05.

Figure 1B shows that over the 5-year period to December 2005, the participation rates for kindergarten services were around 94 per cent, which were slightly below the targets. In 2000, the target was exceeded.

Figure 1B
Participation rates, kindergarten services



Note: Participation rates achieved using the 2005 calculation method based on ABS statistics for the previous year's 3-year-old population.
Source: Victorian Auditor-General's Office using Department of Human Services' data.

Substantial work has been undertaken to identify and address the MCHS and kindergarten service participation gaps. The preliminary results of one exercise initiated in July 2006 indicated that some 4-year old children were attending childcare centres that did not have a funded kindergarten program.

Initiatives are soundly based and generally well implemented

Best Start and MEYPs are sound initiatives that can improve service coordination, integration and delivery, and help maximise resource use. The 3 initiatives encouraged a more coordinated approach to service delivery in a local area by public and private sector providers, and had a focus on engaging vulnerable children and families. The initiatives overcame problems of communication between providers and service duplication when well implemented.

Our focus groups with service users and providers revealed that most participants considered both initiatives had contributed to improving access to, and participation in, early childhood services. DHS' statewide evaluation of Best Start had also identified achievements in some sites.

The children's centre we visited has been a successful initiative as the central location and reasonable cost made programs easier to participate in and more accessible. Services were better coordinated resulting in a more flexible approach to service use and delivery. The early intervention, support and monitoring of families with special needs and at risk, particularly the small number of local indigenous children, has improved.

Evaluation frameworks could be improved

DHS' evaluation framework for the Best Start initiative incorporates a suite of output performance indicators. The framework could be improved by establishing more consistent indicators at the local level that could better integrate into the statewide evaluation. Local evaluations would also benefit from collecting adequate baseline data to identify who is participating, the changes in participation rate and identifying lead indicators that clearly measure progress towards the expected outcomes of the initiatives.

An evaluation framework for MEYPs has not been established. DHS will evaluate the children's centre initiative in 2007.

Recommendations

1.1 That DHS reviews its performance indicators for universal services with a view to selecting indicators that monitor both progress towards outcomes and actual participation.

1.2 That DHS develops guidance for service providers covering the classification of vulnerable clients to improve data collection and analysis of this key group.

1.3 That DHS, in partnership with service providers, establish a common statewide database system for early childhood services across the state, including improved monitoring of vulnerable clients to assist in the development of targeted programs in local areas of need.

1.4 That DHS, in consultation with the Municipal Association of Victoria, evaluates the MEYP initiative so as to assess activity to date and identify areas for improvement, including the monitoring and review processes in municipal early years planning.

1.5 That DHS develops a data collection framework for Best Start that enables consistent local and statewide monitoring and evaluation.

1.6 That DHS considers adopting the outcomes for children framework to measure the effectiveness of its initiatives.

1.7 That DHS reviews its initiatives' indicators so that they measure achievements against the initiatives' objectives, particularly for improved access and participation.

1.8 That DHS uses its proposed evaluation of children's centres to develop a performance measurement framework.

RESPONSE provided by Secretary, Department of Human Services

The Department of Human Services (DHS) welcomes this report. Victoria, in keeping with other jurisdictions nationally and internationally, has had a strong focus in recent years on services for children in the early years of life. This recognises that what occurs in early childhood impacts greatly on later pathways through school and adult life. Your report considers 3 important initiatives, Best Start, municipal early years plans and children's centres, which have been led by DHS, in partnership with other stakeholders, including the Department of Education and local councils.

DHS is pleased to support the report, including its 8 recommendations. I am confident that these recommendations will constructively guide further work by DHS to strengthen this suite of services, particularly for vulnerable families.

RESPONSE provided by Secretary, Department of Education

The Department of Education acknowledges the importance of early childhood development to achieving education outcomes. The findings of the report will be drawn to the attention of relevant department offices and the department will continue to work closely with the Department of Human Services to improve data availability on children and young people.

2 About early childhood services

2.1 Introduction

Research shows that a child's first 8 years are crucial to shaping their long-term wellbeing, physical and mental health, learning and employment prospects, and ability to interact socially[1]. These early years have a lasting influence throughout a person's life.

Investing in children during their early years increases their self-confidence, health and educational prospects. There is also considerable research to show that investing in programs to support young children and their families can substantially reduce the need for expensive remedial, "patch-up" and crisis intervention programs at later stages of life[2, 3, 4, 5].

Investment in the early years is even more important for vulnerable families. These include families with a parent with a psychiatric, physical or intellectual disability; who is alcohol or substance dependent; who engages in or is a victim of violence; who has a serious chronic illness; or who is a teenager. These families may also have a child with a severe problem (such as low birth weight; failure to thrive; a disability or serious illness; or involvement with child protection services)[6].

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[1] Australian Institute of Health and Welfare 2005, *A picture of Australia's Children*, Australian Institute of Health and Welfare, cat. no. PHE 58, Canberra.

[2] Commonwealth of Australia 2003, *Towards a National Agenda for Early Childhood*, Commonwealth Task Force on Child Development, Health and Wellbeing, Commonwealth of Australia, Canberra.

[3] G Vimpani et al., "The Relevance of Child and Adolescent Development for Outcomes in Education", Health and Life Success, in A Sanson (ed), *Children's Health and Development: New Research Directions for Australia*, Research report Number 8, Australian Institute of Family Studies, Melbourne, 2002.

[4] M McCain and F Mustard, *Reversing the Real Brain Drain*, Early Years Study: Final Report, Ontario Children's Secretariat, Toronto, 1999.

[5] J P Shonkoff and D A Phillips, *From Neurons to Neighbourhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood, 2000.

[6] Department of Human Services 2004, *Future directions for the Victorian Maternal and Child Health Service*, prepared with the Municipal Association of Victoria, Community Care Division, Department of Human Services, Victorian Government, Melbourne.

The government has pledged its commitment to investing in early years services for all children and families, including vulnerable families. Since 2002, 7 policies related to children's services have been issued.

The Department of Human Services (DHS), through its Office for Children (OfC), is responsible for overseeing early years services for children prior to school entry and for the special needs of vulnerable children (such as refugees, people from culturally and linguistically diverse backgrounds, recent migrants, children at risk or with special needs) who need protection or care.

In 2005-06, the OfC's budget of $740.8 million was allocated to 3 major programs, including $250.7 million for Early Years Services covering maternal and child health services (MCHS), kindergartens and childcare.

2.2 Early childhood services

Early childhood services aim to meet the care, health, education and development needs of children. There are 3 broad categories of early childhood and family support services.

2.2.1 Universal services

Universal services are for the whole population and aim to provide help to all who need it, without regard to their ability to pay. There are 4 main types of services.

Maternal and child health

Maternal and child health services (MCHS) work to improve the health, development and wellbeing of children from birth to 6 years old[7].

MCHS provides 10 key age and stage consultations from birth to 3.5 years. It also provides a flexible service capacity for services not addressed through the 10 key age and stage consultations. Since 1999–2000, an enhanced service has been available for families with more complex needs in response to research findings that early interventions can avoid a crisis developing at a later stage.

The *Child Wellbeing and Safety Act 2006* has a requirement that the maternal and child health service provider nearest a mother's place of residence must be notified of the child's birth within 48 hours (this requirement was previously found in section IX of the *Health Act 1956*). A MCHS nurse then contacts the mother, and if she agrees, then enrols the child.

At June 2005, around 62 000 children of 63 800 children (97 per cent) aged between 0-1 year were enrolled in MCHS.

[7] ibid.

Childcare

Childcare services address the developmental needs and interests of children under 6 years of age through occasional (short periods) care, long day (all-day or part-day) care and family day care (care at home). Before- and after-school care programs are also available for primary school children.

Under the *Childcare Act 1972*, the Commonwealth Government is responsible for childcare services, including the accreditation of childcare centres. The Victorian Government, through DHS, is responsible for the licensing (*Children's Services Act 1996*) and regulation (Children's Services Regulations 1998) of long-day care and occasional care services provided in centres[8].

Kindergartens

Kindergartens help children aged 4-5 develop their social, emotional, motor, cognitive, language and creative skills. The kindergarten program is a one-year program in the year before the child starts primary school.

Under the *Children's Services Act 1996* and Children's Services Regulations 1998, the Victorian Government, through DHS, is responsible for licensing and regulating kindergartens.

At December 2005, around 57 300 of 60 700 children aged 4 years were enrolled in kindergarten.

School nursing

School nursing has existed since the early 1900s. In 1994, the service moved to a health surveillance focus and a parent questionnaire was introduced. In 1997, the questionnaire was expanded, signalling a greater emphasis on health promotion and the parents' role in monitoring their child's health. The school nurse distributes the questionnaires and visits all children in their first year of school.

2.2.2 Secondary and tertiary services

Secondary services are for people with an identified early stage problem or risk factor. These services include early childhood intervention to support children with a disability or development delay, as well as support and parenting services for families with the aim of reducing the risk or managing the problem.

Tertiary services are for people with needs that require intensive (and often ongoing) intervention. These services include child protection and placement services.

[8] Department of Human Services 2003, *Community Care Policy and Funding Plan 2003–2006,* Department of Human Services, Melbourne.

The need for secondary and tertiary services is commonly identified by a universal services provider. Use of universal services by families, is therefore, seen as a good way to give children an equal start in life[9], and can – if needs are identified early – reduce the call on secondary or tertiary services.

Early years services are funded by Commonwealth, state and local government and delivered by local government, community service organisations and the private sector.

2.3 DHS' initiatives to improve service access, participation and coordination

DHS research indicates that while most children and families make good use of universal services[10], a small but significant minority of families under-use some or all of these services. Also, under-use is very high in certain (disadvantaged) locations.

Access to universal services can also be a problem. Poor integration between services means families have difficulty finding the services they need. Many services are not available when they are needed, while others are stand-alone services, focusing on "one part" of the child or "one aspect" of the family.

In recent years, DHS has developed and implemented 3 major initiatives to improve access to, participation in, and coordination of, universal early childhood services at the local level. These initiatives are detailed below.

2.3.1 Best Start

In 2002, DHS implemented the Best Start program as a whole-of-government program. The program aims to improve the health, development, learning and wellbeing of all Victorian children aged 0-8.

The program's subsidiary aims are to:

- improve access for families and children to child and family support, health services and early education
- improve parents' capacity, confidence and enjoyment of family life
- have communities that are more child- and family-friendly.

Best Start intends to:

- get parents, service providers and relevant community organisations working together to improve the coordination, flexibility and responsiveness to local needs of universal services

[9] Department of Human Services 2000, *Stronger Citizens, Stronger families, Stronger Communities, Partnerships in Community Care*. Prepared by J Carter for the Department of Human Services, Melbourne.

[10] Department of Human Services 2004, Breaking Cycles, Building Futures, Promoting inclusion of vulnerable families in antenatal and universal early childhood services, A report on the first three stages of the project. Prepared by the Brotherhood of St Laurence for the Department of Human Services, Victorian Government, Melbourne.

- improve early interventions for vulnerable children and families
- improve participation by families who do not use services, or use them irregularly.

The conceptual development of the Best Start initiative was overseen by an interdepartmental committee comprising DHS, Department of Education (both departments have representatives in the partnership group), Department of Justice, Department for Victorian Communities, Department of Industry, Innovation and Regional Development, Department of Premier and Cabinet, Victoria Police[11], relevant councils and/or service providers. At the local level, Best Start partnerships include: parents/Elders, local government, health services, education services, family and community support services and community organisations (such as sport and recreation clubs, advocacy groups, peak organisations). Partnerships are also expected to include other members reflective of local needs and services.

In the 2002-03 budget, the government allocated $7.6 million ($3.8 million from DHS matched with $3.8 million from the Community Support Fund) over 3 years (to 2005) for 10 demonstration sites (varying levels of funding allocated to these 10 sites enabled an additional 3 sites to be established):

- 11 “mainstream” sites, of which 5 were established in 2002 and 6 in 2003
- 2 Aboriginal Best Start sites, established in 2004.

In 2005-06, the government allocated a further $10.8 million over 4 years to June 2009 to establish a further 15 Best Start sites (including 4 new Aboriginal Best Start sites) and to continue the 13 demonstration sites. The 13 continuing Best Start demonstration sites each receive $40 000 annually to maintain a part-time coordinator.

Aboriginal Best Start

Aboriginal Best Start aims to overcome the disadvantage experienced by Aboriginal people. About 24 per cent of the Victorian Aboriginal population is aged 0-8 years. About 50 per cent of Aboriginal people live in rural areas.

Aboriginal Best Start is an early intervention initiative for Aboriginal people. In addition to the Best Start aims, Aboriginal Best Start aims to:

- build sustainable partnerships between Aboriginal and non-Aboriginal services
- build culturally relevant services (such as child and family support, health and early education services) and improve access to them.

2.3.2 Municipal early years plans

In 2004, DHS provided $135 000 to the Municipal Association of Victoria (MAV) to develop a framework and provide forums and support to all 79 councils to develop their own municipal early years plans (MEYPs).

[11] Department of Human Services 2003, *Best Start in Action Demonstration Project Guidelines.* Department of Human Services, Melbourne.

MEYPs are a local area plan designed to provide strategic direction for the development and coordination of educational, care and health programs, activities and other local developments that impact on children aged 0-6 years, as a minimum, in a municipality. They do this by:

- improving the ease of access, coordination and responsiveness of early childhood services by better integrating services and having them work more collaboratively
- increasing vulnerable families' use of early childhood services[12]
- tailoring services to specific local needs.

The framework identifies 4 components of plans:

- a clear focus on the 0-6 years age group (and may include school-aged services)
- specification of the councils' role in early childhood services, education and health services delivered within its boundaries (either directly or by other providers) and infrastructure provision, planning, advocacy and community capacity building
- inclusion of universal, secondary and tertiary services and other relevant programs (such as health promotion and environmental planning), and explanations of how these can be better coordinated to improve service delivery
- clear links to other state and local government policy documents, such as the maternal and child health strategic planning framework (*Future directions for the Victorian Maternal and Child Health Service, May 2004*), municipal public health plans, community health plans and Best Start action plans.

MEYPs are to be integrated with councils' 3-5 year planning cycles and guide long-term planning, capital infrastructure development and evaluation of early years' programs, activities and facilities across all departments (such as transport, recreation, health and early childhood services).

MEYPs will be used as the basis for negotiations with the state about resourcing and policy issues. They will feed into the Statewide Plan for Victoria's Children in 2007 by identifying where councils are operating effectively and gaps in service delivery. DHS expects that MEYPs will improve the consistency of local and statewide planning for the early years.

The MAV released a draft framework document in 2004 and finalised it in May 2006. DHS, through the MAV, encouraged councils to prepare their initial MEYP, using the draft framework, by June 2006. DHS did not provide councils with extra funds to develop their MEYPs, and there is no statutory requirement that they do so. At February 2006, 63 of the 79 councils had submitted their completed MEYPs to DHS.

[12] C Hargreaves and J Barrett, *Connecting Locally – A State/Local Government Early Years Planning Initiative*, abstract from XXIV World Congress of World Organization for Early Childhood Education, "One World: Many Childhoods" held in Melbourne, July 2004.

2.3.3 Children's centres

In 2002, the government's Children First policy committed to developing children's centres. Children's centres aim to increase access to, participation in, and coordination of, early childhood services by placing all professional and trained staff from Commonwealth, state and local government services into a single, or connected, building(s). The aim is to improve communication and information exchange between providers and increase exchanges about clients, particularly vulnerable clients.

DHS provides a seeding grant to councils towards the cost of establishing a centre. DHS gives priority to establishing children's centres in under-serviced areas and in communities experiencing significant disadvantage[13].

In the 2003-04 Budget, the government allocated $16 million over 3 years: $8 million for children's centres and $8 million for new kindergartens in multiuse facilities.

At October 2006, seed funding had been allocated to 49 new or redesigned facilities. Of these, 17 had received up to $500 000 each and the remainder up to $250 000. Eighteen had been completed and were operating and 10 were under construction, with the remainder in the planning stage.

2.3.4 This audit

The objective of this audit was to assess whether 3 initiatives (Best Start, MEYPs and children's centres) improved access to, and participation in, universal services (maternal and child health, kindergartens and childcare, but not school nursing) for children and families. It did not cover secondary or tertiary services, and did not seek to assess the quality of services.

The total cost of this report was $794 000.

[13] Department of Human Services 2005, *Capital Funding for Children's Centres Guidelines for applicants 2005-06 funding round*, Department of Human Services, Melbourne.

3 Service participation rates

At a glance

Background

The Department of Human Services' (DHS') reports to parliament on participation in both maternal and child health (MCHS) and kindergarten services using performance indicators and targets. Three separate databases are used to record a range of information on children and families who use these services. DHS uses an extensive range of related data (such as national and statewide data sets, parent surveys and consultations with service providers) to identify and manage gaps in service provision.

Key findings

- Participation in MCHS by 0-1 year olds has been good averaging 89 per cent over the period 2000-01 to 2004-05, and generally met DHS' targets. The rates for children aged 18 months, 2 years and 3.5 years over this period were lower, but trended upwards in line with targets **(see page 16).**
- Over the period January 2001 to December 2005, participation rates for kindergarten services were also good averaging around 94 per cent, though marginally below DHS' targets **(see page 18)**.
- The performance indicators reported to parliament do not measure outcomes or actual participation over the period of the service **(see page 20).**
- Although DHS has conducted extensive research to identify vulnerable children and families, and high risk groups, it recognises both the need to collect better data and to improve service delivery **(see page 21).**
- Although the participation data was complete and accurate, it is inefficient to operate 3 different databases that collect information on the same child albeit at different stages of its development **(see page 26).**

At a glance - *continued*

Key recommendations

3.1 That DHS reviews its performance indicators for universal services with a view to selecting indicators that monitor both progress towards outcomes and actual participation **(see page 20)**.

3.2 That DHS develops guidance for service providers covering the classification of vulnerable clients to improve data collection and analysis of this key group **(see page 24).**

3.3 That DHS, in partnership with service providers, establish a common statewide database system for early childhood services across the state, including improved monitoring of vulnerable clients to assist in the development of targeted programs in local areas of need **(see page 27)**.

3.1 Participation targets

3.1.1 Maternal and child health service

DHS uses a number of performance indicators for the maternal and child health service (MCHS). It reports 2 of these to parliament:

- total number of children aged 0-1 year enrolled
- total per cent of children aged 0-1 month enrolled at MCHS (as a percentage of birth notifications[1]).

DHS' service agreements with councils set a target of 98 per cent of children aged 0-1 month to be enrolled. Figure 3A shows that this target was met or substantially met for the 5 years from 2000-01 to 2004-05.

[1] For this indicator, DHS uses MCH enrolment and birth notification data to estimate the total number of Victorian children in an area who ought to be attending a service, and compares this with actual participation reported by service centres.

Figure 3A
Enrolments, maternal and child health service

Performance indicator	Target	2000-01	2001-02	2002-03	2003-04	2004-05
Number of enrolled children aged 0-1 year *(a)*		58 424	58 951	59 463	61 231	62 044
Per cent of children aged 0-1 month enrolled (as a percentage of birth notifications) *(a)*	98%	97.8	98	98	98	97.2

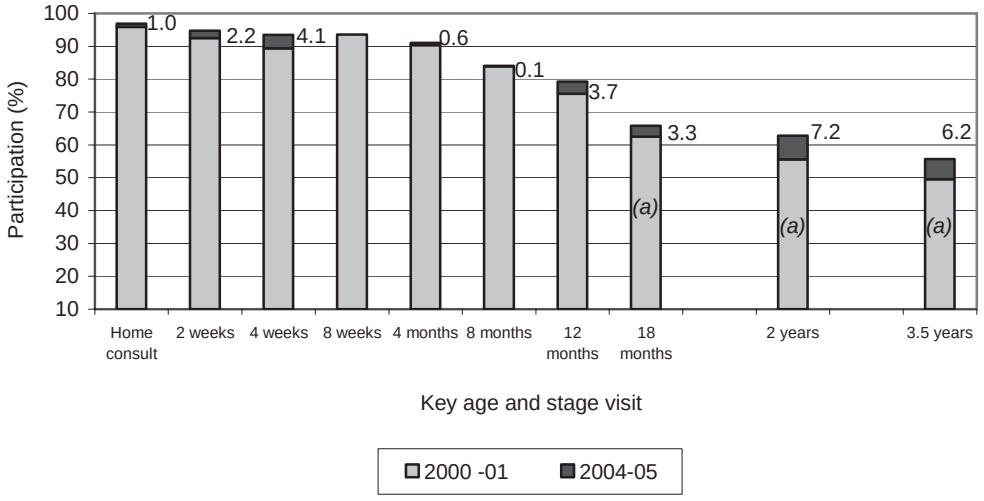
(a) Results against targets reported to parliament as part of the budget process.

Source: Victorian Auditor-General's Office, from Department of Human Services' data.

Participation (i.e. attendance at the first 6 key age and stage visits) by 0-1 year-olds has been high, averaging around 89 per cent over the 5-year period and generally met DHS' target of an annual increase. The participation rates of children aged 18 months, 2 years and 3.5 years over this period, while lower, were trending upwards (see Figure 3B).

In 2004, DHS set targets to increase the participation rate by 8 per cent statewide over 3 years from the 2002-03 rates for the 18 months, 2 years and 3.5 years MCHS consultations (i.e. 70.5, 64.2 and 55.4 per cent, respectively, by 2006-07). The participation rates for the 2 years and 3.5 years consultations have increased in line with meeting DHS' target by 2006-07.

Figure 3B
Participation, maternal and child health services



(a) In 2002-03, participation rates for the 18 months, 2 years and 3.5 years age groups were 62.5, 56.2 and 47.4 per cent, respectively. DHS set a target to increase these rates by 8 per cent by 2006-07.

Source: Victorian Auditor-General's Office, from Department of Human Services' data.

Participation by Aboriginal children aged 0-5 years for all MCH key age and stage consultations in 2001 to 2002 was 39 per cent (1 700 of an estimated population of 4 300). This compared with 56 per cent for the estimated population of all children aged 0-5 years (208 800 out of 370 500).

Enhanced maternal and child health service

DHS measures the performance of the enhanced MCHS by the number of cases closed. A case is opened when a MCHS nurse identifies an issue or issues requiring resolution. The case is closed when the child and mother can be returned back to the universal service.

DHS sets councils a target for cases closed, which is based on the level of funding available for this service to provide 15 hours (17 in rural areas) of consultation for each case. Since 2001-02, DHS has set councils a target of 7 per cent (i.e. the number of closed cases expressed as a percentage of the total number of children aged 0-1 year enrolled in MCHS).

From 2001-06, MCHS referred an average of 6 800 cases annually to the enhanced service. The most common reasons for referrals were for physical health (20 per cent), mental health (13 per cent), isolation (9 per cent), parenting (12 per cent) and relationships (9 per cent).

Figure 3C shows that in 2002-03 and 2003-04, some 80 per cent of cases were closed, while in 2004-05 and 2005-06 this declined to about 65 per cent, although there were less cases. It also shows that the 7 per cent target has been achieved every year except 2004-05.

Figure 3C
Participation, enhanced maternal and child health service

Fiscal year	Children aged 0-1 year enrolled in MCHS	Cases	Cases closed	Cases closed	Target	Actual
	(no.)	(no.)	(no.)	(%)	(%)	(%)
2001-02	58 951	6 490	4 832	74	7	8
2002-03	59 463	7 861	6 196	79	7	10
2003-04	61 231	7 357	6 069	82	7	10
2004-05	62 044	5 776	3 750	65	7	6
2005-06	n.a.	6 930	4 428	64	n.a.	n.a.

Source: Victorian Auditor-General's Office, from Department of Human Services' data.

3.1.2 Kindergartens

Figure 3D shows DHS' participation performance indicators for kindergarten services, as well as targets and results over a 6-year period to 2005.

Figure 3D
Participation, kindergartens

Performance indicator	2000	2001	2002	2003	2004	2005
Children funded to participate in kindergarten (confirmed 1st year enrolment) (no.) - *(a)*	58 846	58 876	58 514	58 476	58 074	57 302
Participation rate (%) - *(a) (b) (c)*	94.0	93.6	94.1	95.1	93.8	94.4
DHS participation rate target (%)	92	95.4	95.4	96	96	96
Increase on previous year (%)		-0.4	0.5	1.0	-1.3	0.6
Clients satisfied with the service provided (%)	n.a.	n.a.	94.2	94.9	93.4	94.9

(a) Targets reported to parliament as part of the budget process.

(b) For this indicator, DHS uses ABS' estimated resident population (ERP) data about the previous year's 3-year old population a more accurate method than previously used (Department of Sustainability and Environment's projected 4-year old population based on the ABS' most recent census). The ERP method was first used in 2005.

(c) Participation rates achieved using the 2005 calculation method based on ABS statistics for the previous year's 3-year old population. Participation rates were recalculated for this audit and differ from those reported to parliament in the budget papers prior to 2005.

Source: Victorian Auditor-General's Office, from Department of Human Services' data.

Figure 3D shows that participation rate targets have not been met in all but one year. However, prior to 2005 the participation rates reported to parliament in the budget papers used a different calculation method and showed that participation rate targets had been met up until 2004. In 2005, DHS took a benchmark approach to setting its participation rate target instead of basing the target on the previous year's performance.

In July 2006, DHS initiated a project to investigate why its target was not being met. Preliminary results indicated that many kindergarten aged children are attending long day care centres that do not have a funded kindergarten program and, hence, are not counted.

Compared with the national average of 83.7 per cent[2], the 2005 rate was high. Victoria's high participation rate results from various strategies, including funding kindergarten places in both stand-alone services and childcare centres, having enough qualified kindergarten teachers and providing kindergartens in areas of need.

Figure 3D also shows that DHS's target for service user satisfaction of 85 per cent was substantially exceeded, with a mean satisfaction level of 94.3 per cent from 2001-04.

[2] Productivity Commission 2005, *Report on Government Services 2005*, Productivity Commission, Canberra, released 28 January 2005, viewed 6 November 2006, <http://www.pc.gov.au/gsp/reports/rogs/2005/chapter14.pdf>.

3.1.3 Childcare

The Commonwealth Government is primarily responsible for childcare services. DHS does not set participation targets for childcare services, because parents are free to choose to use services or not.

3.1.4 Conclusion

DHS' targets for access to, and participation in, MCHS are being met. Also, there has been good progress towards achieving DHS' requirement for an 8 per cent increase in MCHS attendance at 2-year and 3.5-year consultations. The targets for kindergartens are not being met, but only marginally. The participation target for enhanced MCHS is being met or substantially met.

The performance indicators reported to parliament, however, do not measure outcomes. Indicators address outputs (such as participation rates and numbers of enrolments) rather than outcomes (such as the health and wellbeing of the child). The indicators take a point in time to represent participation. Consideration could be given to indicators that better reflect actual participation over the extent of the service, for example, the percentage of children who attend 80 per cent of their kindergarten sessions or the percentage of all eligible families who join first time parent groups and then of these, the percentage that attend for more than half the group sessions.

Recommendation

3.1 That DHS reviews its performance indicators for universal services with a view to selecting indicators that monitor both progress towards outcomes and actual participation.

3.2 Service gaps

3.2.1 Identification of service gaps

Use of data to identify service gaps

To identify and manage gaps in universal service provision, DHS uses an extensive range of related data from national and statewide datasets, parent surveys, project evaluations and consultations with service deliverers (particularly in councils).

DHS also intends to survey – as part of the Victorian Child and Adolescent Monitoring System – children with a disability[3], children of recent immigrants, and children in out-of-home care; and to conduct a survey of Aboriginal children's health and wellbeing (to be piloted as part of Aboriginal Best Start). It anticipates that each survey will be repeated every 2-4 years.

[3] P Muth, *Statewide Outcomes for Children* presentation to Department of Human Services staff, Melbourne, 2006.

DHS uses statewide datasets to monitor performance against certain output indicators for children. Performance shortcomings can indicate service gaps.

DHS is also currently developing the Victorian Child and Adolescent Monitoring System (VCAMS). This system lists 35 outcomes for children, together with performance indicators to measure the outcomes. This system is referred to in *The state of Victoria's children report 2006: every child every chance*[4]. The report states that VCAMS is still being further refined and that the system will enable better monitoring and reporting against the indicators.

DHS has done extensive research to identify vulnerable children and families and to identify high-risk groups that need additional services. However, it recognises the need to collect better data on vulnerable client groups. In 2004-05, it began collecting participation data for Aboriginal clients for the key age and stage visits. DHS' Koori Early Childhood Education Program and the work of the Koori Early Childhood field officers are part of the universal service. These programs can be better targeted to the areas of need now that DHS has information on where these children attend kindergartens, and maternal and child health services.

Reviews and investigations

DHS also conducts reviews of services and investigations to identify service gaps, including the *Future directions for the Victorian maternal and child health service* report in May 2004 and its *Breaking Cycles, Building Futures* report. An internal review of kindergarten participation rates was being conducted at the time of audit.

The Commonwealth Government is currently conducting a longitudinal study that will be useful for planning state programs.

Councils have access to statewide data that could be used to identify service gaps. However, councils often had problems breaking down statewide data so that it was useful for planning universal services at the local level.

Municipal early years plans

In May 2005, DHS reviewed 36 municipal early years plans (MEYPs)[5]. The main gaps and barriers to accessing and participating in universal services were identified as:

- insufficient childcare places (increasing demand for childcare and resulting in lengthy waiting lists)
- poor access to allied health professionals (such as speech therapists and lactation consultants)
- the need to improve MCHS (the most common criticism was that the hours of operation were unsuitable for working families and insufficient MCHS staff)

[4] Department of Human Services 2006, *The state of Victoria's children report 2006: every child every chance,* Office for Children, Victorian Government, Melbourne.

[5] For more information on these plans, see Part 4.1, Municipal early years plans.

- poor public transport to the early childhood services of 12 councils (the worst being in rural and outer metropolitan areas)
- insufficient mental health and counselling services for children
- lack of indigenous and culturally and linguistically diverse (CALD) specific MCHS providers.

Survey of councils

DHS' survey of councils in early 2006[6] identified similar barriers to participation in its services (including MCHS, childcare, early intervention and family support). Councils reported that all barriers were an issue somewhere in Victoria, with some more so than others.

Inconsistent definitions of vulnerability

DHS has undertaken extensive research to identify vulnerable children and families and identified high-risk groups that merit extra servicing. DHS publishes a list of characteristics of vulnerable children and families. Services can decide that a child or family is vulnerable if they meet one or more of these characteristics. In practice, the decision on vulnerability is made by the service provider.

3.2.2 Addressing service gaps

Both DHS[7] and councils recognise the need to improve service delivery to vulnerable children and their families.

Best Start

Best Start[8] aims to address barriers to participation. For example, one Best Start project funded a bus to collect mothers and children who found it hard to travel to their local MCHS.

DHS' Family Support Innovation Projects, among other things, support vulnerable children and their families.

Memorandum of understanding with local government

DHS has used its *Memorandum of Understanding* with local government (through the municipal association of Victoria) to improve MCHS participation rates for the 2-year and 3.5-year age consultations. Most councils increased their participation rates annually for these consultations for the last 3 years, in contrast to the 2 years before when rates were either static or declining.

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[6] Department of Human Services 2006, *Overview & summary of the 2005 – 2006 MCH service improvement plans,* Department of Human Services, Victorian Government, Melbourne.

[7] Department of Human Services 2004, *Breaking Cycles Building Futures*, prepared by Brotherhood of St Laurence for Department of Human Services, Victorian Government, Melbourne.

[8] For more information on Best Start, see Part 4.2, Best Start.

Participation in kindergartens

Since 2000, the participation rate for kindergartens has been around 94 per cent. In early 2006, DHS started a project to better understand where the other 6 per cent of children were. As explained earlier, DHS identified that many of these children attend long day care centres that do not have a funded kindergarten program and so are not included in DHS' statistics.

Statewide Plan for Victoria's Children

In response to a recommendation from his Children's Advisory Committee, the Premier announced in 2004 that the government would develop a plan for Victoria's children to identify gaps and required improvements in current services. The plan – to be developed by the Office for Children and implemented in 2007 – will have 4 goals:

- better access to quality learning and developmental programs, especially those delivered in childcare settings
- a wider range of supports for parents (including vulnerable families)
- more coordinated and conveniently located children's and family services
- greater opportunities for involvement in local planning.

The plan's central principle is that early childhood services should be available to children everywhere, and be easy for them to access and use. To achieve this, the plan aims to integrate services for children aged 0-6 years and to improve local planning, coordination and access to services. Particularly, it will focus on the needs of Aboriginal and Torres Strait Islanders, refugees and newly arrived immigrants, families affected by disability, and those suffering chronic disadvantage or with complex needs (including children in out-of-home care).

DHS intends, through the plan, to address the barriers to access and participation in universal services that it has previously identified. It anticipates that some strategies will build on current initiatives (such as Best Start, children's centres, play groups for areas in need and increased funding for kindergarten children, particularly those attending long day care centres).

3.2.3 Conclusion

DHS identifies and manages service gaps using Australian and state datasets, local government feedback and project evaluations.

DHS does not use data on universal services to identify, manage and report on the access and participation of all vulnerable clients. This poor reporting for vulnerable clients is, in part, linked to the inconsistent way vulnerable clients are classified. DHS could collect better information about its vulnerable clients if it used a standard definition for vulnerable clients. It could also use information from MCHS datasets to develop strategies to increase vulnerable clients' access to, and participation in, particular MCHS areas.

The Statewide Plan for Victoria's Children will, if successful, provide a welcome mechanism for reporting to government and the public about the performance of many early childhood programs.

Recommendation

3.2 That DHS develops guidance for service providers covering the classification of vulnerable clients to improve data collection and analysis of this key group.

RESPONSE provided by Secretary, Department of Human Services

Statewide Plan for Victoria's Children

Work has progressed in relation to early childhood under the Council of Australian Government's National Reform Agenda. On 10 April 2007, the Premier, the Hon Steve Bracks, MP, released Victoria's Plan to Improve Outcomes in Early Childhood. This plan delivers on the 2004 commitment to prepare a plan for children and takes advantage of the broader context offered by the National Reform Agenda. It will provide the foundation for more detailed planning around implementation by DHS.

3.3 Reliability of participation data

3.3.1 Universal services databases

Universal service providers record client information on different databases.

Maternal and Child Health System

Data for around 120 000 clients are collected and recorded by councils. Most (61) councils use the Maternal and Child Health System (MACHS) and 14 still use manual systems. MACHS is a private sector product that records a range of information (such as client details, enrolments, participation in the 10 key age and stage visits, consultations and immunisation details).

Integrated reports and information system

Councils also collect client information for around 4 500-5 000 clients accessing the MCHS enhanced service. Ninety per cent (85) of enhanced service providers enter client information onto the Integrated Report and Information System (IRIS) developed and managed by DHS. The remaining service providers use a manual system. The database records information (such as client details, the reason for attendance), and any subsequent referrals and outcomes.

Children's services on-line system

There are around 60 000 children participating in kindergartens. Individual kindergarten centres manually complete a form that is collated by local government and then forwarded to DHS for entering into children's services on-line (CHISOL) a system also developed and managed by DHS. Information (such as anticipated and actual enrolments and attendance) is recorded on CHISOL.

3.3.2 Completeness and accuracy of data

In assessing the completeness and accuracy of the participation data processed by the 3 IT systems (MACHS, IRIS, CHISOL), we examined the data collection and validation procedures, IT[9] general controls and data security[10].

Aside from some minor weaknesses, mainly in relation to data validation, the required controls were in place and operating satisfactorily. However, there were some design limitations and inefficiencies with the databases.

Design limitations

DHS obtains participation data from MCHS centres and enrolment data from kindergarten services. As this is aggregated data, it does not identify:

- participation rates for most groups of vulnerable children
- whether participation is by the same or different children.

For example, if a vulnerable child stops attending and another child moves to the area and enrols, attendance levels will not change. However, DHS would not know about the non-attendance of the vulnerable child, or the incidence of non-attendance by vulnerable children statewide. Continued contact with the vulnerable child depends on their MCHS nurse taking action.

The MACHS field that nurses use, via a drop-down menu, to record the primary reason a child or family is vulnerable offers limited options. The menu list is not comprehensive and does not enable nurses to record specific or detailed information. Additional information can be recorded in a free-text "Notes" field, but this is difficult to analyse.

The IRIS system is for at risk clients although the primary reason for referral into this system is not recorded. This information can only be entered in the one free text field that is not readily sorted or aggregated. The CHISOL system is designed to record enrolment data and general statistics on nationality, age, gender and funding, but does not record actual participation rates. This is a derived figure based on enrolments and not actual attendance throughout the year.

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[9] Information technology (IT) controls include identifying and documenting responsibilities; staff training and support; regular auditing of compliance with procedures; and periodic review of these controls.

[10] Data security includes ensuring that systems are safe from unauthorised access; that there are password controls; and that there is an audit trail to trace data changes.

Although DHS requires the number of cases closed by the enhanced MCHS to be reported, it does not analyse how many clients are actually involved: one client may be the subject of more than one case. Thus, there is no indication of whether or not vulnerability is widespread or relates to specific interest areas (such as substance abuse) or poor parenting or both. Also, there is no measure of actions taken to encourage more use of the service by vulnerable clients.

MACHS requires reprogramming if a user wants to run a report using their chosen fields. This limits the analysis that service providers, councils or DHS can undertake (such as investigations of particular local needs that may result in changes to intervention programs or activities). The ability to interrogate all the databases is limited and DHS cannot perform simple analyses, for example, comparing postcode, failure to thrive and attendance at MCH key age and stage visits, without reprogramming.

DHS regional and local government staff advised us that there can be long delays (up to 6 months) between data entry and the availability of reports. This limits the ability of MCHS to respond to changed circumstances or local events.

Inefficiencies

Having 3 different systems that collect information about the same child (at different stages of their life) is inefficient. At present, the same data is entered repeatedly as it is transferred from paper systems, to local government systems, to DHS regional offices and finally to DHS central office. This increases costs and the risk of transcription errors, creating a greater need for quality assurance measures.

Further, a client's complete history, including the tracking of referrals and monitoring of progress, may not be accessible. For example, MCHS centres record families who move into or out of their area, but only if the family advises the centres. An MCHS nurse must manually transfer a child's information to another centre.

3.3.3 Conclusion

The participation data for MCHS and enhanced MCHS, and for kindergarten services was complete and accurate. However, the design of the databases that records this information does not adequately provide timely and accurate data about vulnerable clients either to DHS or to service providers.

It is also inefficient to operate 3 separate databases to collect information about the same child. Recording universal services data on one networked, statewide system with an improved design will create common data capture and reduce the difficulties associated with monitoring a highly mobile clientele, including vulnerable clients.

Recommendation

3.3 That DHS, in partnership with service providers, establish a common statewide database system for early childhood services across the state, including improved monitoring of vulnerable clients to assist in the development of targeted programs in local areas of need.

4 Initiatives to improve access and participation

At a glance

Background

We examined 11 councils to assess whether they had developed and implemented municipal early years plans (MEYPs) in line with the MEYP framework, and we examined how well 8 of these councils had implemented the Best Start initiative. We also assessed the extent to which these 2 initiatives and the children's centre (one centre) had improved access to, and participation in, universal services for children and families.

Key findings

- MEYPs are a valuable planning tool. Where successfully implemented, they have improved coordination, service integration and delivery, and helped optimise resource use. As preparation of MEYPs is not a statutory requirement, the level of attention given to plans by councils varied. More work is needed to identify vulnerable clients and their needs more accurately **(see page 30)**.
- Best Start was based on sound research. It improved service coordination and was generally well-managed. More attention needs to be given to vulnerable groups in terms of identifying them, servicing their needs and measuring results. The specific needs of Aboriginal communities need to be tackled at a systemic as well as local level **(see page 33)**.
- The children's centre is a success. Centralising all services in one building made it easier to participate in various programs. Services were well-integrated and their coordination improved. Centralising services has also improved access for vulnerable clients. A performance measurement and evaluation framework needs to be developed **(see page 44)**.

At a glance - *continued*

Key recommendations

4.1 That DHS, in consultation with the Municipal Association of Victoria evaluates the MEYP initiative so as to assess activity to date and identify areas for improvement, including the monitoring and review processes in municipal early years planning **(see page 32)**.

4.3 That DHS considers adopting the outcomes for children framework to measure the effectiveness of its initiatives **(see page 43)**.

4.1 Municipal early years plans

We examined 11 councils to assess whether they had developed and implemented municipal early years plans (MEYPs) in line with the MEYP framework, and whether the plans established a framework to improve access and participation.

4.1.1 Development and implementation of plans

Alignment with council plans

Seven of the 11 MEYPs were clearly aligned with local, state and national policies. Four councils had clearly aligned their plans with all their other strategic documents, and a further 6 had linked plans to their corporate planning processes.

MEYPs were required to cover children aged 0-6 years as a minimum, unlike Best Start that covered children aged 0-8. Some councils' MEYPs did include children aged 0-8 years to align with their Best Start initiative or their own early years definition. Although MEYPs cover school age children, councils did not systematically consult with the Department of Education (DoE) in all cases.

Four had clearly defined roles, as is required of plans under the Municipal Association of Victoria (MAV) framework.

Two of the 11 MEYPs had not been ratified by council, although they were well developed, clearly structured and addressed the issues. Councils that had ratified their plans were using them to guide resource allocations.

Analysis of local needs

Of the 11 MEYPs, 7 were based on thorough service needs analyses. Councils used state and local government area datasets, surveys, reassessments of existing demographic data, focus groups, literature reviews and service mapping to identify local needs. Most of these plans included specific strategies for engaging vulnerable families.

Some councils took the service needs analysis approach used in their Best Start program and repeated it across the municipality. Others also used this approach, but did not research in areas where the program had not operated.

The extent of stakeholder consultation also varied across councils. Those with Best Start programs relied on consultation networks developed for those programs or for similar Department of Human Services (DHS) programs. Some consulted with clients while others gathered information from service providers. Consultation with vulnerable families by local government requires improvement.

The extent of councils investigations was influenced by the resources they allocated and by the skill of the staff involved. A minority of the councils had comprehensive information about their early years' population and a profile of their families.

Identification of priority issues and actions

Most councils used their council plan and municipal public health plan – both of which are statutory documents – to determine goals and priorities in their MEYP. Those without a clear understanding of their community demographics had not clearly identified their priority issues.

Service coordination

Most of the 11 MEYPs we examined addressed service coordination by documenting links between services and program initiatives (such as Communities for Children, Best Start and DHS' Primary Care Partnerships). However, not all were clear on the protocols required to link services and programs together, and how these protocols would be implemented.

Monitoring and review processes

The monitoring and review processes included in 6 MEYPs required improvement. Most councils that did not directly deliver the bulk of early childhood services (except, for example, MCHS and family day care) did not have formal reporting processes and, as a result, service performance was not assessed.

Councils that incorporated their MEYP into their council plan formally reported progress against the MEYP, although in general terms.

4.1.2 Impact of municipal early years plans

Four of the 11 councils had compiled results on their achievements. One council noted a significant increase in the participation rates for the MCHS 3.5 year age and stage consultation, and considered this a result of outreach programs under their MEYP. Another minimised administration overheads by drawing together various early childhood programs into its MEYP. That plan drew on information from other programs (such as Best Start) to address issues such as engaging vulnerable clients.

Our focus groups with service users revealed that most participants considered the MEYP initiative had contributed to improving access to, and participation in, early childhood services.

4.1.3 Conclusion

MEYPs are a valuable planning tool. Where successfully implemented, they improve coordination and service integration and delivery, and help optimise resource use. Some MEYPs required review to ensure that they were consistent with the objectives of the framework.

The quality of MEYPs varied. As preparation of MEYPs is not a statutory requirement, the level of attention given to plans by councils also varied.

The best MEYPs were produced by councils that had:

- demonstrated a longstanding commitment to early childhood services
- received funding from other programs (such as Best Start or Communities for Children), that had produced useful data
- completed a comprehensive needs analysis
- established consultation processes for other initiatives.

All 11 councils had prepared a MEYP. Most stated that the MEYP process was useful as it had helped them clarify how their early years' programs best fitted together, and enabled them to make better use of their limited resources.

Better needs assessments by local government are necessary to more accurately identify their vulnerable clients. These assessments will enable service providers to develop access and participation strategies for these clients.

Recommendation

4.1 That DHS, in consultation with the Municipal Association of Victoria evaluates the MEYP initiative so as to assess activity to date and identify areas for improvement, including the monitoring and review processes in municipal early years planning.

4.2 Best Start

The audit examined 8 of the 13 councils (sites) participating in the Best Start initiative. We also examined 3 councils that were not participating in Best Start – 2 of which received Communities for Children funding from the Commonwealth Government.

4.2.1 Formulation

Policy and research basis

Best Start is one response to 2 goals in the government's *Growing Victoria Together 2001* policy statement:

- to provide high quality, accessible health and community services
- to create a fairer society that reduces disadvantage and respects diversity.

Since the inception of Best Start, 7 major relevant policy documents have been released. Best Start links to these policies and is a key vehicle for implementing them.

Best Start is based on research that shows that increasing children's exposure to various protective factors greatly increases their likelihood of becoming resilient, healthy and valued members of society.

Local government selection

DHS chose the first 5 Best Start sites in 2002 primarily on the basis that the relevant councils had shown strong interest in participating in the program. These sites had also started projects designed around the Best Start philosophy.

DHS conducted an expression of interest process for a further 6 sites in 2003. Sites were assessed against 6 criteria:

- location (aiming for diverse locations)
- birth rate (aiming for locations with high birth rates)
- current and projected population of children aged 0-8
- significant disadvantage (according to a broad range of indicators)
- capacity to undertake the project and achieve service improvement
- consistency with Best Start principles.

We examined the selection process for 4 of the 8 Best Start sites and all demonstrated a high level of need in at least one of:

- high birth rate and numbers of children aged 0-8 years
- high incidence of disadvantage
- high proportion of population considered at-risk or vulnerable.

All sites had shown that a range of local services, community resources, infrastructure and expertise was available for the project. They also demonstrated their interest and readiness to conduct programs to improve services for young children and their families, and showed that they could mobilise parents, the community and service providers to meet identified needs.

The 2 Aboriginal Best Start demonstration sites were selected through a partnership arrangement between DHS and 3 peak Aboriginal bodies: the Victorian Aboriginal Community Controlled Health Organisation, the Victorian Aboriginal Education Association Incorporated and the Victorian Aboriginal Community Services Association Limited.

4.2.2 Implementation

Partnerships

All Best Start sites we examined had formed a partnership to implement the initiative. Partnerships included representatives of DHS, DoE, parents, local government, service providers, community organisations, advocacy groups, peak organisations and other local stakeholders.

Each partnership nominated a person to manage the funds, and employed a facilitator. The facilitator's role was to mobilise local interest, nurture the partnership, provide leadership, encourage collaboration and active participation, and facilitate and coordinate implementation decisions.

The partnership had enabled the development of a shared vision, coordination of services and the conduct of useful evaluations.

The partnerships established could be improved through the increased involvement of all stakeholder agencies, including those with primary responsibility for vulnerable groups.

Roles and responsibilities

Three sites had well-documented management structures. Some relied on the facilitator to define roles and to coordinate interagency projects.

Partnerships perceived they generally operated well, and particularly when there were pre-existing good relationships. For example, when a relationship had been established between existing early childhood services or through other DHS initiatives (such as the primary care partnerships).

Two sites noted relationship difficulties that related to unclear roles and responsibilities.

Department of Human Services and Department of Education support

DHS and DoE are joint partners in Best Start, and their regional offices support Best Start partnership groups.

Most sites considered DoE's involvement to be good, however, some regions indicated that DoE's contribution could have been improved. For example, at least one site considered that DoE could have assisted by making data available for developing strategies and monitoring Best Start's effect on school children.

Five sites considered DHS' regional support to be good. All but one project facilitator had a strong relationship with their DHS regional office. At some sites, DHS undertook key partnership activities (such as drafting the action plan and preparing the evaluation report).

One non-Best Start site reported DHS regional involvement and none mentioned DoE involvement despite developing programs for school-aged children.

DHS and DoE regional officers experienced different levels of support from their agencies. Some DoE staff had extra resources and time allocated for Best Start, while others were expected to accommodate Best Start commitments into their current schedules. The latter did not attend all meetings nor contribute to the same extent as those resourced to do so.

Action plans

As required by DHS, all the sites we examined produced an action plan.

The 3 non-Best Start sites had good delivery plans that outlined community needs, program objectives, proposed strategies, and that they had a means for evaluating progress. Two of these sites had developed plans as part of their Communities for Children programs.

DHS guidelines required action plans to be based on a needs analysis. Only 3 of the Best Start sites had conducted an adequate needs analysis. Weaknesses with the other 5 plans included a lack of adequate baseline data and consultations only with service providers, not service users. In some cases, demographic data was too broad (at the municipal and state level) to be relevant to the site.

The 3 non-Best Start sites had undertaken comprehensive consultations with their communities.

Communication strategies

Best Start intends to improve participation by families who do not use services, or use them irregularly.

About half the sites examined had written communication strategies to promote their services. However, one site only promoted local government and not private service providers. Some sites used regular newsletters or weekly newspaper items to promote their programs. Others tailored communications to particular groups using verbal, written, one-on-one and group methods of communication.

DHS has prepared a communication strategy for Best Start. It includes regular newsletters, a website and seminars at key stages of the initiative.

Vulnerable families

One of the Best Start aims is to improve access for vulnerable families to universal services.

All 8 sites had acted to improve access for vulnerable families. Actions included running culturally-specific playgroups, for example an Iraqi playgroup with an Iraqi facilitator; giving parents welcome kits and Best Start show bags; building links between families living in a caravan park; organising work exchanges between maternal and child health services (MCHS) and other early childhood service providers; and running outreach programs for Aboriginal children.

One Aboriginal site relied (unsuccessfully) on elders to pass information to vulnerable families: those families were reluctant to relay their problems through the elders.

DHS guidelines do not define “vulnerable”, and sites used different definitions. Definitions varied according to locality (such as people beyond a certain distance from the service were considered vulnerable), type of project or agency (such as whether the project was education- or health-based), historical and cultural factors (such as ethnicity or migration status), and to some extent by clinical judgments (such as obesity).

The sites we examined did not establish baseline data about vulnerable clients and hence could not demonstrate whether or not Best Start had improved access for, and participation by, this group.

All the non-Best Start sites had strategies to engage vulnerable clients.

The Breaking Cycles Building Futures Project[1] was funded through Best Start. The project aimed to trial ways to better engage vulnerable clients with antenatal and universal early childhood services. The 3 sites that participated in this project had increased kindergarten enrolments and retentions, increased participation by parents and achieved greater use of MCHS. However, it also found that staff attitudes and lack of knowledge, cost, language and cultural differences were barriers to engaging vulnerable clients.

DHS’ 2004 *Aboriginal Best Start Status report* made 11 recommendations for aboriginal Best Start sites and a further 7 for mainstream Best Start sites with Aboriginal communities. The report identified barriers to access and participation by Aboriginal communities (such as cost and transport difficulties), and suggested ways to overcome them. However, some barriers can only be overcome by broader actions to overcome Aboriginal disadvantage generally.

One Aboriginal site we examined had developed strategies to overcome some of the barriers identified in the 2004 report. Six of the 8 the mainstream sites with Aboriginal communities had developed programs specifically for their Aboriginal communities. No site had baseline data for Aboriginal communities to use to monitor performance.

[1] Department of Human Services 2004, *Breaking Cycles Building Futures,* prepared by Brotherhood of St Laurence for the Department of Human Services, Victorian Government, Melbourne.

Sustainability

As the government has committed to 3-year funding for Best Start sites, plus ongoing funding of $40,000 per year for demonstration sites following completion of the initial 3-year allocation, their ongoing viability depends on them acquiring the necessary resources from other sources. Of the 8 Best Start sites we examined, 3 had a strategy to achieve funding independence. The successful programs of one had been incorporated into its local government MEYP. Another had been funded by the Commonwealth Government's Communities for Children program, although this funding also has a 3-4 year timeline. The third considered it had achieved the Best Start aims and project partners planned to continue to fund the successful new activities.

The 3 non-Best Start sites all had strategies to achieve their programs sustainability.

RESPONSE provided by Secretary, Department of Human Services

Communities for Children funding

The Communities for Children initiative was implemented by the Commonwealth Government with a methodology essentially the same as Best Start, but with a significantly higher level of funding and a focus on increased service activity. Given the different levels of resourcing available for the projects, it could be expected that sites receiving Communities for Children funding would have a greater capacity than that of Best Start sites.

4.2.3 Performance and evaluation

Performance indicators

In July 2005 DHS reviewed the Best Start indicators set. The small revisions improved alignment of the Best Start indicators with the outcomes for children framework. Figure 4A shows the 15 indicators that DHS uses to monitor Best Start performance. The indicators are grouped according to DHS' aims for Best Start for children from pregnancy through to transition to school (0-8 years) and since 2006 projects are expected to use at least 4 of these indicators.

Figure 4A
Best Start indicators from July 2005

Health and wellbeing	Learning and development or education and schooling	Safety or housing/child protection
Increased rate of breastfeeding	Increased rate of parents reading to their children	Decreased rate of re-notifications to child protection
Decreased rate of women smoking during pregnancy	Increased participation in kindergarten *(a)*	Decreased rate of unintentional injury (attendance at hospital emergency departments. for specific conditions) *(a)*
Decreased rate of children exposed to tobacco smoke in the home	Reduced absences from primary school	Proportion of children whose parents report high levels of social support
Increased rates of immunisation *(a) (b)*	Improved reading, writing and numeracy	
Increased attendance at Maternal and Child Health *(a) (b)*		
Increased rate of children who are protected from summer sun		
Increased rate of children who participate in physical activity		
Proportion of children who clean their teeth at least twice a day		

(a) Aboriginal health indicators for which DHS has specified targets.

(b) Indicators identified in DHS' Aboriginal Services Plan as being important for monitoring Aboriginal early childhood health.

Source: Victorian Auditor-General's Office.

We found that the 15 Best Start performance indicators were relevant, appropriate and fair. However, there were no indicators for children's safety or security as measured by stable and affordable housing. DHS has used them to measure trends over time and to compare the performance of different Best Start sites.

The Best Start indicators have limitations in terms of measuring outcomes, as distinct from measuring program outputs. Health behaviour is complex and good behaviour is a result of many factors, only one of which might be the Best Start project. For example, of the Best Start sites that had breastfeeding activities, some increased and others decreased their breastfeeding rate. This is not necessarily a reflection of the value of the activity or otherwise. Equally, in some communities performance indicators may have been met regardless of the Best Start activities.

DHS recognises that the Best Start indicators are general population indicators that could be supplemented with more culturally appropriate indicators where communities include Aboriginal or culturally and linguistically diverse (CALD) families. For example:

- for CALD communities, literacy in a language other than English may be culturally important to families
- in Aboriginal communities, the knowledge of Aboriginal culture by Aboriginal children may be as equally important as the population based Best Start indicators.

DHS' *Aboriginal Services Plan Key Indicators*[2] identifies 5 key indicators of Aboriginal early childhood development and growth: perinatal mortality; birth weight of babies; maternal age; immunisation coverage; and use of MCHS. Best Start sites use the last 2 indicators and since 2006 are expected to use at least 4 of these indicators. The *Aboriginal Services Plan*[3] specifies targets for all indicators: to decrease the rate of still births, infant mortality, the rate of low birth weight babies, rates of infectious diseases, the percentage of children with hearing loss and the rate of teenage mothers. Most of these additional indicators are not used to measure Best Start performance.

DHS did not specify to sites how performance data for an indicator should be collected.

Evaluations

DHS established 2 levels of evaluation (statewide and project) to assess performance of the Best Start initiative in terms of its aims.

DHS required each site to participate in the statewide evaluation and to undertake their own evaluation. DHS did not require sites to use standard indicators, but expected them to use at least 4 of the 15 statewide indicators, including at least one for each Best Start aim (health, learning and development, and safety). It also expected sites to regularly report on progress against their action plans.

Statewide, Best Start did not use quantitative data to measure access by disadvantaged people to universal services, but qualitative data (focus groups). It, therefore, does not have statistics either about all Best Start program users or about specific groups (such as vulnerable clients, clients with sleep disorders or clients with breastfeeding issues).

All 8 sites were measuring the performance of their activities. Some used their own indicators; others used the statewide indicators. Four used at least one indicator for each of the 3 Best Start aims. Two sites used local government data that was not sensitive enough to pick up local changes.

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[2] Department of Human Services 2006, *Aboriginal Services Plan Key Indicators 2004-05*, Koori Human Services Unit, Portfolio Services and Strategic Projects Division, Department of Human Services, Victorian Government, Melbourne.

[3] Department of Human Services 2004. *Aboriginal Services Plan 2004*, Koori Human Services Unit, Portfolio Services and Strategic Projects Division, Department of Human Services, Victorian Government, Melbourne.

To measure performance, some sites used anecdotal evidence of increased participation rather than participation data.

The lack of baseline data at several sites, particularly Aboriginal Best Start sites, made it difficult to measure performance over time.

There are limitations using statewide data to measure the performance of sites' activities. Councils collect statewide performance indicator data (such as breastfeeding rates) from service centres: DHS aggregates it to state level. If the Best Start activity results in changes at one or 2 sites or service centres, municipality-wide data is unlikely to show the change. Site-specific reporting would improve the capacity to measure performance.

Research indicates that children may not experience the outcomes of early childhood services until their late teen years. The (similar) United Kingdom Sure Start project had a 10-year time frame to measure its outcomes. The 13 Best Start demonstration sites were funded for 3 years. All 8 sites stated that this was too short a time frame to measure Best Start's effect. One facilitator stated that, after 3 years, it seemed like the project had only just started, considering the time needed to build relationships, change the way services were delivered and reach vulnerable clients.

Four sites had documented their evaluation process, the findings and any program modifications as a result of the evaluation.

4.2.4 Impact of Best Start

DHS conducted statewide evaluations of the 13 demonstration sites in November 2004, August 2005 and September 2006. The same methodology was used for all 3 evaluations. The evaluation also included an omnibus survey of parents of 3-year old children[4].

The evaluation results were used to improve activities at sites, to help partnerships conduct their own evaluations, and to plan and run new programs for vulnerable families.

DHS' statewide evaluations found:

- the rate of infants fully breastfed at 3 months and 6 months at some Best Start sites was greater than the state average
- at Best Start sites, participation in 3.5 year MCHS key age and stage consultations had significantly increased between 2002-03 and 2004-05
- some sites showed increases in physical activity
- nutrition had improved at 2 sites.

[4] Department of Human Services 2005, *Best Start Omnibus Survey for Parents of 3 Year Old Children*, prepared by the Best Start Evaluation Team for use in evaluating Best Start demonstration projects, Victorian Government, Melbourne.

DHS' statewide evaluations found that services need to provide their staff with professional development so they understand how to work effectively with vulnerable clients, for example, particularly in parental reading, literacy programs and cross-cultural liaison[5].

All the 8 sites we examined stated that service collaboration and cooperation had improved as a result of Best Start. At Best Start sites seeking to engage Aboriginal and CALD people, volunteers had been an important and trusted liaison point between the facilitator and the community. However, volunteers had been hard to recruit and difficult to retain, particularly in rural areas.

Service providers stated that they had increased participation with new approaches (such as providing a bus or an outreach service for people with transport difficulties).

Service providers also stated that they had successfully promoted Best Start activities through services with high participation rates (such as schools and MCHS centres) and through an outreach (such as providing MCHS at childcare centres).

In July 2006, we surveyed some 600 users[6] of early childhood services in 11 municipalities (8 with Best Start sites and 3 without) to ask if they thought service delivery had improved in the past 2 years. While most respondents from all local government areas considered it easier to access and participate in all services, a small number experienced some barriers. These were that:

- their preferred service centre could not accommodate their child
- their work commitments made it hard to find time to attend the service centre
- the service centre's hours of operation were inflexible.

Most users who were referred to other childhood services were satisfied with the referral.

Outcomes for children framework

In October 2006 DHS published *The state of Victoria's children report 2006, every child every chance*[7]. In this report the Victorian Government identified 35 aspects of the safety, health, development, learning and wellbeing of children which matter most, according to current knowledge of how children grow, thrive and succeed in the world. These are known as the outcomes for children. Some of these outcomes are about the child itself; others are about their family, their community and the services and supports available.

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[5] Department of Human Services 2005, *Best Start Statewide Evaluation Progress Report*, Department of Human Services, Victorian Government, Melbourne.

[6] In May 2006, we distributed 30 hard copy questionnaires to 22 randomly selected maternal and child health services, kindergartens and child care centres within 11 councils – 8 Best Start sites (n=513) and 3 non-Best Start sites (n=358). A total of 1980 questionnaires were posted out and a total of 871 were completed and returned. Although only 44 per cent of users were surveyed the results give an indication of user perceptions.

[7] Department of Human Services 2006, *The state of Victoria's children report 2006, every child every chance*, Department of Human Services, Victorian Government, Melbourne.

This first report provided an overview of the wellbeing of Victoria's children and young people from the antenatal period to 18 years (zero to 18 years) within an outcomes framework. This framework was developed by the Office for Children in DHS, in collaboration with the Department for Victorian Communities and DoE. DHS intends to produce annual updates of this report.

4.2.5 Conclusion

Best Start was based on sound research into early childhood development. DHS' criteria for choosing Best Start sites, and the selection of sites against the criteria, were sound.

The partnership approach has improved the coordination of services and was generally well-managed in all sites. The level of support provided to local partnerships by DoE and DHS was variable. Greater involvement by agencies with specific responsibility for vulnerable groups is necessary.

Inconsistencies in the quality of action plans were identified, particularly around the quality of their needs assessments and the quality of baseline data used.

A small percentage of sites had developed strategies to facilitate their capacity to sustain the program.

The performance measures need to be improved so that they measure Best Start site performance in engaging vulnerable families. While the indicators were not designed for Aboriginal or CALD communities, indicators and targets for Aboriginal health need to be better incorporated into Best Start.

There is qualitative evidence that access and participation has improved, however, except in 2 Best Start sites, there is very little quantitative data to support this.

The contribution Best Start has made to improving children's health, wellbeing, education and safety cannot be clearly identified using the current measures. The Best Start monitoring, assessment and evaluation framework can be improved by:

- incorporating standard performance measures to enable comparisons between sites
- using indicators that monitor local program effects rather than relying on statewide datasets and adopting culturally sensitive indicators
- ensuring baseline data is adequate
- better articulation of local and statewide evaluations.

DHS could consider the use of its outcomes for children framework to monitor the effectiveness of various programs that are run by its different sections. Specific programs (such as early years services) need to have objectives that match results that are within the timeframe and control of the particular initiative. DHS could consider the use of lead indicators that can clearly point to whether an objective is being met and hence whether the ultimate outcome for a child is likely to be achieved over time.

The lack of a consistent definition of vulnerability is leading to discrepancies in the strategies, activities, data collection and evaluation methodologies of different sites. While recognising that vulnerability may well differ from family to family and localities and localities, the term needs to be better defined.

The specific needs of Aboriginal communities need to be tackled at the systemic as well as local levels. To effect long-term change and real engagement of Aboriginal people, Best Start needs to include strategies (such as specific cultural awareness training for early childhood service providers and sponsored training programs for Aboriginal people to become maternal and child health nurses, kindergarten teachers and deliverers of early childhood services to their people). This could also include the involvement of agencies that represent specific vulnerable groups (such as the Victorian Aboriginal Child Care Agency) in the design and conduct of evaluations.

Recommendations

4.2 That DHS develops a data collection framework for Best Start that enables consistent local and statewide monitoring and evaluation.

4.3 That DHS considers adopting the outcomes for children framework to measure the effectiveness of its initiatives.

4.4 That DHS reviews its initiatives' indicators so that they measure achievements against the initiatives' objectives, particularly for improved access and participation.

4.3 Children's centres

4.3.1 Sound planning and evidence

The government's commitment to children's centres is underpinned by national and international research that shows the importance of strengthening the integration of, and collaboration between, children's services. Children's centres support professionals who previously worked in isolation by providing a ready network of peers. Centres also strengthen the capacity of professionals to identify families needing parenting support, and children at risk of intentional and unintentional harm[8].

4.3.2 Impact of children's centres

We audited one children's centre. The centre provides parents with affordable childcare and children's services. The centre also runs a pre-school/primary school transition program for children and parents. To establish the centre, DHS contributed $250 000, the Commonwealth Government $147 000. The council provided $200 000 and the land, and met project management costs.

The centre opened in February 2005 with kindergarten programs, childcare (licensed for 30 children), a 45-place pre-school, and administration for family day care, outside school hour's care and vacation care. A MCHS nurse also operates from the building. The centre also offers support and advice to families, including those with children who have additional needs.

Parents and carers told us the centre's central location and reasonable cost made it accessible, and that centralising all services in one building made it easier to participate in programs. Many families use several services. The closeness of the facilities makes the transition from day care to kindergarten and school easier. Services are well-integrated. Better coordination has resulted in a more flexible approach to service use: for example, the centre has been able to meet the needs of families for out-of-school childcare.

The centre has improved early intervention, support and monitoring of families with special needs and at risk, particularly the small number of local indigenous children. The centre has developed programs for children and carers that document the transition from being at risk to successfully dealing with issues such as the transition from pre-school to primary school.

[8] Department of Human Services 2005, *Funding for Children's Centres, Guidelines for applicants 2005 -06 funding round,* Department of Human Services, Victorian Government, Melbourne.

The centre brings together services that traditionally operated in relative isolation, and improved their profile and accessibility to the community. Families can choose from centre-based or family day care, or a combination, depending on what best meets their child's needs. This has enabled children to form relationships with the same staff over time in different services.

The centre has not formalised its aims and objectives, nor documented its expected outcomes. It does not have a monitoring, performance measurement and evaluation framework.

DHS intends to evaluate children's centres in 2007. At the time of the audit, the evaluation brief was being finalised.

4.3.3 Conclusion

The children's centre is a success, but a monitoring, performance measurement and evaluation framework that would guide a continuous improvement program needs to be developed. Such a framework would also enable the precinct to better identify and respond to changes in community demographics. The centre's sustainability relies on continuing demand for early childhood services, and on the capability of the local government and centre staff to keep the centre responsive to community needs.

Recommendation

4.5 That DHS uses its proposed evaluation of children's centres to develop a performance measurement framework.

Appendix A. Audit approach

What did we do?

We examined whether 3 key government initiatives, namely, Best Start, municipal early years plans and children's centres, were improving families' access to, and participation in, universal early years' services (maternal and child health, and kindergartens). We also examined whether the data that the Department of Human Services (DHS) uses to report on participation rates, in early years programs, was complete and accurate.

The audit did not evaluate the quality of early childhood universal services, nor did it cover specialist services, child protection services or other specialised family support services (secondary and tertiary services).

We asked 3 questions:

- Is the number of children and families accessing and participating in universal early childhood services meeting government policy objectives?
- Have the key factors that affect access and participation in universal early years childhood services, particularly for vulnerable families, been identified?
- How well have recently implemented state and local government programs and initiatives aimed at improving access and participation in early childhood universal services been formulated and implemented?

Method

We examined DHS' documentation and files and interviewed key staff about the initiatives. We visited both central and regional DHS offices and the Municipal Association of Victoria where we interviewed staff and examined documentation.

We visited 12 local government councils in total and interviewed staff: 8 participating in the Best Start initiative, 3 which were not and one council that had successfully received funding under the Children's First initiative to develop a children's centre. The councils were in metropolitan and rural regions. These were:

- Baw Baw Shire Council
- Frankston City Council
- Greater Shepparton City Council
- Horsham Rural City Council
- Hume City Council
- Swan Hill Rural City Council
- Wellington Shire Council

- Yarra Ranges Shire Council
- East Gippsland Shire Council
- Greater Bendigo City Council
- Yarra City Council
- Shire of Northern Grampians.

We also surveyed families who were using kindergarten, maternal and child health services and childcare centres within 11 local government councils.

Maribyrnong City Council assisted in the piloting of the fieldwork tool.

Assistance to the audit team

We consulted with a wide range of people and organisations to obtain information about the issues related to access and participation in universal services:

- central and regional offices, Department of Human Services and Department of Education
- peak bodies, including the Centre for Excellence in Child and Family Welfare (formerly the Children's Welfare Association of Victoria) and the Victorian Aboriginal Child Care Agency
- Municipal Association of Victoria
- Kindergarten Parents Victoria
- Community Child Care Association
- Centre for Adolescent Health, Royal Children's Hospital
- local government
- academics and researchers in the early childhood field.

Audit assistance

Specialist support was provided by:

- reference committee, comprising Professor Dorothy Scott, Director, Australian Centre for Child Protection, University of South Australia; Ms Pam Stilling, Early Parenting Consultant and Educator; and Ms Muriel Bamblett, Chief Executive Officer, Victorian Aboriginal Child Care Agency
- Impact Consulting Group, which visited the 12 councils to conduct focus groups with those who had experienced early childhood services, and reviewed all associated documentation
- the Australian Survey Research Group, which analysed the responses of the survey questionnaire completed by families using early childhood services in the 12 different council areas.

We thank all those involved in the audit and found their contributions most valuable, particularly the officers from DHS' Office for Children.

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