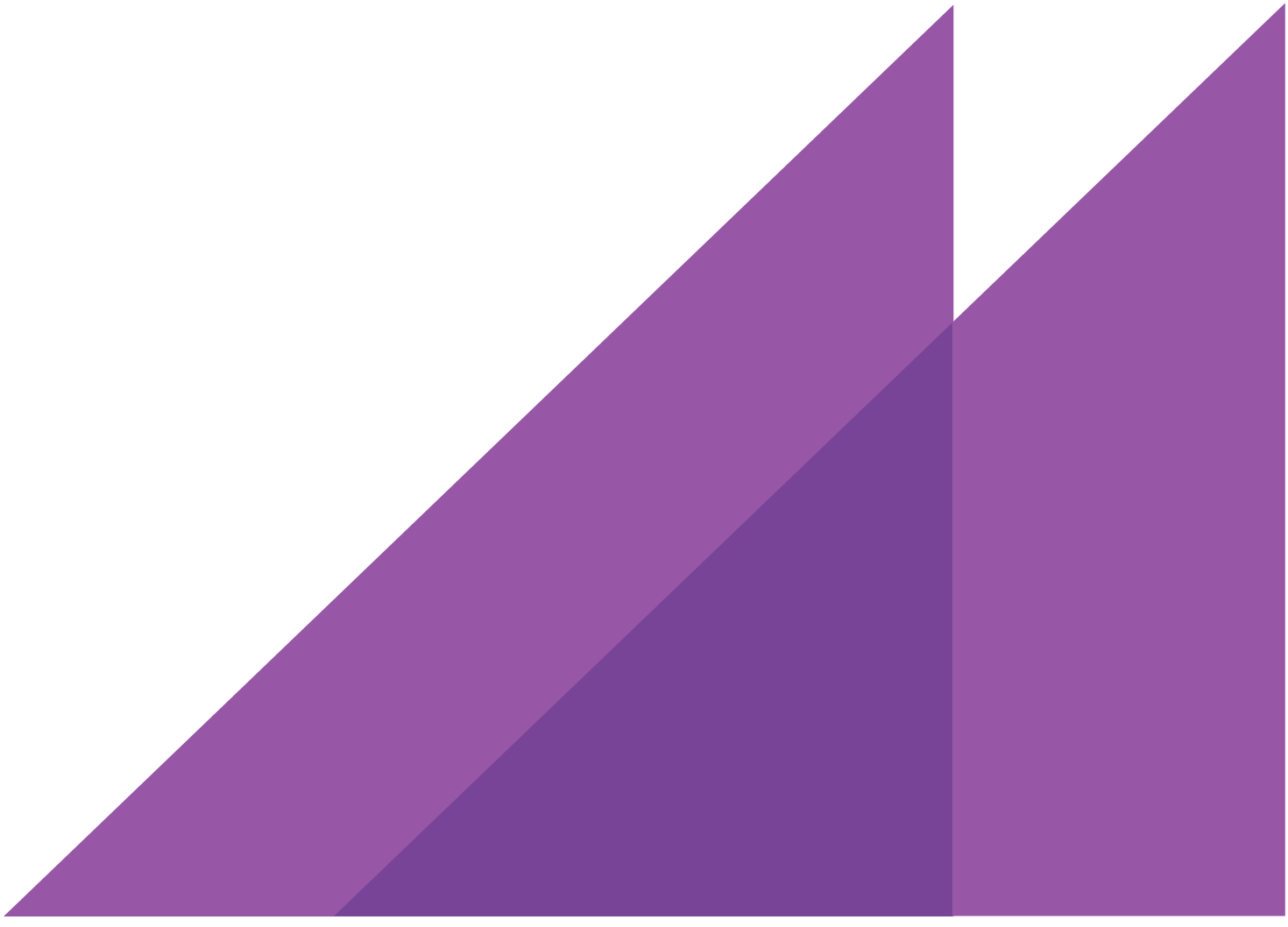
REPORT TO
DEAKIN STRATEGIC CENTRE FOR SOCIAL AND EARLY EMOTIONAL DEVELOPMENT AND THE DEPARTMENT OF EDUCATION AND TRAINING
26 APRIL 2019

EVALUATING THE IMPLEMENTATION OF THE TODDLER DEVELOPMENT INSTRUMENT

IMPLEMENTATION REPORT (INTERIM)



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1 EVALUATION CONTEXT

1.1 Project overview

ACIL Allen Consulting (ACIL Allen) has been engaged by the Strategic Centre for Social and Early Emotional Development at Deakin University (the University) and the Department of Education and Training (DET, the Department), oversighted by the Comprehensive Monitoring Project (CMP) committee, to evaluate the implementation of the Toddler Development Instrument (TDI) in selected sites in Victoria.

The implementation of the TDI is being undertaken by an implementation team, principally comprising the Department, University and the Social Research Centre (SRC). The Department is managing the project on a day-to-day basis and will be the initial point of contact for ACIL Allen inquiries and requests.

1.2 Background

Comprehensive monitoring seeks to systematically capture and connect knowledge about children and young people's development at key points in their lives.

The importance for communities is to understand whether children and young people are making progress and whether efforts and supports are in place to optimise outcomes across the developmental years. It recognises that every age and stage of development matters and that family and community environments play a central role in promoting positive development.

The TDI marks one of the earliest stages of development, defined by toddlerhood, and was designed by a team of researchers at the Human Early Learning Partnership (HELP) at the University of British Columbia, Canada. The TDI is completed by parents/primary caregivers of 16-20 month old children. The TDI asks a range of questions related to numerous factors that influence early child development, such as daily routines, family-child interactions, and available parental/caregiver and community supports. The purpose of the TDI is to better understand the needs, early life experiences, and social contexts of toddlers and their families. This information can then be used to build and strengthen resources and support systems for families and communities.

In 2015, an early feasibility trial of the TDI was undertaken through the Victorian Maternal and Child Health (MCH) services in two locations, Frankston and Warrnambool. The feasibility trial was supported by an advisory group of local and international experts including A/Professor Martin Guhn from HELP at the University of British Columbia. The findings from this feasibility trial were distributed and discussed with the advisory group and were used to inform the current implementation evaluation strategy for the TDI.

The TDI has been designed to fill a data gap, by collecting systematic social context data relevant to children's development during the early years. The TDI is also part of a broader approach to comprehensive monitoring and will initially link with other surveillance activities being undertaken in later childhood and early adolescence, in particular, the Australian Early Development Census (AEDC) at entry to school (5 years of age), and the Middle Years Development Instrument (MDI) at 10 to 14 years of age. Together these three universal monitoring tools provide a core mechanism to understand development from early childhood into early adolescence.

1.3 Objectives of the TDI trial

The TDI trial examines the TDI as a means of addressing key gaps in the current monitoring system of child development in Victoria.

The project has three primary objectives:

1. establish a reliable protocol for using MCH, Immunisation, Supported Playgroup and "Gathering Place" visits to achieve a 90 per cent response rate on the TDI
2. establish methods for online and in person data collection as well as methods of data visualisation that enhance community, understanding, engagement and use of developmental profiles obtained from the TDI
3. undertake comprehensive evaluation of all aspects of project implementation from commencements to completion, including key learnings from initial project design through to data collection, data presentation, and community uptake and engagement.

The TDI research protocol[1] outlines how the study will be conducted and evaluated to answer the research questions, and ensures clarity in the method, analysis and reporting.

Under the approach, recruitment of families occurs through a three-tiered approach to recruit participants, namely through:

- family attendance at the 18-month MCH Key Age and Stage (KAS) appointment[2]
- family attendance at immunisation clinics
- family attendance at supported playgroups.

The TDI trial is occurring in five participating areas in Victoria: East Gippsland, Greater Frankston, Mallee (3 councils), Wimmera/Southern Mallee (5 councils) and Greater Warrnambool. In each of the five areas, data were collected over a 6-month period from June to December 2018 to achieve a 90 per cent response rate at each site. Parents/ caregivers of children are invited to complete the TDI for a child between 16-20 months of age.

Following the data collection, communities will receive and be engaged with results from the TDI to support service and community activity and planning. This will occur from early to mid-2019.

1.4 Evaluation purpose and approach

ACIL Allen has been contracted to conduct an external evaluation of the implementation of the TDI. The key evaluation questions are:

- *Is it possible to implement a universal monitoring system in toddlerhood (16-20 months of age)?*
- *Was the TDI implementation framework implemented effectively and efficiently?*
- *Did the TDI implementation framework achieve its intended benefits?*
- *What changes are required in scaling-up the TDI implementation framework across communities?*

The evaluation is guided by an evaluation plan and framework and follows two main implementation stages:

- *Part 1* – evaluation of the nurse experience in preparing for and implementing the TDI, including enablers and barriers to the achievement of 90 per cent participation. This was completed in 2018.

[1] Olsson, C. & Watkin Nolan, C (2018) PROTOCOL - Trial of the Toddler Development Instrument (TDI) - For monitoring children's early experiences in family and community environments; HREC Number: 37323; Version: 1; Date: 17/01/2018

[2] Victoria's MCH service provides ten Key Ages and Stages (KAS) consultations for children from birth through to three and a half years of age. A KAS framework sets out evidence-based activities for each of the ten KAS visits.

— *Part 2* – evaluation of the achievement of intended benefits including the engagement of communities with results, the requirements for scaling up across communities, and the feasibility and benefits of including the TDI at the Victorian 18-month MCH Key Ages and Stages visit.

1.5 Report purpose and scope

This *Implementation Report* has been prepared to examine the achievements and experiences in Part 1 of the TDI trial (i.e. data collection in the five sites). It builds on the *Implementation Update* report (September 2018) which examined the early implementation experiences of TDI sites.

Report overview

This report provides the implementation team with an outline of:

— an overview of the implementation model for Phase one, changes to implementation in Phases two and three, and the implementation experience of sites across phases (refer ***Chapter 2***)

— analysis of TDI completions across sites, modes and settings (refer ***Chapter 3***)

— enablers and barriers to implementation drawing on site experiences (refer ***Chapter 4***)

— opportunities raised by stakeholders and arising from the analysis to improve TDI implementation in preparation for scaling up TDI data collection (refer ***Chapter 5***)

— next steps for the evaluation (refer ***Chapter 6***).

Report data sources

The report draws on data and experiences post the final TDI data collection in mid-December 2018 and incorporates information from three main data sources:

— consultations with community leaders and MCH managers from the five implementation sites at the early-mid point (Week 12-15) of the evaluation and post the mid-December 2018 end point of TDI data collection

— an electronic survey completed by 15 nurse facilitators at the early-mid point of the evaluation (with 15 nurse respondents) and post TDI data collection (with 15 nurse respondents)

— an interview with DET staff on implementation activities

— data updates from TDI progress reports through to the end of collection.

Further evaluation activities and reporting

Further evaluation activity will occur during the first half of 2019 (Part 2) in line with the evaluation plan and framework.

A final evaluation report will be prepared in mid-2019 covering Parts 1 and 2 of the TDI trial.

2 IMPLEMENTATION PHASES AND SITE EXPERIENCES

This Chapter provides an overview of the implementation activities for the TDI trial data collection across phases and the implementation experience of sites. TDI collection was undertaken between mid-June 2018 (Week 1 of collection) through to mid December 2018 (Week 27 of collection).

2.1 Phase one implementation

Phase one was the original implementation approach to data collection. Phase one of implementation occurred from mid-June 2018 to the end of September 2018 (Week 15 of collection).

2.1.1 Implementation model for Phase one

An implementation model is a conceptual view or description of how component parts are intended to work together in delivering a service or product. The TDI implementation model is summarised in Table 2.1, including the roles of the central TDI implementation team, nurse facilitators and families.

As a starting point, the central TDI Team is responsible for planning and distributing the TDI. Site coordinators (typically a nurse manager) in larger sites coordinated the distribution of TDI surveys to nurses. Nurse facilitators promote the TDI in the community and specifically invite parents to complete the survey. Under the implementation approach, families review, complete and return the TDI. Finally, the central TDI Team receives TDI surveys (in paper or online) and monitors completion. Each step is critical in the implementation model to achieve the goal TDI response rate.

TABLE 2.1 TDI DISTRIBUTION AND COMPLETION PROCESS

	STEP 1 ->	STEP 2 ->	STEP 3 ->	STEP 4
Lead	**Central TDI Team (DET, SRC)**	**Site coordinators and nurse facilitators**	**Families**	**Central TDI Team (SRC, DET)**
Main activities in each step	– Plan and coordinate TDI distribution – Distribute TDI to sites in paper or as an online survey – Ongoing DET and SRC support for implementation	– Coordinate TDI distribution to nurses – Promote TDI to families and community – Invite families to complete the TDI, explaining the purpose and voluntary nature of participation	– Review, complete and return the TDI – Nurses may facilitate completion in some instances	– Receive TDI surveys and monitor completion

SOURCE: ACIL ALLEN, 2019

2.1.2 *Implementation Update* report and options to adapt implementation

As part of the evaluation, an *Interim Update* report was prepared at the early-mid point of implementation.

Consultations at this time examined survey completion rates and site experiences. Overall, the number of completions was low relative to the expected response rates. The update report identified potential barriers and corresponding opportunities to enhance uptake, including:

- Continuing to utilise nurse knowledge in engaging families by providing facilitators the flexibility to integrate TDI distribution within their day-to-day business.
- Creating opportunities for nurses to more directly facilitate TDI completion, including development of a TDI format which could be facilitated by nurse facilitators during appointments, such as: building it into the KAS visit at 18 months; reducing the length and complexity of the TDI; and improving acceptability of the TDI to families by making its appearance more family friendly and allowing families to choose whether they provide personal details for linkage purposes.
- Supporting access to resources that assist implementation, such as: authorisation to use MCH time to facilitate completion of the TDI, providing access to iPads across communities, and more resources/ materials to engage immunisation nurses or playgroups.
- Improving feedback loops for nurse facilitators in relation to TDI completion, including data that assists nurses to understand groups that have not completed surveys to enable further promotion.
- Sharing examples of best practice implementation between communities to enhance understanding of practice across sites, particularly what is working well.

2.2 Phases two and three

In response to lower than expected TDI completion rates and insights to implementation barriers, the implementation team examined potential adaptations to the Phase one implementation approach. As a result, two new approaches or phases were designed and implemented to understand their impact:

- Phase two retained the 'TDI distribution and completion process' as described in Figure 2.1 with some adaptations, including:
  - *An optional shorter survey* – the shorter survey comprised 37 items, reduced from 59 items, to encourage completion in-service, such as through nurses reading questions aloud and the parent/caregiver completing the survey.
  - *Survey re-organisation* – collection of personal information was placed is at the end of the survey and details, such as name and address, made optional
  - *Greater site support from DET* – DET increased site support to include checking in more regularly to provide local up to date participation information, collecting feedback and responding to inquiries and discuss challenges.
- Phase three altered the 'TDI distribution and completion process' such that external researchers facilitated survey completion directly with parents during immunisation visits.

The characteristics of the different phases are described in Table 2.2. Phase two was introduced at the beginning of October 2018 (Week 16 of collection) and Phase three in November 2018 (Week 22 of collection). Two sites used the full survey only in Phase two. Three sites chose to pilot the shorter survey in addition to the full survey as part of Phase two. Further, there was nested application of Phase three activities in Frankston using the shorter survey during November 2018 only.

TABLE 2.2 TDI IMPLEMANTATION: CHARACTERISTICS OF PHASES ONE, TWO AND THREE

	Phase one	Phase two	Phase three
Overview of approach	*Full survey with base level of site support (June – Sept 2018)*	*Shorter survey option and additional site support (Oct – Dec 2018)*	*Full survey delivered by external researchers (Nov 2018)*
Site participation	All five sites	All five sites – full survey Three sites – shorter survey	Frankston only
Survey mode	Paper, SMS link, iPad	Paper, SMS link, iPad	iPad

	Phase one	Phase two	Phase three
Survey length	59 items	59 items or 37 items	37 items
Survey coordination	Sites	Sites	Sites and researchers
Survey distribution	Mainly MCH nurse, some immunisation nurse and / or playgroup facilitator	Mainly MCH nurse, some immunisation nurse and / or playgroup facilitator	External researcher / facilitator
Survey distribution timing	In advance of MCH visits, in-service for completion, or in-service for later completion	In advance of MCH visits, in-service for completion, or in-service for later completion	In-service (immunisation visit)
Survey completion	Parent Parent with Nurse / Facilitator	Parent Parent with Nurse / Facilitator	Parent with external facilitator
Monitoring and support from DET	Monthly completion statistics and responses to questions	More frequent completion statistics, coaching, sharing best practice and FAQs	Site updates

SOURCE: ACIL ALLEN, 2019

2.3 Implementation experience of sites across phases

Consultations with site coordinators and nurse surveys were undertaken at the early-mid point of implementation and post collection. Feedback from sites provided insights to implementation experiences.

Valuing the TDI

MCH site coordinators and nurse facilitators are engaged with, and value, the TDI. Sites were asked what they see as the purpose of the TDI and why they are participating in the TDI implementation. MCH nurse managers stressed the importance of data from the TDI, and how it could be used to support their community in future. This included benefits of:

- having data that can be shared with their community on the development of young children
- using the data to understand which services families are using (or not using) and whether families in their local area had service needs that were not being met
- connecting the data with the AEDC and MDI to build a comprehensive picture of children in the community.

Through the surveys, 90 per cent of nurses indicated that the TDI was 'very valuable' or 'somewhat valuable' for their community both in the early-mid point and post collection nurse surveys.

Site coordination and preparation

MCH site coordinators reported that they generally use the 18-month MCH visit to determine eligibility and promote the survey. Sites reported using scheduled 18-month KAS appointments to determine eligibility (if a child was up for the appointment, they would be provided with the survey). Information systems were also used to identify families to be provided with the survey. For example, in one site a list of children within the age range was extracted from their Child Development Information System (CDIS) and shared across the team either weekly or fortnightly in advance of the scheduled visit. Generally, families were introduced to the survey and provided with the survey at the appointment. Distribution of the TDI in immunisation sessions occurred mainly in Frankston and Warrnambool. Promotion of the TDI through playgroups with MCH nurse facilitators attending playgroups in East Gippsland and Warrnambool.

The additional support by DET as part of Phase two was well received. For the second half of the collection, sites noted that greater support through phone discussions, visits and information bulletins was positive and beneficial. The extra support provided opportunities to ask and resolve questions and gain insights to the practice and experience of other communities. The support enabled more

open communication and was seen to address several areas of feedback at the early-mid point consultations. Sites also reported that the encouragement assisted to stay optimistic and motivated, particularly when reports of completion rates weren't as high as anticipated.

TDI distribution to families

Sites reported that their approach to distributing the survey was aligned to local context and resourcing. In Phase one, smaller regional LGAs used the paper version of the full survey (e.g. Buloke, Gannawarra, Hindmarsh, West Wimmera, Yarriambiack), while larger and medium-sized sites also used hard copy surveys but in conjunction with online channels. Large and medium-sized sites had more online completions and completions undertaken outside of MCH centres. In Phase two, the additional shorter survey was adopted by three communities in combination with their current approach, though smaller regional LGAs generally continued to use the paper version of the full survey as their main approach. Sites reported that the Phase two shorter survey provided an additional option, particularly that was more feasible to use in the KAS visit. However, sites also reiterated the value of having different modes which could be used depending on the circumstance.

Nurse confidence to distribute the TDI improved over time. The survey of nurse facilitators found that most nurses (approximately 50 per cent) felt 'somewhat ready', 30 per cent 'not at all ready' and 20 per cent indicated that they were 'ready'. Nurses reported increased confidence in talking to families about the TDI increased with 50 per cent indicating they were 'Confident' at the early-mid point nurse survey, rising to 80 per cent in the post collection survey.

However, nurses reported limited discussion with families about TDI responses. At both the early-mid point survey and the post collection survey approximately 20 per cent of nurses indicated that they 'sometimes' or 'always' discuss the results with families, and a similar percentage reported that they 'sometimes' or 'always' connect families with services in response to TDI results. The majority (80 per cent) of nurses indicate that they 'never' discuss the results with families or connect families with services in response to TDI results. This is likely to arise mainly as a result of TDI surveys being completed outside of the KAS visit or from limited time for nurse interaction during the KAS visit.

2.4 Summary

TDI collection was undertaken between mid-June 2018 (Week 1 of collection) through to mid December 2018 and involved three collection approaches or phases.

The Phase one collection model required distribution of the TDI by nurses and completion and return by parents. The approach was adapted in response to emerging understanding of lower than expected TDI completion rates. Phase two retained the core distribution and completion model, while providing an optional shorter survey for completion and greater site support from DET. All sites continued to use the full TDI survey, while three sites additionally used the shorter survey. A third phase involved external researchers facilitating survey completion directly with parents during immunisation visits in the Frankston site. TDI survey completion is discussed in Chapter 3.

Site consultations and feedback through a facilitator survey indicated that MCH site coordinators and nurse facilitators are engaged with, and value, the TDI. MCH site coordinators reported that they mainly used the 18-month MCH visit to determine eligibility and distribute the TDI to parents. Sites also distributed the TDI according to local context and resourcing. For example, smaller regional LGAs used the paper version of the full survey, while larger and medium-sized sites also used hard copy surveys but in conjunction with online channels. The additional site support provided by DET in Phase two was well received and assisted with site coordination and engagement.

In the survey responses, nurses indicated that their confidence to distribute the TDI to parents improved over time. However, nurses reported limited discussion with families about TDI responses.

TDI implementation enablers and barriers are discussed in Chapter 4.

3 SURVEY COMPLETIONS

This chapter provides an analysis of TDI completions across sites, modes and settings.

3.1 Survey completions

Overall survey completions

Overall, 349 surveys were completed during the 27 week collection period. The number of completed surveys by site is presented at Table 3.1.

The largest completion site was Frankston with 131 surveys completed, representing 38 per cent of all completed surveys. The next largest completion site was Wimmera Southern Mallee with 65 surveys completed (19 per cent of all completed surveys) which was a significant result as Horsham, the largest community in the Wimmera Southern Mallee, commenced only in October 2018. At the time of writing, seventeen completed surveys (five per cent of all completed surveys) did not have sufficient detail to be attributed to a site.

TABLE 3.1 NUMBER OF COMPLETED SURVEYS BY SITE

Site	Entire collection	Phase one	Phase two
TOTAL	**349**	*159*	*190*
East Gippsland	**43**	*7*	*36*
Frankston	**131**	*76*	*55 (includes Phase 3 data)**
Swan Hill, Buloke, Gannawarra	**54**	*24*	*30*
Warrnambool	**39**	*9*	*30*
Wimmera Southern Mallee	**65**	*32*	*33*
Unknown site	**17**	*11*	*6*

NOTES: EIGHT SURVEYS WERE COMPLETED AS PART OF PHASE THREE

SOURCE: DET TDI WEEK 27 TDI PROGRESS REPORT, 2019

Survey completions by phase

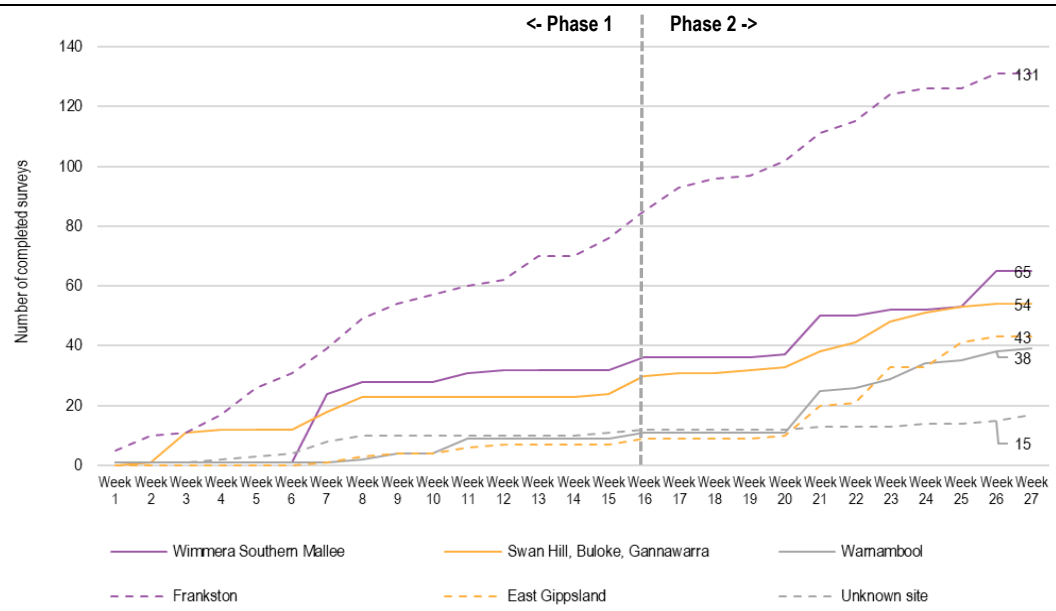
The cumulative build-up of completions by site is summarised in Figure 3.1. Phase one is the period to the end of September (Week 15) of collection and Phase two commenced at the beginning of October 2018 (Week 16 of collection), while Phase three was a nested activity in the Frankston site and occurred in November 2018.

Some uplift in completion occurred in the first week pf Phase two, and overall, the number of completions during Phase one (weeks 1-15) was 159 surveys and during Phase two (weeks 16-27)

was 190 surveys (including eight Phase three surveys). Phase two growth can be seen particularly in East Gippsland and Warrnambool, while other sites showed similar completion numbers between Phases one and two.

As part of Phase three, immunisation visits were attended by external researchers on five occasions. During these collections, approximately 60 families attended these clinics, but only eight were eligible (i.e. had a toddler aged 16-20 months). All eligible families approached to do the TDI as part of this phase completed the survey.

FIGURE 3.1 NUMBER OF COMPLETED SURVEYS BY SITE, OVER TIME



Note: Frankston commenced on the 8th of June, figures have been rolled into week 1. All paper copies and data allocated to site and mode appear in week in which data entry occurred. Unknown refers to surveys that could not be allocated to a site based on the child's address.

SOURCE: DET TDI WEEK 27 TDI PROGRESS REPORT, 2019

Thirty-two families[3] through the online mode had been identified as commencing the survey but did not complete it. Through the online mode of the TDI it is possible to see the question at which families drop out when they do not complete the survey. Of the families who did not complete the survey, most drop out early. Forty-seven per cent discontinued when asked their child's name and date of birth, and a further 22 per cent discontinued when asked for their address. In Phase two, the online survey was amended in Phase two to move these questions to the end of the survey.

Mode of completion by site

Five modes were used for survey completion – the full length paper version and four online modes (via Flyer, SMS / email, Local website, online KAS Short version survey).

The mode used to complete surveys, by phase is shown in Table 3.2. The most common mode of completion was the paper-based full version of the survey, representing 157 surveys completed (45 per cent of all completions). SMS / emailed survey links were the next most common with 74 surveys completed though most were completed by this mode in Phase one.

TABLE 3.2 NUMBER OF COMPLETED SURVEYS BY MODE

Site	Entire collection	Phase one	Phase two
TOTAL	**349**	**159**	**190**
Flyer	**45**	17	28
SMS / email	**74**	62	12

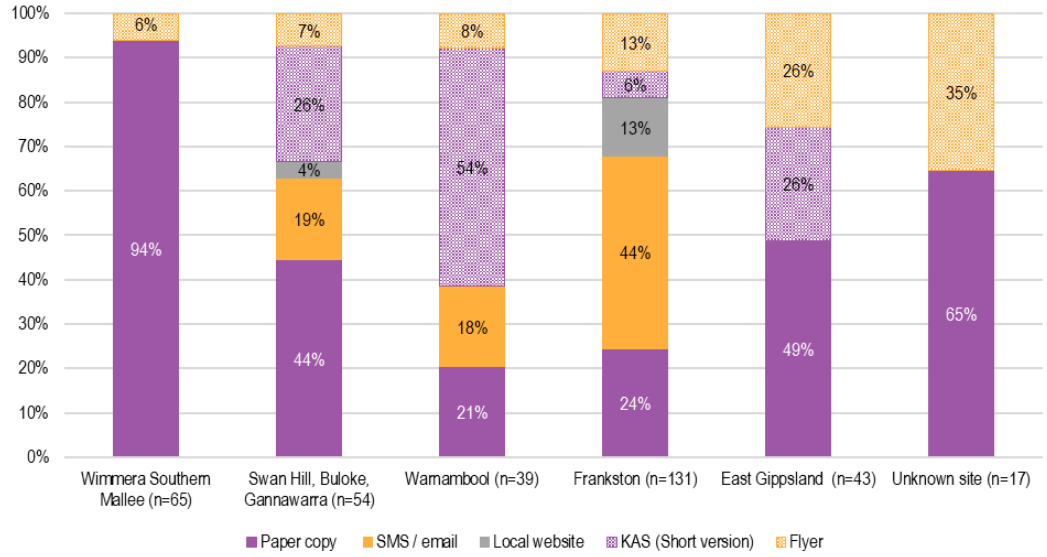
[3] This represents 14 per cent of the surveys that were commenced online (i.e. 192 completions (Flyer, SMS / email, Local website, KAS (Short version) and the 32 surveys that were commenced but not completed).

Site	Entire collection	Phase one	Phase two
Local website	**19**	11	8
KAS (Short version)	**54**	n/a	54 *(includes Phase 3 data)**
Paper copy	**157**	69	88

NOTES: EIGHT SURVEYS WERE COMPLETED AS PART OF PHASE THREE
SOURCE: DET TDI WEEK 27 TDI PROGRESS REPORT, 2019

The mode used to complete surveys, by site, is shown in Figure 3.2. From this data, and aligned to the implementation method of sites, paper-based completions were preferred in Wimmera Southern Mallee. Online completions (flyer, SMS / email, website, shorter version) were prominent in medium-sized and large LGAs, particularly Frankston (76 per cent of surveys completed) and Warrnambool (79 per cent of surveys completed).

FIGURE 3.2 MODE OF SURVEY COMPLETIONS BY SITE



Note: Frankston commenced on the 8th of June, figures have been rolled into week 1. All paper copies and data allocated to site and mode appear in week in which data entry occurred. Unknown refers to surveys that could not be allocated to a site based on the child's address.
SOURCE: DET TDI WEEK 27 TDI PROGRESS REPORT, 2019

Setting of completion by site

Surveys could be completed in different settings including, the MCH Centre, At home, Immunisation clinic, Playgroup, GP clinic, or other (e.g. any location on a mobile device).

The setting in which surveys were completed is shown in Table 3.3. The most common setting for completion was at home, representing 180 surveys completed (52 per cent of all completions) followed by the MCH centre with 119 completions (34 per cent) showing growth in Phase two.

TABLE 3.3 NUMBER OF COMPLETED SURVEYS BY SETTING

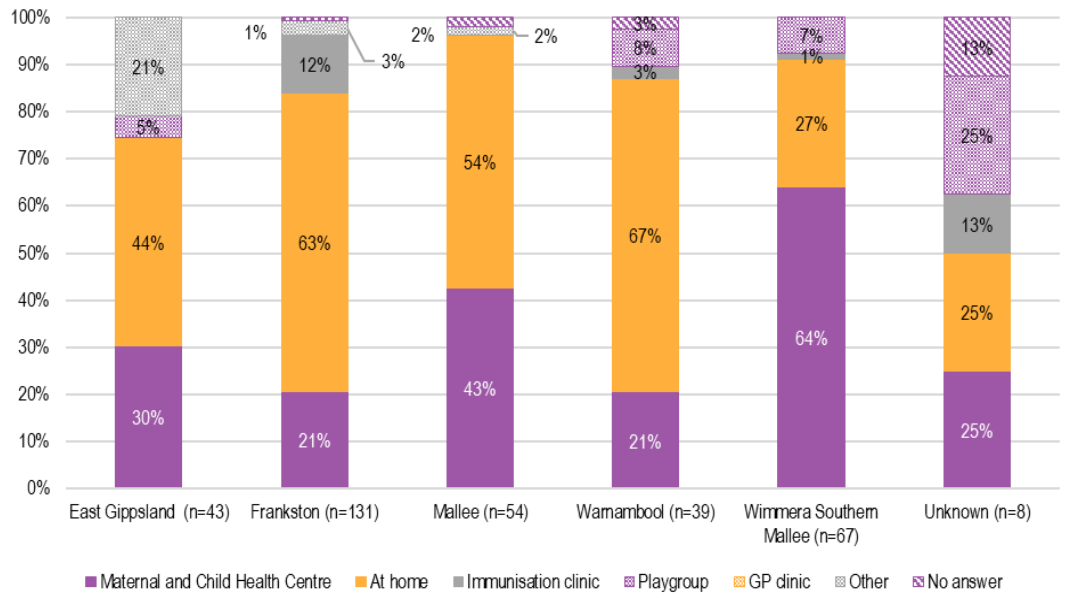
Site	Entire collection	Phase one	Phase two
TOTAL	**349**	**159**	**190**
Maternal and Child Health Centre	119	45	74
GP clinic	0	0	0
Immunisation clinic	20	7	13 *(includes Phase 3 data)**
Playgroup	12	6	6

Site	Entire collection	Phase one	Phase two
At home	180	96	84
Other	14	4	10
No answer	4	3	1

NOTES: EIGHT SURVEYS WERE COMPLETED AS PART OF PHASE THREE
SOURCE: DET TDI WEEK 27 TDI PROGRESS REPORT, 2019

The settings where surveys were completed is outlined in Figure 3.3. While most surveys are completed at home, the completion location differed for Wimmera Southern Mallee where completions primarily occurred at the MCH Centre. Completion of the survey at immunisation clinics was low overall, with some higher uptake observed in Frankston, likely due to Phase three implementation. Completions in playgroups occurred in Wimmera Southern Mallee, Warrnambool and East Gippsland.

FIGURE 3.3 LOCATION OF SURVEY COMPLETIONS BY SITE AND SETTING



Note: Frankston commenced on the 8th of June, figures have been rolled into week 1. All paper copies and data allocated to site and mode appear in week in which data entry occurred. Unknown refers to surveys that could not be allocated to a site based on the child's address. Data provided for the 'location of completion by site' differs from 'mode of completion by site' for the Wimmera Southern Mallee and the Unknown categories.

SOURCE: DET TDI WEEK 27 TDI PROGRESS REPORT, 2019

3.2 TDI survey completion rates

A key metric for the trial is whether a representative proportion of the population completes the survey to enable population-level reporting. The initial benchmark to ensure the adequacy for reporting is that 90 per cent of intended population have completed the survey in the community.

For the trial, the total population is defined in three ways:

- *Projected population* – the number of children expected to be in the target age of 18-20 months in the community based on forward projections of birth records
- *Presenting population (nurse reported)* – the number of children in the target age of 18-20 months for the community based on nurse reports for KAS visits
- *Presenting population (database recorded)* – the number of children in the target age of 18-20 months for the community based on data entered into MCH information systems.

Completion rates reflect the number of surveys completed as a proportion of the population that were expected to have completed the survey by Week 27 based on the three methods of understanding the intended population described above. At the time of preparing the report, data for completion rates was being collated. Completion rates will be added and discussed as part of final reporting.

3.3 Summary

Overall, 349 surveys were completed during the 27 week collection period. The largest completion site was Frankston with 131 surveys completed, representing 38 per cent of all completed surveys. The next largest completion site was Wimmera Southern Mallee with 65 surveys completed (19 per cent of all completed surveys).

One hundred and ninety TDI surveys were completed in Phase two (including eight Phase three surveys) in contrast with 159 TDI surveys being completed Phase one. Phase two growth was seen particularly in East Gippsland and Warrnambool.

Five modes were used for survey completion – the full length paper version and four online modes (via Flyer, SMS / email, Local website, online KAS Short version survey). The most common mode of completion was the paper-based full version of the survey, with 157 surveys completed (45 per cent of all completions). SMS / emailed survey links were the next most common with 74 surveys completed though this mode dropped off substantially in phase two. Paper-based completions were preferred in Wimmera Southern Mallee and online completions were prominent in medium-sized and large LGAs.

Surveys could be completed in different settings including, the MCH Centre, At home, Immunisation clinic, Playgroup, GP clinic, or other (e.g. any location on a mobile device). The most common setting for completion was at home, representing 180 surveys completed (52 per cent of all completions) followed by the MCH centre with 119 completions (34 per cent) showing growth in Phase two. Frankston was the main site in which surveys were completed in immunisation clinics. Completions in playgroups occurred in Wimmera Southern Mallee, Warrnambool and East Gippsland.

The enablers and barriers to TDI implementation are discussed in Chapter 4.

4 IMPLEMENTATION ENABLERS AND BARRIERS

This chapter summarises enablers and barriers to implementation drawing on site experiences from early-mid point and end-point consultations. The terms 'enablers' and 'barriers' in this chapter are used in relation to key activities or resources that support and enable TDI implementation, while barriers are factors that have impeded TDI implementation.

4.1 Enablers for TDI implementation

4.1.1 Community engagement with the purpose of the TDI

"I hope it will create more awareness of our area's needs and also help parents to think about age appropriate development."

– Regional pilot site, survey of nurse facilitators

Sites reported that the purpose of the TDI has been important to their engagement and continuing focus through the data collection. Sites consistently identified the importance of the information collected by the TDI, and the ways in which improved knowledge of the needs and circumstances of their communities would enhance service provision. This was explained as motivation to the promote and distribute the TDI.

At present, sites see that there is a gap in information systematically collected, particularly that there is presently no tool to seek input from families prior to entry into school.

Anticipated local benefits of the TDI results for sites included:

- improved understanding of parent viewpoints
- ability to identify gaps in service provision and plan for community needs
- prompting parents to think about what's happening in the community for their child
- increased possibilities for timely intervention for children at the earliest stage possible in their lives.

In addition, sites anticipate that the data contributes to better informed policy across the state and can enhance the focus on children's development and circumstances prior to school.

4.1.2 MCH as a platform for engagement

"A relationship approach has worked for me very well"

– Regional pilot site, consultations with leaders and managers

MCH is a key service platform engaging families with young children and nurses reported that their relationships with individual families and knowledge of the community to support distribution of the TDI was important to survey uptake. Feedback on MCH nurse facilitator readiness to implement indicated significant depth of experience in asking families questions as part of Key Age and Stage visits and having other experiences with surveys provided by MCH. Nurses reported some tailoring of the messages and support aligned to their knowledge of the family.

Nurses involved in implementation sites of the TDI are highly experienced. Among respondents to the MCH nurse facilitator survey, more than half had at least 20 years of experience. Nurses reported historical experience with research and data collection supported their ability to successfully distribute the TDI in their communities.

Engagement at a leadership level was important to enable prioritisation of resources. Sites were authorised through managers and their organisations to prioritise resources to support TDI distribution. Examples of such resources included:

- additional MCH nurse activities and time, such as: home visits to distribute the TDI; attending playgroups to speak with families about the TDI; assigning greater time for a specific discussion on the TDI with some families
- use of the reception area and staff in MCH offices to distribute the TDI to families while waiting for a KAS appointment
- use of iPads owned by MCH services were used to enable families to complete an online version of the TDI waiting for a KAS appointment
- use of CDIS to send SMS to families to remind them to complete the TDI.

4.1.3 Flexibility of survey modes

Across sites there was uptake of the different survey modes. Sites highlighted use of different survey modes, hard copy and / or online modes, for TDI completion was important to best suit service operations and community needs.

For some sites, particularly the smaller regional sites, the paper survey version was seen as practical and tangible mode for collection that would make it easier for families to engage with and support survey completion in the KAS session. In addition, paper versions reduced the risk that where is inconsistent access to the internet which may mean surveys would not be completed or returned.

The experience of some sites however, was that the paper versions were too bulky and its appearance was acting as a barrier to completion. As a result, the sites used the online version, or an iPad in the KAS session, and found this approach more straightforward. For these sites, the online version was more appropriate for the increasing number of families where electronic devices are the main mode for managing tasks.

4.1.4 Site training and support

Nurse preparation to implement the TDI was reported as an implementation enabler. Training was offered through an on-site training session in most sites and video of the training online. In addition, guidance materials and a nurse facilitator information sheet were developed to support nurse preparation.

Important aspects of training and preparation raised by sites included the opportunity to bring together the main nurses to be trained on the background and purpose of the work. Training also enables immediate questions to be resolved quickly. Nurses highlighted the benefits of detail regarding recommended coordination processes and key responsibilities at a site level, suggested application with families (i.e. introducing the TDI to families, encouraging parent completion), and practical 'communication-ready' information that could be shared within council or across organisation on why and how the data collected through the TDI would benefit the community.

4.2 Barriers to TDI implementation

As with enablers, barriers to implementation are examined in relation to site engagement and readiness, the survey tool, and implementation. These are discussed in the following sections.

"It is very valued, but it is about getting it right so it is not onerous…so it is something that is looked forward to it every time it needs to be done"

– Regional pilot site, consultations with leaders and managers

4.2.1 Benefits for parents are limited

Through the site consultations, the limited benefit/s for parents to complete the survey was identified as a key barrier. As further recognised, the need for a clear parent benefit is more important when seeking a substantial proportion of the community to complete a survey.

Normal service activities through the MCH, immunisation or playgroup have immediate and clear benefits. For example, the benefits for parents from participating in MCH can include professional access to parenting information, reassurance about child development or assistance to address child or parenting issues.

The benefit of the TDI is less direct and less immediate, with survey completion contributing to a better understanding of the environment for children's development and availability of services across a community. In the context of busy family life, this benefit may see TDI completion as a lower priority than other activities. The additional protocols and procedures under a research trial further emphasise the voluntary nature of survey completion and the time cost required.

As raised through the site consultations, the benefits of TDI completion can be strengthened through different mechanisms. For example, several sites suggested that parents would value TDI completion if it informed immediate practice and parent feedback. Alternatively, as with many population surveys, several sites suggested that the time and costs of participation are recognised and financially recompensed.

4.2.2 Service time and resource constraints

Implementation was undertaken through in-kind support of local areas and MCH services. However, the capacity of services guided what role the services could take.

"We have families that have struggled to fill it in, but we don't have the resources to help them do that."

– Regional pilot site, consultations with leaders and managers

Sites generally identified that the busy workloads of MCH services constrained their role to promotion and that time for further TDI collection activities, such as parent assistance or completion follow-up, was limited. In addition, MCH managers in two regional communities indicated that staff shortages had created substantial delays to roll-out.

Several sites also noted that the 18-month KAS visit involved a substantial schedule of requirements and that additional activities within the current time allocated to this visit would be difficult to sustain. MCH nurses described 18-month KAS sessions as busy, noting that an additional 15 minutes per child was likely to be required for the TDI to be incorporated in the session in its current format. This was described as a missed opportunity to ensure completion and enable MCH nurses to identify issues early and undertake referrals.

Sites have different access to information technology to support the TDI collection. In several sites, iPads were used for TDI completion while waiting for, or during, the KAS appointment and that this had worked effectively. Similarly, information systems were used by some sites to arrange TDI collection in forthcoming KAS appointments or send SMS reminders, however this capability was not available across the sites.

4.2.3 Survey tool challenges

"The intro letter is very wordy, for someone with minimum literacy this is too difficult."

– Regional pilot site, consultations with leaders and managers

Feedback on the survey tool highlighted barriers relating to the first perceptions of families when receiving the survey and challenges for some families in completion. While parents may be initially interested for their child's benefit, parents' engagement reduced for a number of reasons:

- *Survey length* – The length of the TDI was reported to be a barrier to implementation across most sites at the early stage consultations. Several of these sites switched to mainly promote online survey completion which did not involve presenting families with the survey in its paper form. As part of Phase two, the survey was reduced in length for the online versions. This was taken up by several sites. The shorter form survey was reported as an improvement though still quite long, and generally continued to be too long to conduct during the KAS session.

"…offering surveys to vulnerable families who maybe overwhelmed and experiencing hardship feels like you might be adding more stress or that they are unlikely to complete even if well intentioned."

– Regional pilot site, survey of nurse facilitators

- *Language complexity for families with low levels of English* – nurses noted that families who have low levels of literacy, or come from non-English speaking backgrounds, would struggle to understand the TDI's introductory letter and complete the survey. The Mallee pilot site reported that they were especially affected because the TDI was not translated for the diverse communities living in Robinvale and Swan Hill.
- *Concerns about privacy* – In addition, several sites reported that some families held privacy concerns. Examples of family concerns included that their details would be forwarded to Centrelink, or used for telemarketing. This is supported by the finding that most dropouts occurred early in the survey when asked their child's name or address. As a result, questions relating to a child's name or address were moved to the end of the survey. Sites reported that this was an improvement though it remained important that nurses or facilitators explained data privacy.

4.2.4 Monitoring distribution and completion

A barrier to implementation related to a lack of clarity for sites regarding population coverage for survey distribution and completion.

Its unclear for sites whether children who do not attend a KAS appointment have received the survey. Parents may have received the survey through a web-post, immunisation setting or playgroup setting. Attendance rates at 18-month KAS appointments can be lower than the desired TDI survey response rate of 90 per cent. In 2016-17, only Horsham, West Wimmera and Yarriambiack were at or above 90 per cent for participation at this visit (DET, MCH Annual Report, 2016-17). Similarly, sites don't know if families have completed the survey. Sites indicated that it would be beneficial for them to know which families had completed the TDI, so that they could target follow up reminders.

As a result of this feedback at the early-mid point consultations, DET provided additional support in Phase two which was well received by sites. This included improved access to completion rate data, checking in more regularly to provide local up to date participation information and providing opportunities to ask and resolve questions.

This support partially addressed the barrier, though limitations remained. Tracking of participants directly was not technically possible as expected participant names or locations were not known, and MCH managers noted that while this information was important for the data collection, they reiterated that additional resources would be required for a site-based monitoring role.

4.3 Summary

Four main enablers identified by sites and TDI facilitators were:

— *Community engagement with the purpose of the TDI* - sites identified the importance of the TDI and the role of community engagement to commit to TDI collection and use to make change.

— *MCH as a platform for engagement* - sites identified the reach, experience and skills of the MCH workforce support readiness to implement the TDI and particularly to engage families.

— *Flexibility of survey modes* - sites highlighted use of different survey modes, hard copy and / or online modes, for TDI completion was important to best suit service operations and community needs.

— *Site training and support* - nurse preparation to implement the TDI was reported as an implementation enabler.

Four main barriers or factors identified by sites and TDI facilitators were:

— *Benefits for parents are limited* - the limited and indirect benefit/s for parents to complete the survey was identified as a key barrier with sites identifying the need for clear benefits as particularly important when seeking a substantial proportion of the community to complete a survey.

— *Service time and resource constraints* - implementation was undertaken through in-kind support of local areas and MCH services. The capacity of services was a constraint to their level of involvement and meant that potential strengths of MCH for implementation (e.g. facilitation during the KAS visit, TDI completion follow-up) could not be undertaken in many sites.

— *Survey tool challenges* - feedback on the survey tool highlighted barriers relating to survey length and the language complexity for families.

— *Monitoring distribution and completion* - a barrier to implementation related to a lack of clarity for sites regarding population coverage for survey distribution and completion. DET provided additional support in Phase two which was well received by sites, though limitations remained, such as being able to track participants by name or location.

The opportunities raised by stakeholders to improve TDI implementation in preparation for scaling up TDI data collection are discussed in Chapter 5.

5 IMPLEMENTATION CHANGES FOR TDI SCALE UP

The chapter outlines opportunities raised by stakeholders and arising from the analysis to improve TDI implementation in preparation for scaling up TDI data collection.

5.1 Strengthen community engagement with the TDI and complementary data sets

"We see this as an opportunity, to be able to gather this data. So, we are really hopeful that it will be extremely valuable for us. Things can be improved with the planning and resources to make it sustainable – that's what does need to happen. But we do see it as a great opportunity"

– Regional pilot site, consultations with leaders and managers

The foundation for the TDI trial has been to work with communities (through local champions and key services) to collect data that informs their understanding of opportunities and enablers to support local to turn TDI data and other complementary data sets 'into action' that results in improved outcomes for children.

The next stage of the TDI trial will see the development of TDI results reports for participating sites. This will be particularly important to reinforce and strengthen the benefits of collecting the TDI for communities.

The area reports will summarise the TDI respondent characteristics to identify risk factors that were elevated with each site. Data will be presented and discussed with community members / representatives. Reports will be aligned with the presentation of AEDC results from 2018 and potentially collections of the MDI. As a result, participating sites will have a deeper understanding of the strengths and challenges for the community impacting across childhood and adolescence.

"If early childhood is so important why don't we have this assessment tool in there?"

– Metropolitan pilot site, consultations with leaders and managers

Sites also expressed interest in opportunities to further build the profile of the TDI and increase support in their community. Facilitators noted dual benefits of broader TDI promotion – community engagement raised the profile of child and family issues in the community, and that TDI promotion means that families are more likely to have prior knowledge of the TDI and be more likely to accept and complete it. Suggested activities included:

- advertising the TDI in social media, at local events, and in local magazines to raise awareness among families
- integrating information on the TDI into the MCH phone application
- improving awareness of the TDI in early years forums and local children's wellbeing collectives to raise the profile of the survey among practitioners and gather support for implementation.

5.2 Integrate the TDI into routine service activity

Nurse facilitators in each community have found methods to effectively distribute the TDI in their communities and are working towards developing ways to follow up with families. MCH and immunisation services are a deep source of information on the community, including information on the best way to encourage families to take part in the TDI.

Feedback from sites explored the value and the opportunity of the TDI as a research activity, but raised that sustainable delivery of the TDI would most likely arise from integrating the TDI into business as usual for nurses. For example, several medium and larger sites indicated an interest in the integration of the TDI into their standard KAS visits.

Integration into MCH would require several barriers to be addressed:

— *Clarity of benefits for families* – addressing the lack of parent benefits as a key barrier to completion by use of results in nurse practice, particularly to access supports and early intervention

— *Greater support for families who struggle to access the TDI* – development of a TDI format which could be facilitated by nurse facilitators during appointments, or ability to link completed TDI responses back to individual families

— *Ensuring population-wide coverage for monitoring and reporting* – likely meaning that the opportunity to complete TDI is available to all families by extending the possibility of it being completed at multiple points or KAS visits (e.g. at 12 month, 18 month and / or 24 month-age KAS visits).

Sites raised a number of possible ways in which this could be achieved, such as inclusion of the TDI in a schedule of KAS activities and structurally built into the *My Health, Learning and Development Record* (the Green Book), and integration of the TDI in CDIS or in the MCH smartphone application. This would enable nurse facilitators to use the TDI results to support their day-to-day activities. Additional options could include a phone completion mode with access to support in other languages.

5.3 Adapt the survey tool for service integration

"I feel that a large sector of the target population has been excluded from survey due to literacy, non-English speaking backgrounds and lack of translated materials."

– Regional pilot site, survey of nurse facilitators

A barrier identified by sites was that the survey was too long or inaccessible to families with literacy or English language issues.

As part of Phase two, the survey was shortened for online use. While sites using the Phase two survey mode considered this an improvement, the survey remained too long to be routinely integrated into the KAS visit.

Reducing the length and complexity of the TDI would reduce these barriers to completion in time constrained families and those with low literacy and provide an option that can be relatively quickly administered by a nurse during KAS appointments. Several different approaches were suggested across sites:

— A briefer survey capturing essential items only

— A briefer survey capturing essential items only with secondary follow up questions if an issue is flagged

— Use more open-ended questions that provide for a structured interview format.

It was noted that the Parents Evaluation of Developmental Status (PEDS) is completed by parents prior to attending a KAS visit and the results discussed between the nurse and parents. This form of shorter survey was reported by sites to be effective in providing a basis for discussion with parents.

5.4 Support access to resources that assist implementation

"…there has been no available extra time been able to be given [sic] to enable completion within a KAS visit - hence we are not able to discuss results, nor does it influence our practice in any way currently"

– Regional pilot site, survey of nurse facilitators

Most sites indicated that it was not feasible for them to routinely complete the TDI with families within current activities. MCH managers suggested that the provision of additional funded time during 18-month KAS appointments would enable them to introduce the TDI with families, assist them to complete the survey, and discuss any additional needs identified as a result of completing the TDI. Additional time and resources, aligned to a well-defined implementation approach, would support sustainable delivery.

In addition, several sites reported that provision of identified resources would improve the effectiveness and efficiency of survey processes. This may include: authorisation to use additional time to facilitate completion of the TDI with some families; consistent access to iPads across communities; information systems that systematically reach families; and resources/ materials to engage immunisation nurses and playgroups.

5.5 Improve feedback loops for nurse facilitators and extend site support

Sites noted that the ability to track completion of the survey within their community, at either an LGA or family level, would provide them with the opportunity to follow-up with families who had not completed the TDI or who had completed the TDI and needed additional support. Without this information, they were limited in what could be done to follow-up families who had not completed the survey.

Further development of methods allowing sites to track family level completions would enable nurses to understand and improve response rates. For example, nurses in regional locations report an interest in response rates for their community (rather than pilot site in aggregate). Understanding respondent characteristics enables sites to assess the strengths and developmental areas in implementation for their community.

As part of the additional support in Phase two, sites were provided additional support in Phase two. This included improved access to completion rate data and opportunities to ask and resolve questions. Further opportunities raised by sites involved the recording of data survey completion and question response on information systems that were available as a live information source to nurses.

The support by DET was received well by sites. This role is essential to both provide coordinated leadership and the support through implementation. The role requires a number of functions, for example: mobilising key stakeholders and community champions; facilitating sites to plan and adapt to how they reach the population; providing access to data and building and supporting local capacity to use and learn from data; and sharing of best practice examples across communities to enhance understanding and practice across sites.

BOX 5.1 FIVE OPPORTUNITIES TO IMPROVE IMPLEMENTATION IN PREPARATION FOR SCALING UP

The chapter outlines key messages at this point of the evaluation, including five opportunities raised by stakeholders to improve TDI implementation in preparation for scaling up TDI data collection. These opportunities are:

1. **Strengthen community engagement with the TDI and complementary data sets** - the next stage of the TDI trial will see the development of TDI results reports for participating sites. This will be particularly important to reinforce and strengthen the benefits of collecting the TDI for communities.
2. **Integrate the TDI into routine service activity** - Feedback from sites identified that sustainable delivery of the TDI as part of the MCH service would most likely arise from integrating the TDI into business as usual for nurses. Sites raised a number of possible ways in which this could be achieved, such as inclusion of the TDI in a schedule of KAS activities and structurally built into the My Health, Learning and Development Record (the Green Book), and integration of the TDI in CDIS or in the MCH smartphone application
3. **Adapt the TDI survey tool for service integration** - A barrier identified by sites was that the survey was the survey length and inaccessibility to families with literacy or English language issues. Several different approaches were suggested across sites and stakeholders to adapt the survey tool for service integration, such as a brief survey format and / or using more open-ended questions that provide for a structured interview format. The PEDS is completed by parents prior to attending a KAS visit and the results discussed between the nurse and parents. This form of shorter survey was reported by sites to be effective in providing a basis for discussion with parents.
4. **Support access to resources that assist implementation** - most sites indicated that it was not feasible for them to routinely complete the TDI with families within current activities and considered that a clear implementation approach and aligned additional resources would be needed to sustain delivery.
5. **Improve feedback loops for nurse facilitators and extend site support** - sites noted that the ability to track completion of the survey within their community, at either an LGA or family level, would provide them with the opportunity to follow-up with families who had not completed the TDI or who had completed the TDI and needed additional support.

6 NEXT STEPS

This Chapter outlines the next steps for TDI trial activities, and the evaluation data collection and reporting.

6.1 TDI trial activities

As part of TDI trial activities, the first half of 2019 will see the development of five area reports will be developed and will summarise the TDI respondent characteristics to identify risk factors that were elevated with each site. The results will be presented and discussed with participating communities.

6.2 Part 2 evaluation activities and final reporting

Part 2 evaluation activities will centre on individual or small group interviews with community leaders and MCH program managers in the five implementation sites. These are expected to be 1-2 hours in length and conducted in sites where possible. The focus of the site visits is to understand:

- the effectiveness the reporting of results at the community level
- practical applications and implications of the results, and other system benefits that can be achieved through the TDI
- practices must be retained and what changes must be made to TDI implementation.

The visits are likely to occur with one to two months of the provision of TDI community reporting, allowing time for communities to have considered the practical implications of the results.

In addition, a small group workshop with the implementation team will identify the feasibility and benefits of rolling-out the TDI in Victoria through the MCH Service. The output of the workshop will be incorporated into the final evaluation report.

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