Final Project Report

Process Evaluation of the CBD Homelessness Health Access Protocol

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Acknowledgements

Executive Summary and Recommendations

The CBD Homelessness Access Protocol (the Protocol) aims to improve efficiency and effectiveness for health service delivery to homeless people in Melbourne's CBD through strengthening the relationships and knowledge shared between the health and homeless sectors. Although the Protocol has been implemented for some time; a formal evaluation had not been conducted. The aim of this project was to conduct a process evaluation to examine the implementation and embedding of the Protocol amongst services providers and agencies, and provide findings to improve service delivery and coordination amongst agencies in Melbourne's CBD.

The study design was an observational study design, more specifically a one-group post-test only design where a mixed methods approach was used, collecting quantitative and qualitative data. An ethics application to La Trobe University FHEC was granted on 8 July 2013. Data collection involved distributing a survey questionnaire, to agencies providing services for the Homeless population that have implemented the Protocols. Data was voluntarily self-reported, and collected indirectly from individuals. Inclusion criteria were those aged 18 and over; are a current employee with a service provider/agency; able to provide informed consent and comprehend and communicate in English. Part One of the survey contained general demographic information and part two was adopted from the RE-AIM framework (Glasgow etal.,1999) to review the uptake of agencies that have embedded the protocols into their practices; and identify any information or feedback from agencies that identifies any improved client outcomes in accessing health services in Melbourne's CBD.

The Survey was distributed to 65 service providers. 25 of 65 (38%) local service providers responded to the survey. Of the 25 participants, only 14 completed the survey (56%). Results indicated respondents had not embedded or utilised the Protocol. However, 65% (n=11) of respondents had not attended training and 60% of respondents (n=25) were employed less than 12 months to 3 years.

In order to assist the implementation and embedding of the Protocols, improve service delivery and coordination amongst agencies in Melbourne's CBD, agencies are encouraged to: engage in bi-annual training, by utilising the tools developed; provide an induction to the Protocols when new staff are employed; and Managers need to be responsible for the Protocols being used throughout the organisation.

Keywords: CBD Homelessness Health Access Protocol, homelessness, process evaluation, implementation, embedding, service providers and agencies.

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Introduction

In an attempt to decrease the number of people accessing hospital and health services for conditions not requiring hospitalisation, the Government of Victoria established Primary Care Partnerships in order to assist capacity building amongst health providers within local government areas (INWPCP.,2011; Victorian Government.,2009). The Inner North West Primary Care Partnership (INWPCP) works across the local government area of the City of Melbourne, Moonee Valley, Moreland and Yarra, and aims to "improve the health and wellbeing of their target population" (INWPCP.,2011; Victorian Government.,2009); and be in close contact and support with local providers regarding improved coordination of services, health promotion and management of chronic diseases(INWPCP.,2011; Victorian Government.,2009). For further information regarding Primary Care Partnerships and INWPCP, please refer to Appendix 1.

Project Aims and Objectives

Overall Aim:

To conduct a process evaluation of the CBD Homelessness Health Access Protocols Project using a survey questionnaire regarding the implementation and embedding of the CBD Homelessness Health Access Protocols and guiding principles amongst services providers and agencies, and provide findings to improve service delivery and coordination amongst agencies in Melbourne's CBD, by November 2013.

Objectives/Interim Goals:

The aims of the project are as follows:

(i)   To review the uptake of agencies that have embedded the protocols into their practices; and

(ii)   To identify any information or feedback from agencies that identifies any improved client outcomes in accessing health services.

The project rationale has been adapted from the project brief, CBD Homelessness Health Access Protocol that was undertaken by the Inner North West PCP Project Officer Ms Georgia Savage in August 2011.

Project Rationale

The CBD Homelessness Access Protocol aims to improve efficiency and effectiveness of health service delivery to homeless people in Melbourne's CBD through strengthening the relationships and knowledge shared between the health and homeless sectors (Savage.,2011). This has the potential to impact the ability of workers to complete timely and appropriate referrals for homeless clients. The project provides agreed upon guidelines for good practice which may help ensure a more uniform understanding of the needs and challenges facing homeless people in accessing health services (Savage.,2011). The project aligns with the Strategic Directions of the INWPCP, which states a priority area to be to *"improve the service system's capacity to support people with chronic disease and/or mental illness and their co-morbidities"(*Savage.,2011,p.9).

The development of the project began in December 2007 and ran until August 2010. The implementation of the project began in August 2010 and ran until March 2012. As of March 2012, a final project report was completed by the INWPCP and the Working Group completed its final activities as part of the implementation (Savage.,2011). It is desirable the CBD Health and Homelessness Alliance will continue beyond this date as part of the service development component of the Central City Community Health Service run by Doutta Galla Community Health and the work of the PCP (Savage.,2011).

Given the Protocol has been implemented for some time; a formal evaluation had not been conducted. For the purpose of this research, a process evaluation of the CBD Health and Homelessness Access Protocol was conducted. The application of a process evaluation included examining the implementation and embedding of the protocols and guiding principles amongst service providers and agencies that provide services to the homeless population of Melbourne's CBD. The INWPCP will be able to utilise research findings and consider possible recommendations and opportunities for improvement to the implementation of the Protocols. In addition, review uptake of the agencies that have embedded the Protocols into their practices, identify any feedback from agencies that identify any improved client outcomes in accessing health services, improve service delivery and coordination, amongst service providers and agencies in the CBD who provide services for Melbourne's homeless population.

The Background has been adapted from the project brief CBD, Homelessness Health Access Protocol that was undertaken by the Inner North West PCP Project Officer Ms Georgia Savage in August 2011.

Background/Literature Review

Homelessness is associated with a high prevalence of co-morbidities, social isolation, substance misuse, psychiatric disorders and poor health-seeking behaviour are contributing factors (Savage.,2011). The multiple, complex needs of a homeless person can mean several services are involved in their care. Alternatively, a homeless person may have a number of needs that have not been addressed by services (Savage.,2011). Given this knowledge, it is important health and welfare services are equipped with the knowledge and capacity to coordinate service provision and refer in an appropriate manner.

The Homelessness and Primary Health Service Coordination in the Melbourne CBD Project commenced in December 2007 and was initially funded by the Moonee Valley Melbourne Primary Care Partnership, the City of Melbourne ($40,000) and the Department of Human Services Primary Care Branch ($12,500)(Savage.,2011). The project sought to improve coordination between health and homelessness services in the central business district, with the production of the CBD Homelessness Health Access Protocol as its centrepiece (Savage.,2011). The Access Protocol was endorsed by the Steering Group for the Project at a meeting on June 27 2008. In late 2008, a project report *titled 'Homelessness and Primary Health Service Coordination in the Melbourne CBD'* was produced by the Moonee Valley Melbourne Primary Care Partnership summarised the progress of the project and provided recommendations for next steps(Savage.,2011).

Throughout 2009, the focus of the project and the Steering Group was the creation of a Guide to Accessing Services, which listed a number of health and homelessness services in the CBD which could be used as referral points. This document was launched at The Living Room, a health and homelessness service located in the CBD, in August 2010(Savage.,2011). As of August 2010, after changes to the PCP boundaries occurred, the INWPCP assumed responsibilities for this project. It was re-titled the CBD Homelessness Health Access Protocol Project, and began to focus on the implementation of the CBD Homelessness Health Access Protocol (Savage.,2011).

Since project inception, there have been two stages to this project, development and implementation. During the development stage (December 2007 – August 2010), the CBD

Homelessness Health Access Protocol and Guide to Accessing Services were developed in consultation with health and homeless services in the CBD(Savage.,2011). To complement and form parts of these documents, three other documents were developed including: Guidelines for making referrals to Health Services; Guidelines for receiving referrals in a Health Services; and a Quick Reference Guide to Sourcing Health Services(Savage.,2011).

During the implementation phase (August 2010 - current), a Training Handbook was developed to assist workers and managers to operationalise the Protocol. All documents are published on the INWPCP website, and communicated and marketed through a series information sessions directed at senior managers and training sessions directed at frontline workers(Savage.,2011).

Methods

STUDY DESIGN

An observational study design, more specifically a one-group post-test only design was adopted(Hawthorne.,2000). The rationale for choosing this design was that the CBD Homelessness Health Access Protocol commenced in December 2007 with the development phase until August 2010, followed by implementation until March 2012, and continued with implementing the Protocols into daily activities of service providers since then. However, no formal evaluation regarding the implementation and embedding of the Protocols was undertaken.

A mixed-methods approach was used, involving qualitative and quantitative data collection methods to maximise the research evidence and triangulate findings. This approach provided a comprehensive and balanced approach to the project to review the uptake of agencies that have embedded the protocols into their practices; and to identify feedback from agencies that identified any improved client outcomes in accessing health services in Melbourne's CBD. The principal research student adopted quantitative methods to measure and review the uptake of agencies that have embedded the protocols into their practices; and qualitative methods to identify any information/feedback from agencies to answer the *'how'* and *'why'* questions and classify responses into major themes(Round etal.,2005) by distributing one survey to all relevant service providers in the Melbourne CBD who provide services for Melbourne's homeless population(Hawthorne.,2000).

RECRUITMENT STRATEGY

The INWPCP's Executive Officer distributed a letter on behalf of the INWPCP with the Participant Information Statement and a web link to the survey to all relevant service providers inviting them to participate in the evaluation via email.

After consulting with the INWPCP's Executive Officer it was decided *'gender'* and breakdown of males and females at each service provider was difficult to determine. The survey participants' gender was irrelevant to this study and requested that gender of the staff not to be asked in the survey. The aim was to evaluate the service provision, delivery and coordination of agencies who provide services to people affected by homelessness within Melbourne's CBD and not to compare responses of male against female staff amongst service providers.

How names and contact details of potential participants were obtained

Once approval from the sponsoring organisation and from the Faculty of Health Sciences Ethics Committee at La Trobe University was obtained, the research student contacted the INWPCP's Executive Officer who distributed a letter extending an invitation to participate in the survey to all the relevant service providers already engaged in the CBD Homelessness Health Access Protocols who provide services to Melbourne's Homeless population. The suggested time frame for participants - service providers who wished to participate was four weeks to complete the data collection process. A reminder email was sent by the INWPCP's Executive Officer prior to the closing date and a gentle final reminder email was sent two days prior to closing.

From where they were recruited

The potential participants were recruited from all the relevant service providers already engaged in the CBD Homelessness Health Access Protocols.

How they were invited to participate,

The INWPCP's Executive officer informed all the relevant service providers already engaged in the CBD Homelessness Health Access Protocols via email, with the invitation and participant information statement of the opportunity to participate in the survey.

Who approached potential participants to seek their involvement.

The aim was to recruit between 30 - 45 staff members across the relevant service providers for this evaluation through the existing database/internal email system that was utilised by the INWPCP's Executive Officer to assist with recruitment/timing of the recruitment; however direct access was not provided to the principal research student.

According to the *La Trobe Research Ethics, Guidelines for completing the low risk application* form (2012,page9-10), states *"the ethics committee accepts that a questionnaire completed and returned by a participant may constitute implied consent. A signed agreement to participate is not required if the project only necessitates the return of a questionnaire that does not contain information identifying the participant, for example, an anonymous survey" …. "It may be sufficient to provide participants with a Participant Information Statement as a cover page to the questionnaire, and cover all the information required in a standard PIS and consent for with the exception of the signature block at the end of the form."*

Given participation was voluntary and responses were completed anonymous, participants were not under any obligation to consent to complete the survey. In this study, submitting a completed survey was an indication of a participant's informed consent to participate in the study. Participants may have elected to withdraw any time prior to submitting their survey. However, once participants submitted their survey anonymously, their responses could not be withdrawn and was explicitly stated in the invitation letter and Participant Information Statement.

This study only involved adults, aged over 18 years of age, and current employees of the service provider(s) and it was reasonable to assume some degree of autonomy, self-determination and competence in having made an informed decision regarding their participation once they have received the appropriate information, so that participants may make a reasoned and rational choice, that was voluntary and could be withdrawn at any time.

DATA COLLECTION INSTRUMENTS/METHOD

Data collection involved distributing a survey regarding implementation and embedding of the Protocol amongst services providers to improve service delivery and coordination amongst agencies in Melbourne's CBD. Surveys were self-administered, data was self-reported, and collected indirectly from individuals(Hawthorne.,2000).

A data collection instrument was agreed upon based upon the RE-AIM framework by Glasgow R, Vogt T and Boles S(1999) in consultation with the INWPCP's Executive Officer, Project Coordinator, Dr. Priscilla Robinson and the principal research student. The survey contained questions relating to the following aspects of the Protocol in terms of:

- Reach, the proportion or representativeness of target population participating;
- Effectiveness, the degree to which the Protocols and principles are being used;
- Adoption, the proportion of service providers and agencies that have adopted the Protocols and guiding principles;
- Implementation, extent to which the Protocols are being implemented as intended; and
- Maintenance the extent to which the Project's benefits are sustained over-time.

Several questions addressed each section using a 4 point Likert scale:

- Not at all, Some of the time, Most of the time, All the time;
- Not at all, Not well, Well, Very well;
- Not at all, A little, A lot, A great deal;
- Not improved, Remained the same, Improved a little, Much improved;
- Never heard of it, Less than before, About the same, More than before;

Following each question, there was an opportunity for respondents to provide additional written feedback, comments, and/or examples. This section wasn't compulsory; however provided an opportunity to participants who wanted to provide additional feedback, and explain or elaborate on their response(s) to the survey questions.

DATA ANALYSIS METHOD

The data/responses were recorded on survey monkey. Once the survey data collection period closed, the principal research student downloaded a summary report of the data collected and examined the response percent, response count, how many people answered the question and how many skipped the question. The data was exported to an Excel spreadsheet that was password protected on a separate computer. EpiData was used to prepare and design a database to turn the questionnaire into a database and enter the data into a database built in a database package.

EpiData was chosen to assist with the data analysis, as it provided a means to store electronic data, and given it is difficult to accidently change stored data in a database and look for/counting similar strings of bytes for the quantitative questions. The data was analysed using a logical sequence of analyses; whereby looking for /counting /summarising similar strings of bytes as a tool for the data analysis. For qualitative analysis, codes were assigned to sections of text that were automatically labelled with codes that relate to the survey number.

EpiData was used to assist the research student design the questionnaire, construct a database from the questionnaire, include a check file to assist the student in a clean data entry. In terms of data organisation, the principal research student decided on the variable type, field length and a variable name for each question. Given the Likert scale rating for most of the questions, there was a variable level. For example: "0"for Not at all, "1"for Some of the time, "2"for Most of the time, and "3"for All the time. The data was entered into the database, and exported the data to other statistical packages, and saved the analysis output. The output was used to create graphs, as required to present data for the report and poster. Thus, EpiData manager was used to design the database and data entry screens; EpiData entry was used to upload and complete the data entry; and EpiData analysis was the data analysis package used(Round etal.,2005; Hawe etal.,1990).

DATA STORAGE

During the study, all hard data was kept in a locked filing cabinet specifically set aside for this purpose during the course of this project at La Trobe University and at the INWPCP's Office. All soft or electronic data was kept in password protected files on a separate computer. At the conclusion of the project, all data was collected and stored in the secure compactus storage facility located in the Faculty of Health Sciences at La Trobe University for a period of 5 years. Soft data was transferred to a USB stick for storage.

The electronic quantitative data was securely stored, on a password protected computer, that was made difficult to change, and impossible to change by accident. Quantitative data was stored in byte units, where each number/letter was stored separately, and could not be changed; where each row related to one set of observations; and each column related to a variable. The reasons for this, was that units are short, normally only a few numbers/letter wide. In terms of the collating, storing and analysing the comments sections of the survey, these were stored in text files, given responses may have been lengthy and difficult to store in a way which can retrieve similar strings of letters and will be securely stored, on a password protected computer.

Data security

Project documentation was stored in secure, lockable location, on campus, at La Trobe University (Franklin Street Campus). Computer files were password protected and data, was de-identified where appropriate.

Ethical issues

An ethics application was submitted on 29th May 2013 and a response from the FHEC noting minor amendments was provided on 17th June 2013. A response to the FHECs memo was submitted noting responses to the comments on 5th July 2013, and final Ethics approval from the FHEC was received on 8th July 2013 (approval number: FHEC13/123).

Results

The CBD Protocol Evaluation Survey was distributed to a total of 65 local service providers. The survey was open from 19th July 2013 until 16th August 2013. During this time, 25 of 65 (38%) local service providers responded to the survey. Of the 25 participants, 14 completed the survey (56%). Overall, the results indicated that respondents had not embedded or utilised the Protocol. However, 65% (n=11) of respondents had not attended training; and 60% of respondents (n=25) were employed less than 12 months and up to 3 years. It is noteworthy that the last training sessions were provided in late 2011. The results are summarised below and in Appendix 2.

Question 1.

All the survey participants responded to Question 1. Thus, of the 25 participants, 24.0% (n=6) were managers, 12% (n=3) were team leaders, 24% (n=6) were coordinators, 24% (n=6) were practitioners and 16% (n=4) were classified as other (Strategic Planner, Clinician, Support Worker, and Project Worker).

[Inset Figure 1 here]

Question 2.

All the survey participants responded to Question 2. Thus, of the 25 participants, 52% (n=13) provided General health services, 44% (n=11) provided Support services, 44% (n=11) provided Outreach services, 40% (n=10) provided Mental health services, 24% (n=6) provided Emergency Assistance services, 24% (n=6) provided Drug and Alcohol services, 20% (n=5) provided Domestic violence support, 16% (n=4) provided Dental health services, and 32% (n=8) provided Other services – such as Community health, research, advocacy, case management, legal services, pregnancy support programs, Education, Community Legal Advice/Centre.

[Inset Figure 2 here]

Question 3.

All the survey participants responded to Question 3. Thus, of the 25 participants, 76% (n=19) provided services for people with complex needs, 60% (n=15) provided services for women, 60% (n=15) provided services for men, 56% (n=14) provided services for youth/adolescents, 36% (n=9) provided services for families and 32% (n=8) provided services for children.

[Inset Figure 3 here]

Question 4.

All the survey participants responded to Question 4. Thus, of the 25 participants, 16% (n=4) had less than 12 months experience, 24% (n=6) had between 13 months and three years experience, 8% (n=2) had between four and five years experience, 12% (n=3) had between six and seven years experience, 0% between eight and nine years experience, and 40% (n=10) had 10 years or more experience.

[Inset Figure 4 here]

Question 5.

All the survey participants responded to Question 5. Thus, of the 25 participants, 28% (n=7) had less than 12 months, 32% (n=8) had between 13 months and three years, 8% (n=2) had between four and five years, 8% (n=2) had between six and seven years, 8% (n=2) had between eight and nine years, and 16% (n=4) had 10 years or more.

[Inset Figure 5 here]

Question 6.

A total of 20 out of 25 participants responded to Question 6. Thus, of the 20 respondents, 75% (n=15) were aware and 25% (n=5) were not aware of the Guide to Accessing Services. 65% (n=13) were aware and 35% (n=7) were not aware of the Guidelines for making referrals. 60% (n=12) were aware and 40% (n=8) were not aware of the Key access points in Health. 45% (n=9) were aware and 55% (n=11) were not aware of the Guidelines for receiving referrals. 35% (n=7) were aware and 65% (n=13) were not aware of the Training handbook.

[Inset Figure 6 here]

Question 7.

A total of 20 out of 25 participants responded to Question7. Thus, of the 20 respondents, 45% (n=9) had not embedded the Guide to Accessing Services at all. 45% (n=9) had not embedded the Guidelines for making referrals at all. 50% (n=10) had not embedded the Key access points in Health at all. 50% (n=10) had not embedded the Guidelines for receiving referrals at all. 55% (n=11) had not embedded the Training handbook at all.

[Inset Figure 7 here]

Question 8.

A total of 20 out of 25 participants responded to Question 8. Thus, of the 20 respondents, 45% (n=9) have been utilising the Protocols, whereas 55% (n=11) have not been utilising the Protocols.

It is noteworthy to mention, that a skip logic function/jump was embedded into the survey, if participants answered NO to Question 8, as Questions 9 through to 14 relate to those who responded that they were using the Protocols. Instead, participants who answered No to Question 8, were directed to Question 15.

[Inset Figure 8 here]

Question 9.

This question was relevant to the nine survey participants who answered Yes to Question 8. Of the nine respondents, eight provided a response to Question 9 and one missing. Of the eight participants:
- 37.5% (n=3) said not at all, 50% (n=4) said some of the time and 12.5% (n=1) said most of the time in terms of using the Guide to accessing services.
- 37.5% (n=3) said not at all, 50% (n=4) said some of the time and 12.5% (n=1) said most of the time in terms of using the Guidelines for making referrals.
- 50% (n=4) said not at all, 37.5% (n=3) said some of the time and 12.5% (n=1) said most of the time in terms of using the Key Access points in Health.
- 50% (n=4) said not at all, 37.5% (n=3) said some of the time and 12.5% (n=1) said most of the time in terms of using the Guidelines for receiving referrals.

- 87.5% (n=7) said not at all, 0% said some of the time and 12.5% (n=1) said most of the time in terms of using the Training handbook.

[Inset Figure 9 here]

Question 10.

This question was relevant to the nine survey participants who answered Yes to Question 8. . Of the nine respondents, eight provided a response to Question 10 and there was one missing. Of the eight participants 25% (n=2) responded not at all, 50% (n=4) responded a little easy, 25% (n=2) responded very easy.

[Inset Figure 10 here]

Question 11.

This question was relevant to the nine survey participants who answered Yes to Question 8. Of the nine respondents, six provided a response to Question 11 and there were three missing. Of the six participants 16.7% (n=1) responded not improved, 33.3% (n=2) responded remained the same, 33.3% (n=2) responded improved a little and 16.7% (n=1) responded much improved.

[Inset Figure 11 here]

Question 12.

This question was relevant to nine survey participants who answered Yes to Question 8. Of the nine respondents, six provided a response to Question 12 and three missing. Of the six participants, in terms of:Service outcomes for clients, 16.7% (n=1) said not improved, 66.7% (n=4) said remained the same, 16.7% (n=1) said improved a little.

- Referrals to the appropriate health services, 16.7% (n=1) said not improved, 50% (n=3) said remained the same, 33.3% (n=2) said improved a little.
- Ease of access to other services, 16.7% (n=1) said not improved, 50% (n=3) said remained the same, 33.3% (n=2) said improved a little.
- Timely access to health services, 16.7% (n=1) said not improved, 50% (n=3) said remained the same, 33.3% (n=2) said improved a little.

[Inset Figure 12 here]

Question 13.

This question was relevant to the nine survey participants who answered Yes to Question 8. Of the nine respondents, six provided a response to Question 13 and there were three missing. Of the six participants in terms of:

- Service outcomes for clients, 50% (n=3) said remained the same, 50% (n=3) said improved a little.
- Referrals to the appropriate health services, 66.7% (n=4) said remained the same, 33.3% (n=2) said improved a little.
- Ease of access to other services 66.7% (n=4) said remained the same, 33.3% (n=2) said improved a little.
- Timely access to health services66.7% (n=4) said remained the same, 33.3% (n=2) said improved a little.

[Inset Figure 13 here]

Question 14.

This question was relevant to the nine survey participants who answered Yes to Question 8. Of the nine respondents, six provided a response to Question 9 and there were three missing. Of the six participants in terms of

- Primary health services, 16.7% (n=1) responded not improved, 33.3% (n=2) responded remained the same, 33.3% (n=2) responded improved a little and 16.7% (n=1) responded much improved.
- Mental health services, 16.7% (n=1) responded not improved, 66.7% (n=4) responded remained the same, 16.7% (n=1) responded improved a little.
- Improved health outcomes, 16.7% (n=1) responded not improved, 66.7% (n=4) responded remained the same, 16.7% (n=1) responded improved a little.
- Improved service outcomes, 16.7% (n=1) responded not improved, 83.3% (n=5) responded remained the same.

[Inset Figure 14 here]

Question 15.

Of the 20 respondents, 17 provided a response to Question 15 and there were three missing. Of the 17 participants, 35.3% (n=6) attended a facilitated training session and 64.7% (n=11) had not received any training.

[Inset Figure 15 here]

Question 16.

This question was only relevant to respondents who answered Yes to Question 15. Of the six participants, 50% (n=3) responded their understanding of the services available remained the same, 33.3% (n=2) responded improved a little and 16.7% (n=1) responded much improved.

[Inset Figure 16 here]

Question 17.

Of the 25 respondents, 16 provided a response to Question 17 and there were nine missing. Of the 16 participants,

- 25% (n=4) never heard of the Guide to accessing services, 18.8% (n=3) used it less than before, 31.3% (n=5) used it about the same, and 25% (n=4) used it more than before.
- 25% (n=4) never heard of the Guidelines for making referrals, 18.8% (n=3) used it less than before, 37.5% (n=6) used it about the same, and 18.8% (n=3) used it more than before.
- 31.3% (n=5) never heard of the Key access points in Health, 25% (n=4) used it less than before, 31.3% (n=5) used it about the same, and 12.5% (n=2) used it more than before.
- 37.5% (n=6) never heard of the Guide for receiving referrals, 18.8% (n=3) used it less than before, 31.3% (n=5) used it about the same, and 12.5% (n=2) used it more than before.
- 50% (n=8) never heard of the Training Handbook, 18.8% (n=3) used it less than before, 18.5% (n=3) used it about the same, and 12.5% (n=2) used it more than before.

[Inset Figure 17 here]

Question 18.

Of the 25 respondents, 16 provided a response to Question 18 and there were nine missing. Of the 16 participants 56.3% (n=9) responded not at all, 18.8% (n=3) responded a little, 12.5% (n=2) responded a lot and 12.5% (n=2) responded a great deal.

[Inset Figure 18 here]

Question 19.

Of the 25 respondents, 15 provided a response to Question 19 and there were ten missing. Of the 15 participants 40% (n=6) responded Yes and 60% (n=9) responded No.

[Inset Figure 19 here]

Question 20.

Of the 25 respondents, 15 provided a response to Question 20 and there were ten missing. Of the 15 participants 13.3% (n=2) responded Yes and 86.7% (n=13) responded No.

[Inset Figure 20 here]

Question 21.

Of the 25 respondents, 15 provided a response to Question 21 and there were ten missing. Of the 15 participants 20% (n=3) responded not at all, 46.7% (n=7) responded a little, 20% (n=3) responded a lot and 13.3% (n=2) responded a great deal.

[Inset Figure 21 here]

Question 22.

Of the 25 respondents, 14 provided a response to Question 22 and there were 11 missing. Of the 14 participants 57.1% (n=8) responded not at all in terms of working practices of the agency, 57.1% (n=8) responded not at all in terms of policies of the agency, 50% (n=7) responded not at all in terms of practices of the agency, 64.3% (n=9) responded not at all in terms of inter-agency agreements, and 64.3% (n=9) responded not at all in terms of the quality improvement plan of the agency

[Inset Figure 22 here]

Question 23.

Of the 25 respondents, 14 provided a response to Question 23 and there were 11 missing. Of the 14 participants 50% (n=7) responded online training, 50% (n=7) responded face to face training, 14.3% (n=2) responded train-the-trainer, 7.1% (n=1) responded mentor support and 42.9% responded other.

[Inset Figure 23 here]

Discussion

The majority of respondents were managers, coordinators and practitioners, with the most popular service types being general and mental health, support services, and outreach services, dealing with people experiencing homelessness who had complex needs. Also, the majority of respondents were fairly new staff who participated in the survey, who were not aware of the Protocols and had not attended or received training in how to use the Protocols. It is difficult to ascertain why staff in senior positions and/or staff with longer years of service within the homeless sector or length of service with the service provider did not participate in the survey.

In terms of:

- **Reach**, the majority of respondents were aware of the Protocol – Guidelines to accessing services, Making referrals and Key access points; however not aware of the guidelines for receiving referrals and training handbook. There was a general consensus among the sample that the Protocol had not been embedded into the service providers' daily activities.

- **Effectiveness**, of the respondents using the Protocol most described it was easy to implement into daily activities and their knowledge /skills of referral practices either improved a little or remained the same. The majority agreed as a result of utilising the Protocols, service outcomes for clients, referral to the appropriate health service, ease of access to other services and timely access to service remained the same. Similarly, the benefits for service provider using the same indicators, suggested these remained the same. Results indicated that improved access due to the protocol for people experiencing homelessness in terms of primary and mental health service, improved health outcomes and improved service outcome remained the same.

- **Adoption**, results suggested the Protocol had not supported collaborative relationships or developed partnerships with other agencies.

- *Implementation*, results suggested there were no internal or external factors affecting the implementation of the Protocol. However, perhaps the questions may have been better phrased i.e. what have been some of the barriers and/or enablers to implementing the Protocol may have provided more reliable data.

- *Maintenance*, results suggested respondents had not embedded the Protocol into the service providers' working practices, policies and procedures, interagency agreement or quality improvement plan. However, results revealed service providers require online training and face to face training to support the ongoing use of the Protocol. Overall the results indicated that respondents had not embedded or utilised the Protocol. However, 65% of respondents had not attended training; and 60% of respondents were employed less than 12 months and up to 3 years. It is noteworthy the last Training Sessions were provided in late 2011, however it was anticipated that part of the sustainability regarding the Protocols, the onus would be on the service providers to provide ongoing training to their staff utilising the tools that were developed and accessible via the website to implement and embed the Protocols within their agencies.

Bias, Confounding, Limitations

In terms of limitations, some possible methodological limitations include:

- *Sample size* – The total number of service providers/agencies invited were 65. Of the 65 service providers, 25 responded (38.4%; however only 14 completed the survey). Thus, a small sample size may make it difficult to make inferences as results may not be reliable or generalizable.

- *Survey response rate* - Of the 65 service providers 25 responded(38.46%) which is low.

- *Survey completion rate* - Of the 25 respondents only 14 of managed to finish and complete the survey(56%).

- *Lack of available and/or reliable data* would potentially limit the scope of how the results are analysed and make it difficult to make conclusions(Brutus etal.,2013).

- *Data collection tool used to collect the data* – was the survey too long, too complicated, time consuming, required too much reading or had too many parts.

- *Whether the questions relating to internal and external factors should* have been expressed differently i.e. what have been some of the barriers and/or enablers, and thus the manner in which survey respondents interpreted the questions may have influenced the results.

A possible confounder includes:

- *Self reported data* – for some of the survey items, rating scales such as: a little, a lot, a great deal may be, as different individuals would have different perceptions of how they interpreted the question(s) and how individuals respond would need to be taken at face-value, given self-reported data is limited by the fact that it rarely can be independently verified (Brutus, et al.,2013).

Conclusions and Recommendations

In conclusion, homelessness is associated with a high prevalence of co-morbidities, social isolation, substance misuse, psychiatric disorders and poor health-seeking behaviours. The Protocol aims to improve efficiency and effectiveness for health service delivery to homeless people in Melbourne's CBD through strengthening the relationships and knowledge shared between the health and homeless sectors. The aim of this project was to conduct a process evaluation to examine the implementation and embedding of the Protocol amongst services providers and agencies, and provide findings to improve service delivery and coordination amongst agencies in Melbourne's CBD. Results indicated respondents had not embedded or utilised the Protocol. However, 65% of respondents had not attended training and 60% of respondents were employed less than 12 months to 3 years.

Some of the recommendations in order to assist the implementation and embedding of the Protocol improve service delivery and coordination amongst agencies in Melbourne's CBD, agencies are encouraged to:

- Engage in bi-annual training, by utilising the tools developed and accessible online via the website; or participate in face to face training which will be available in 2014;
- Agencies to provide an induction to the Protocols when new staff are employed; and
- Managers need to be responsible for encouraging the use of the Protocols throughout the organisation.

Thus, suggestions for future research may involve conducting a follow up survey, given the recommendations and suggestions, and/or reconsider the data collection tool.

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Appendix 1. Background information on Primary Care Partnerships and the Inner North West Primary Care Partnership.

The Background information below has been provided courtesy of the Inner North West Primary Care Partnership's website www.inwpcp.org.au.

"The Primary Care Partnership Strategy is a Victorian Government initiative that provides Primary Care Partnerships across the State with funding to strengthen relationships, improve service coordination, integrate health promotion and chronic disease management activities and reduce the preventable use of hospital services and partnerships between health service providers in their specific catchment area"(INWPCP.,2011; Victorian Government.,2009). "This is undertaken with the overarching goal to improve the consumer's health outcomes, with better continuity of care, early intervention and communication between services"(INWPCP.,2011; Victorian Government.,2009). "Each Primary Care Partnership represents a specific region within Victoria and forms a voluntary alliance with a range of service providers"(INWPCP.,2011; Victorian Government.,2009).

"The Inner North West Primary Care Partnership (INWPCP) covers four local government areas of Melbourne, Moonee Valley, Moreland and Yarra and is part of the North West Metropolitan region, with a direct working relationship with the Department of Health (Regional Office) who provide support and liaison via a Program and Service Advisor"(INWPCP.,2011; Hollo.,2010).

"The INWPCP's vision is founded on the social model of health, and aims to improve the health and wellbeing of its target population, and seeks to achieve this by engaging and collaborating with member agencies in the primary and acute sectors around integrated health promotion, service coordination and integrated chronic disease management"(INW PCP.,2011; Hollo.,2010).

"The INWPCP has identified particular priorities unique to its catchment area, which include: promoting social inclusion and freedom from violence and discrimination; mental health and wellbeing; physical activity and nutrition; chronic disease management; improving service system capacity to support people with chronic disease and/or mental illness; and strengthening partnerships in order to respond effectively to catchment demands"(INW PCP.,2011; Hollo.,2010).

Appendix 2. Figures and Tables
Question 1.
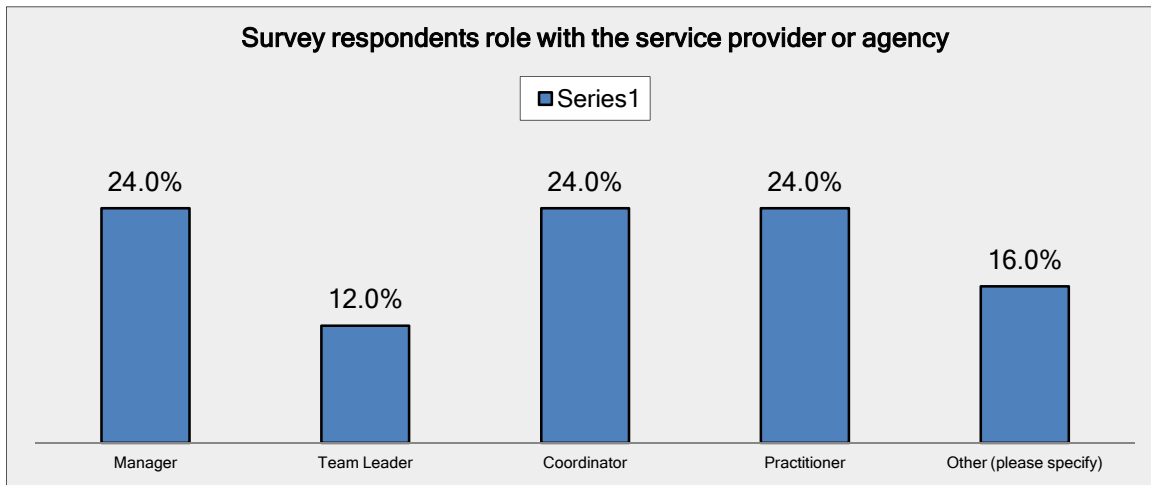
Figure 1. Survey respondents role within the local service provider.
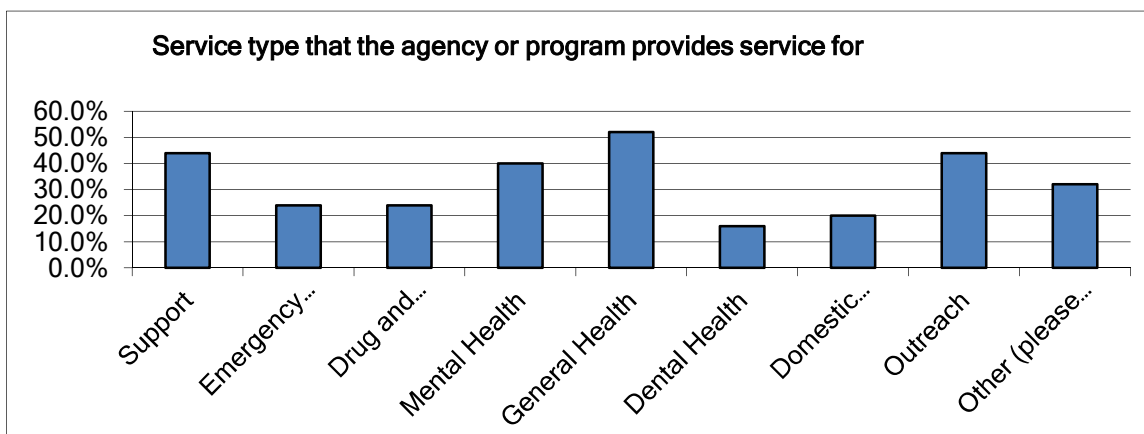
Question 2.

Figure 2. Service type the local service provider / program provides services for.

Question 3.
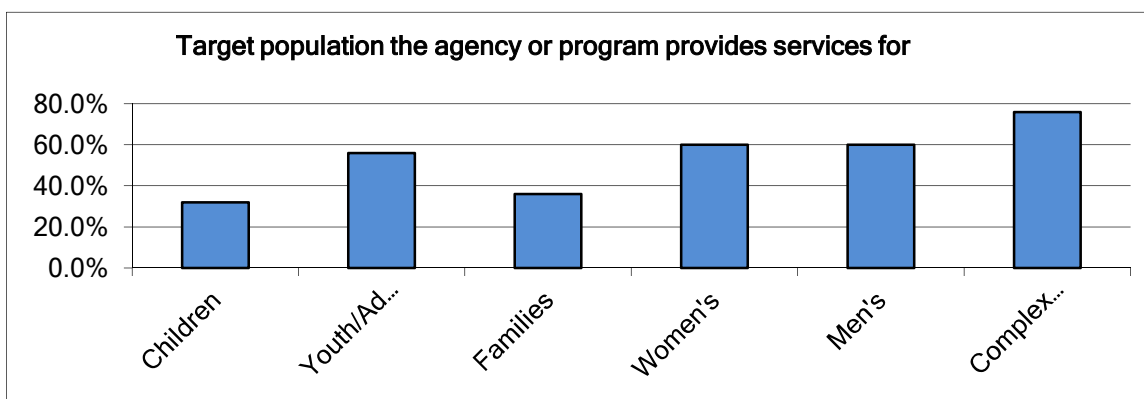
Figure 3. Target population the agency or program provides services for.

Question 4.

Years of experience of survey respondents within the homelessness sector
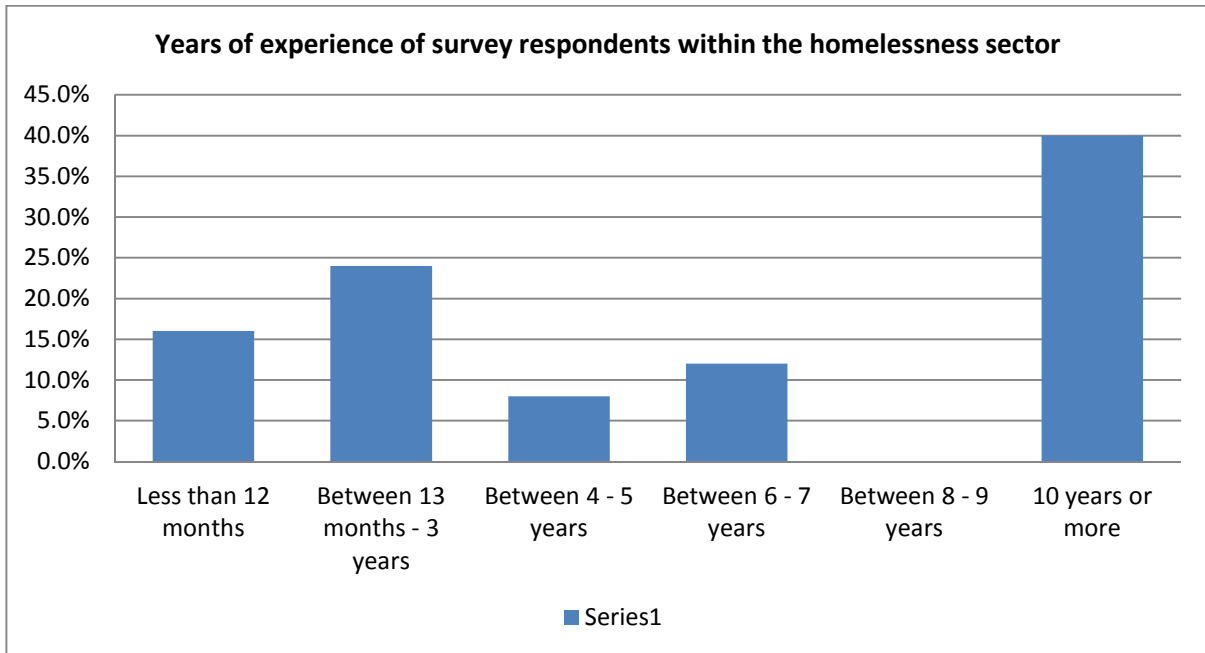
Figure 4. Respondents years of experience within the homelessness sector.

Question 5.

Length of time survey respondents have been employed with the current agency
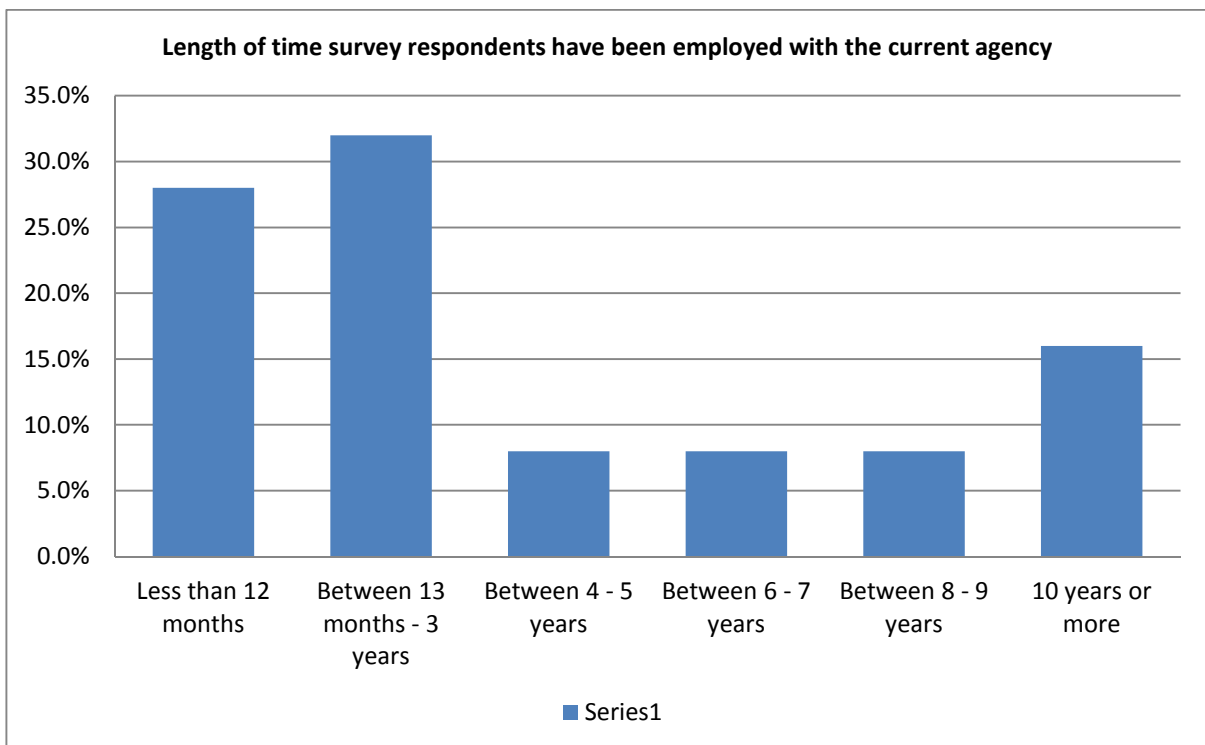
Figure 5. Respondents length of time employed with the local service provider.

Question 6.

Awareness of the CBD Homelessness Health Access Protocol and Guidelines
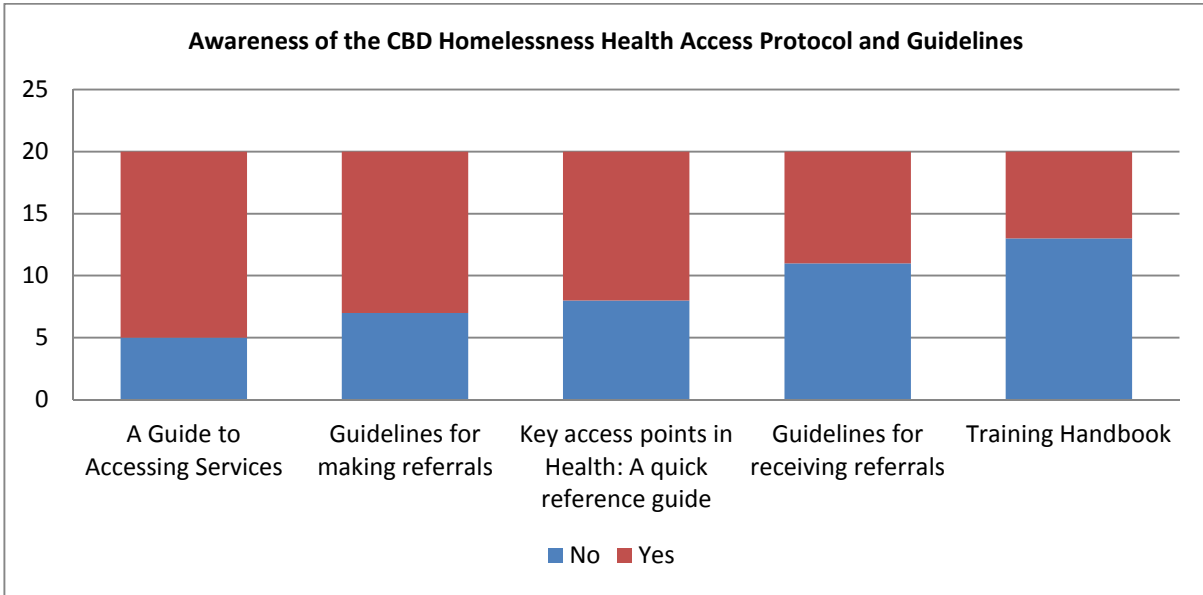
Figure 6. Respondents awareness of the CBD Homelessness Health Access Protocols.

Question 7.

How well have the CBD Homelessness Health Access Protocol been embedded into daily activities
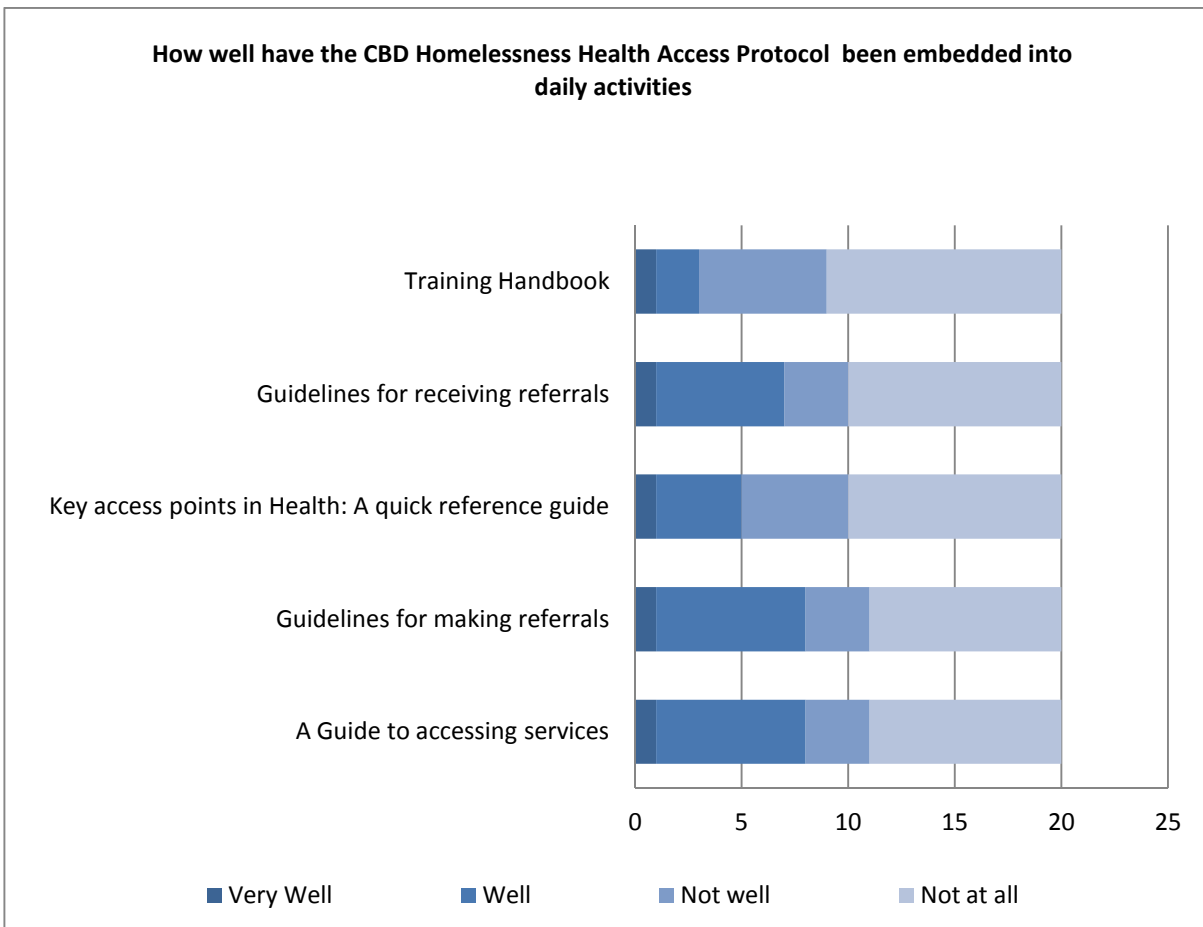
Figure 7. How well local service providers have embedded the Protocols into daily activities.

Question 8.
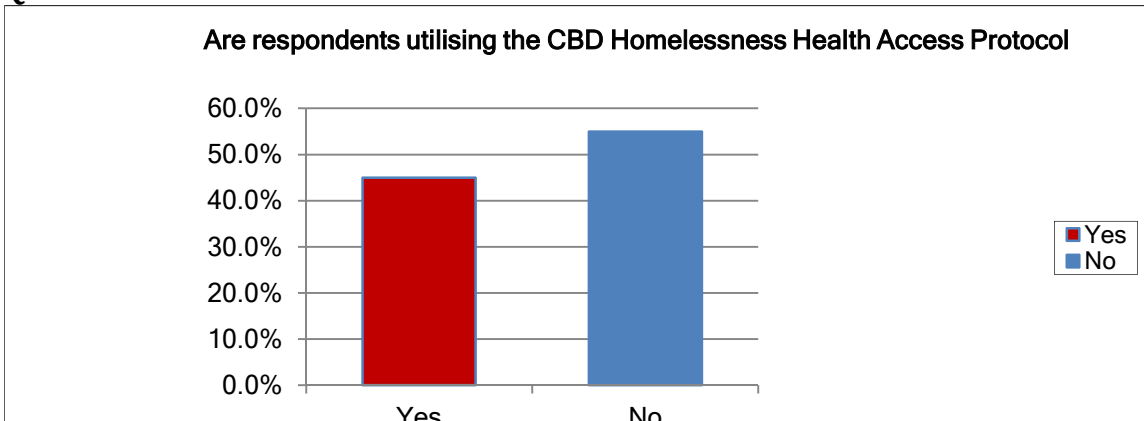
Figure 8. Are respondents are utilising the CBD Homelessness Health Access Protocols.

Question 9.
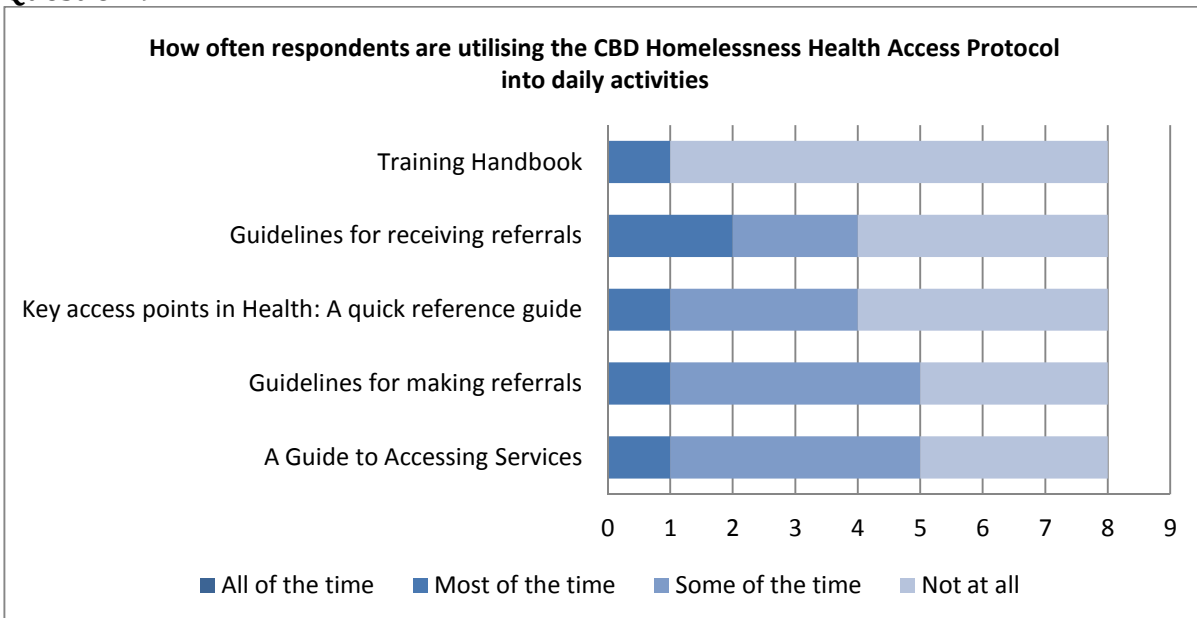
Figure 9. How often are respondents utilising the Protocol into their daily activities.

Question 10.
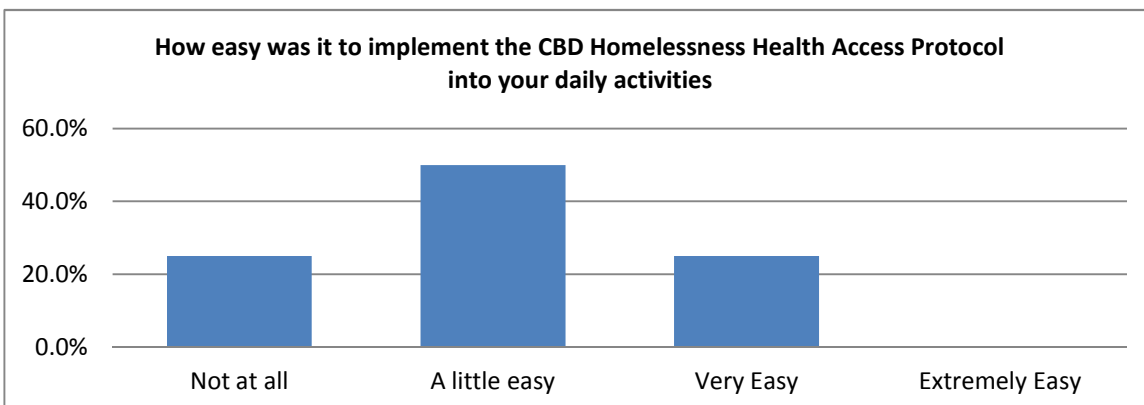
Figure 10. Ease of use to implement Protocols into daily activities.

Question 11.

To what extent have the Protocol improved your knowledge/skills of referral practices, services and options?

■ Series1
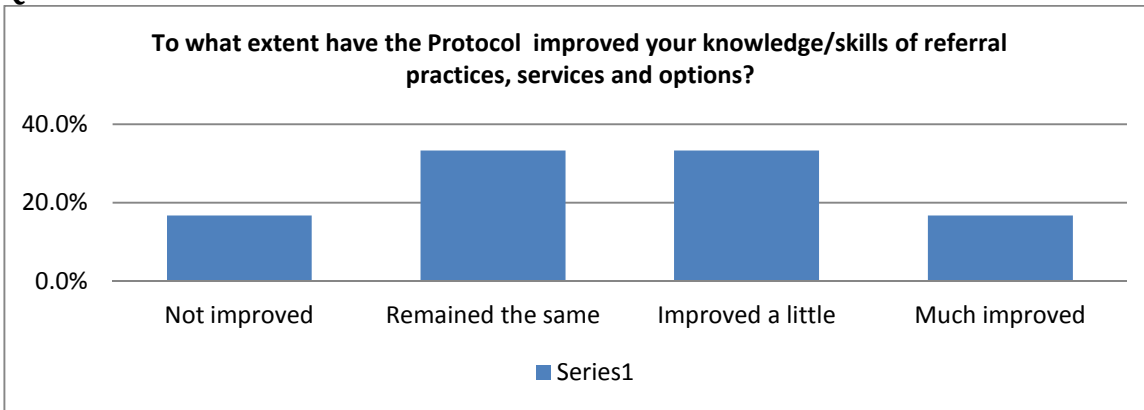
Figure 11. The extent to which CBD Homelessness Health Access Protocols have improved respondents knowledge/skills of referrals practices, services and options.

Question 12.

As a result of utilising the CBD Homelessness Health Access Protocol, the services for my clients have improved in terms of

■ Much improved ■ Improved a little ■ Remained the same ■ Not improved
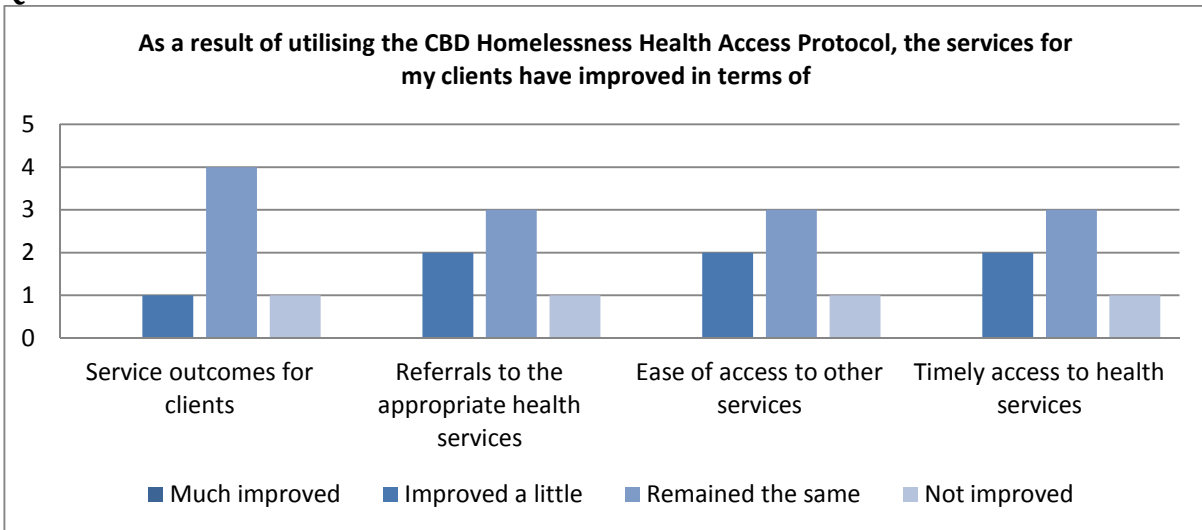
Figure 12. The extent to which respondents believe services for clients have improved.

Question 13.

As a result of utilising the CBD Homelessness Health Access Protocol, the benefits for service providers/agencies have improved in terms of

■ Much improved ■ Improved a little ■ Remained the same ■ Not improved
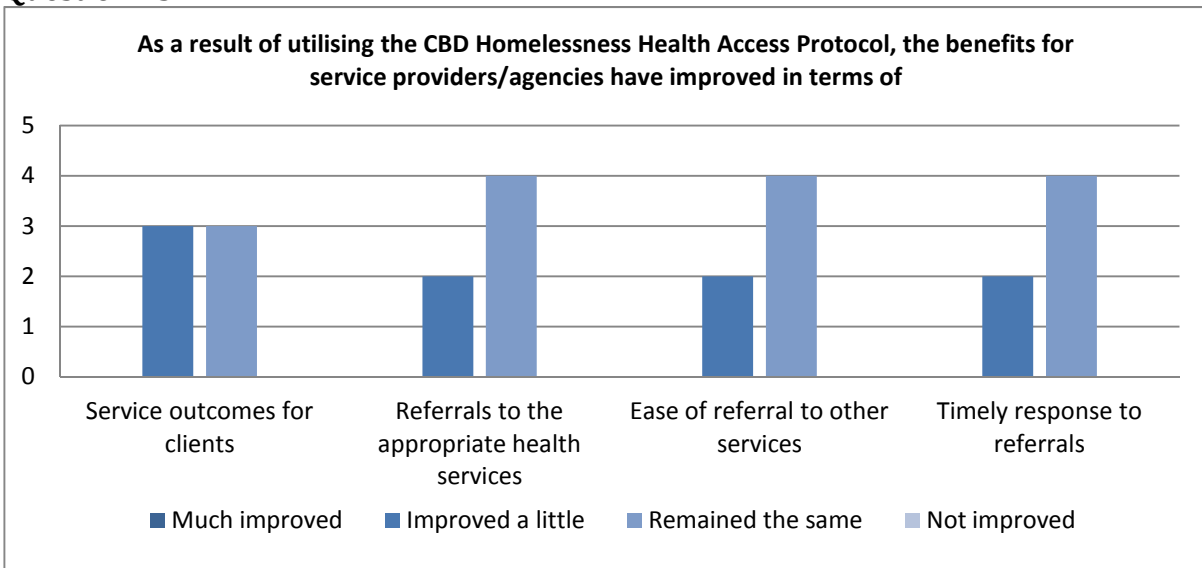
Figure 13. The extent to which respondents believe benefits for service providers have improved.

Question 14.
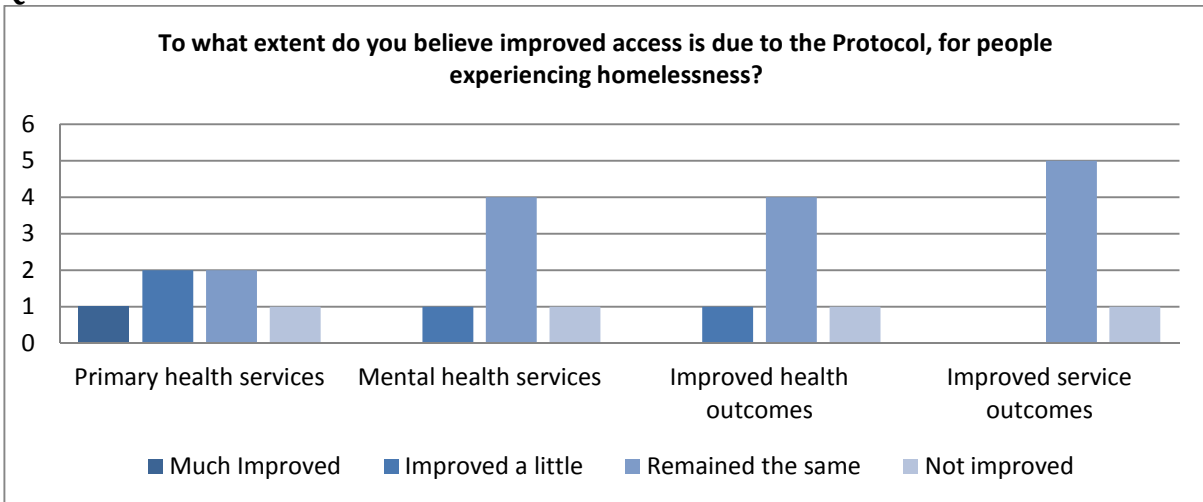
Figure 14. The extent to which respondents believe improved access is due to the Protocols, for people experiencing homelessness.

Question 15.
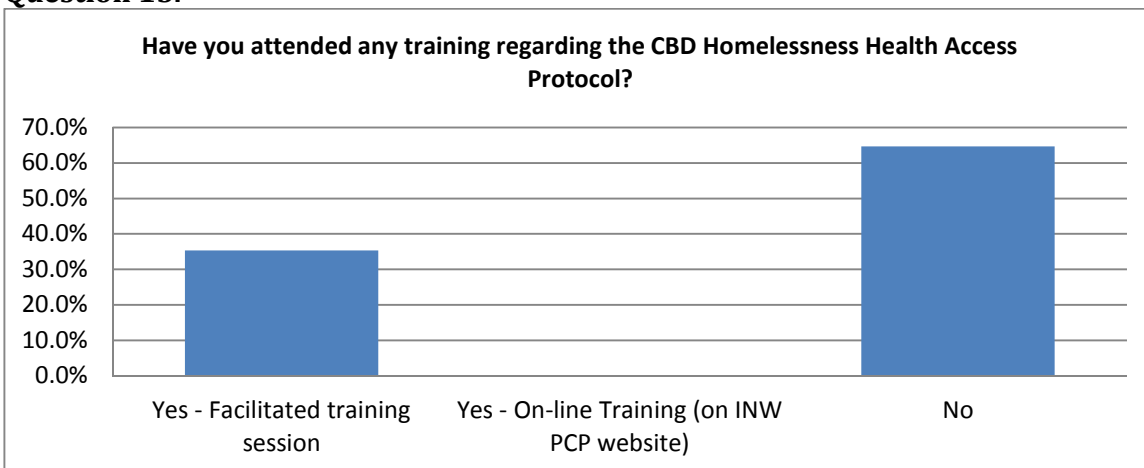
Figure 15. Whether respondents have attended any training regarding the CBD Homelessness Health Access Protocol and guidelines.

Question 16.
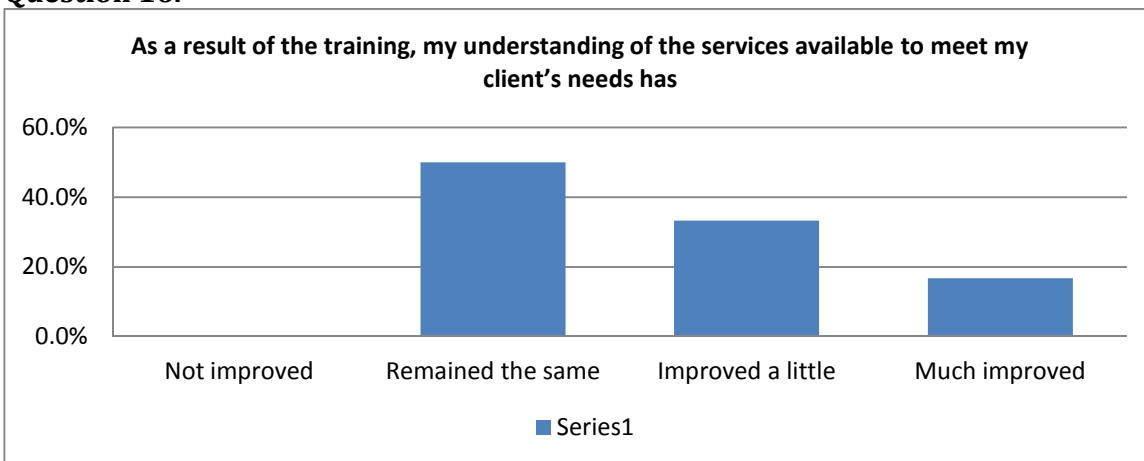
Figure 16. Whether respondents understanding of the services available to meet their client's needs has improved as a result of the training.

Question 17.
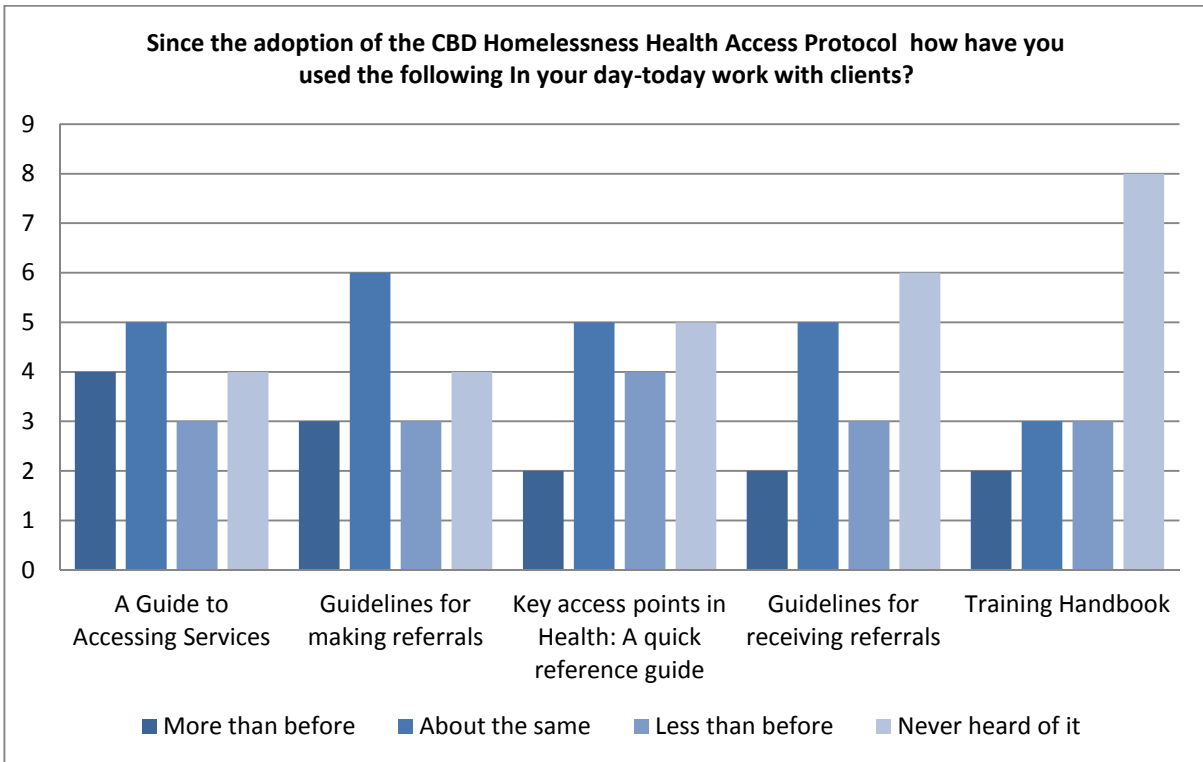
Figure 17. How respondents have used the CBD Homelessness Health Access Protocol in their day to day work with clients.

Question 18.
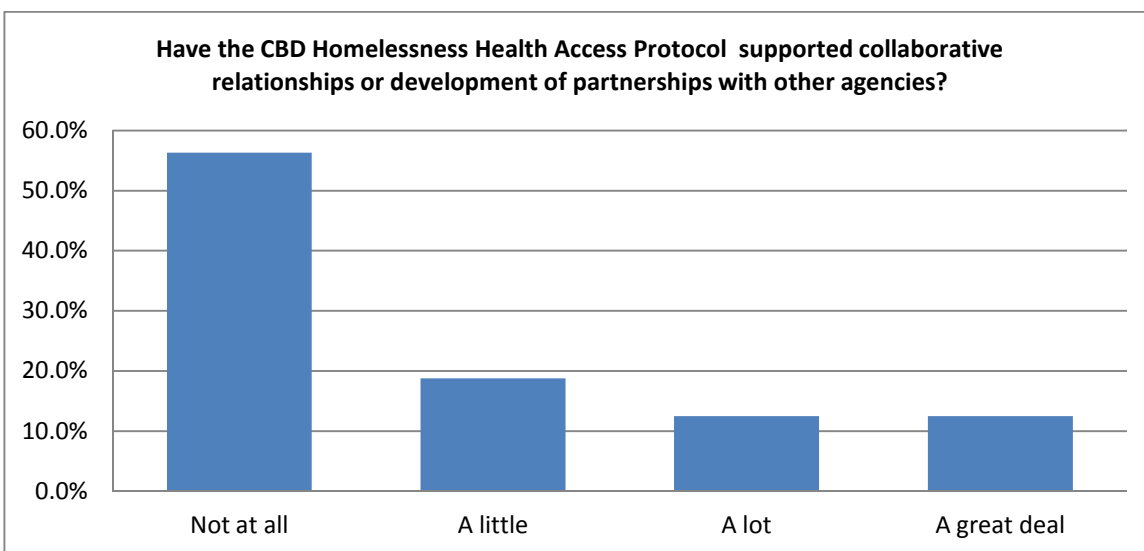
Figure 18. The extent to which the CBD Homelessness Health Access Protocol have supported collaborative relationships or development of partnerships with other agencies.

Question 19.

Have internal factors within your agency affected the implementation of the CBD Homelessness Health Access Protocol?

Yes, 40.0%

No, 60.0%
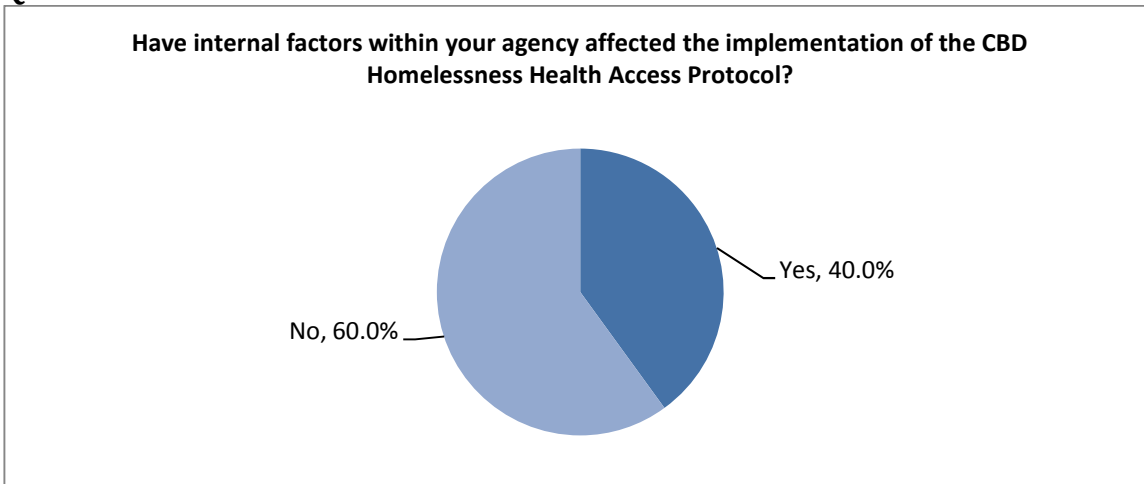
Figure 19. Internal factors within the agencies that may have affected implementation of the CBD Homelessness Health Access Protocol.

Question 20.

Have external factors outside your agency affected the implementation of the CBD Homelessness Health Access Protocol?

Yes, 13.3%

No, 86.7%
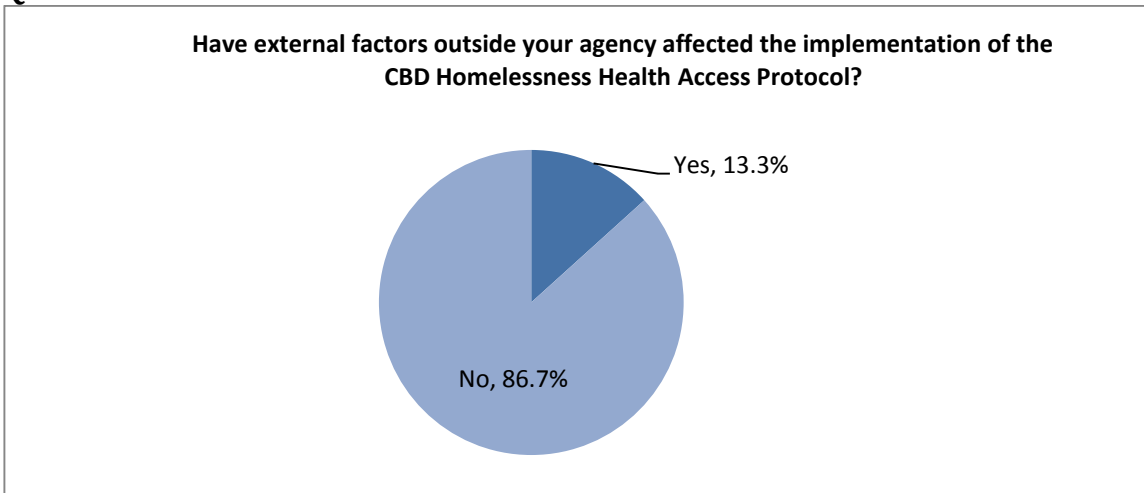
Figure 20. External factors within the agencies that may have affected implementation of the CBD Homelessness Health Access Protocol.

Question 21.

In your experience, do you believe the CBD Homelessness Health Access Protocol are useful for service providers/agencies?
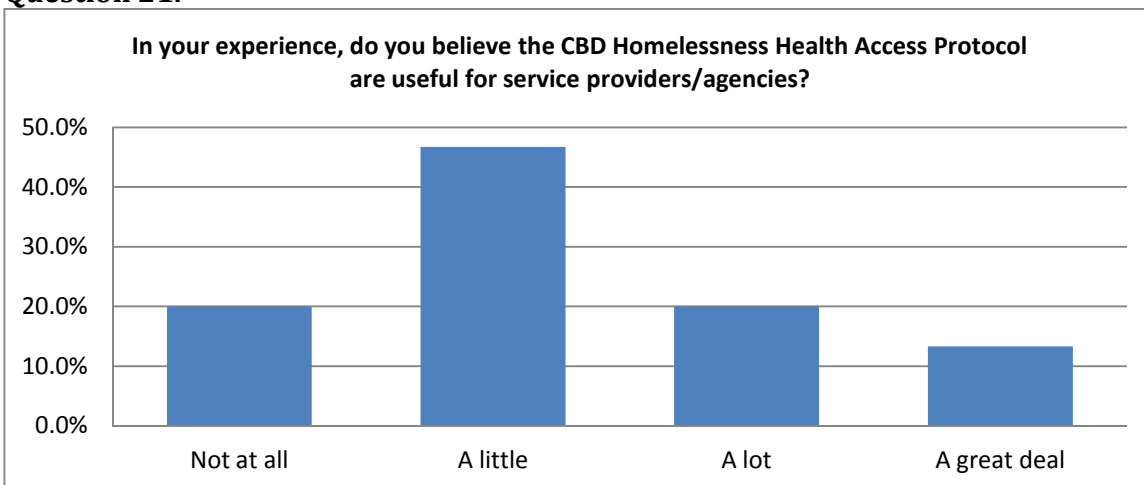
Figure 21. Respondents opinion on whether the CBD Homelessness Health Access Protocol are useful for local service providers.

Question 22.

Have the CBD Homelessness Health Access Protocol been embedded into:
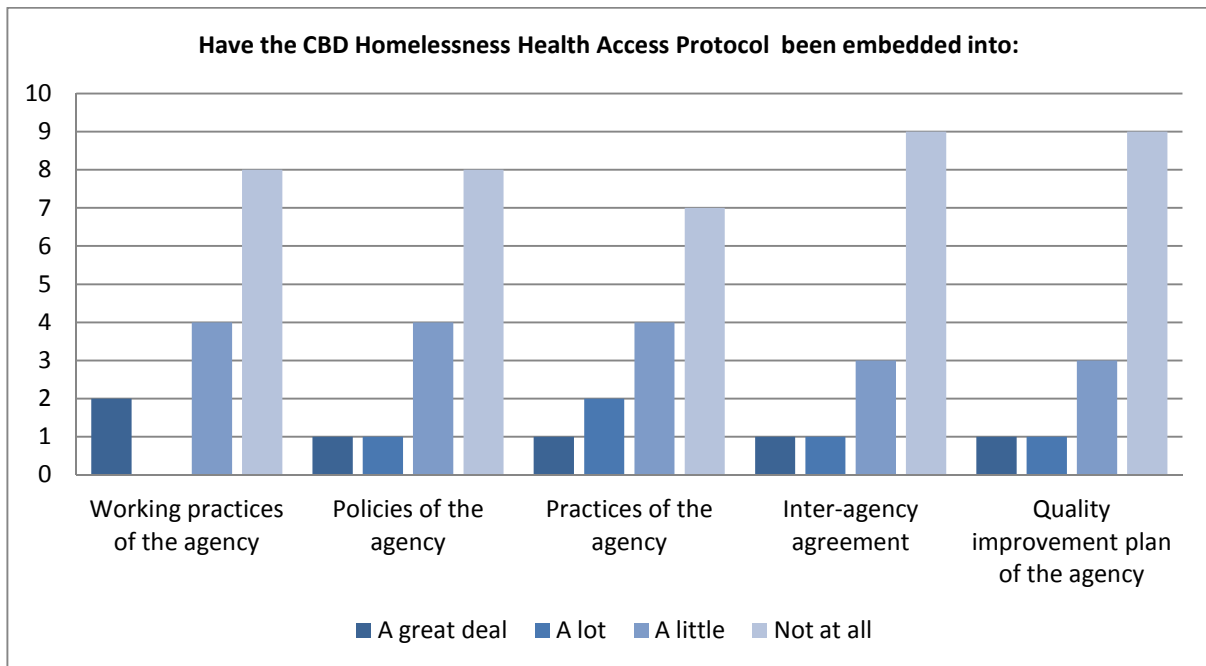
Figure 22. The extent to which the CBD Homelessness Health Access Protocol has been embedded within the local service provider.

Question 23.

What structures and processes are required within your agency to support the ongoing use of the CBD Homelessness Health Access Protocol?
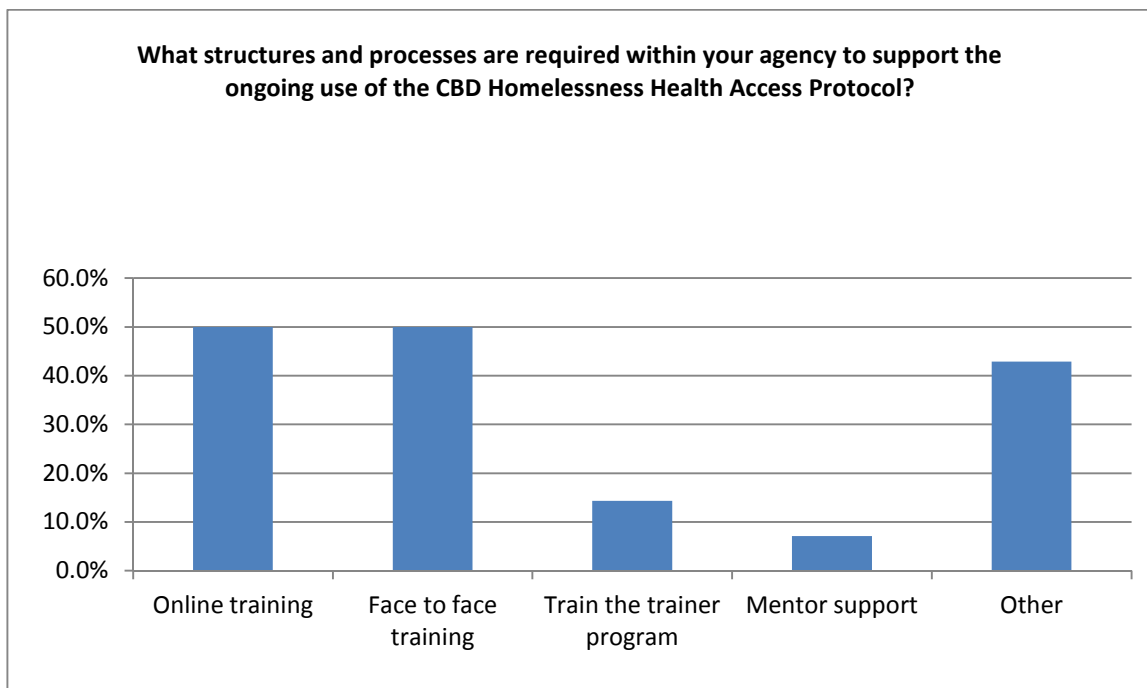
Figure 23. Structures and processes identified by respondents that are required within local agencies to support the ongoing use of the CBD Homelessness Health Access Protocol.

Appendix 3. Project Logic Model

Please see below for details of the project logic model.

Components	Program Plan				Outcome Plan		
	Target Group(s)	Activities	Inputs [Resources]	Outputs [Deliverables]	Learning [Short-term]	Action & Impact [Intermediate]	Impact [Long-term]
Each row relates to one component of your project. Divide your project up into its main components – components that will reach different target groups, or use different activities or draw on distinct resources.							
To review the uptake of agencies that have embedded the protocols into their practices.	Staff from the Service Providers and Agencies in the CBD who provide services for Melbourne's homeless population within INW PCP.	Administer surveys Data collection Data audit Data analysis Data interpretation Development of an evaluation report	Project Manager's time Stakeholders time Service Providers and Agency staff Computer access	Survey/questionnaire Data analysis results Project Report Project Poster Final Article	Knowledge of the uptake of agencies that have embedded the Protocols into their practices.	Baseline information available to complete Components 2 and 3.	As per Components 2 and 3.
To identify any information or feedback from agencies that identifies any improved client outcomes in accessing health services.	Staff from the Service Providers and Agencies in the CBD who provide services for Melbourne's homeless population within INW PCP.	Administer surveys Data collection Data audit Data analysis Data interpretation Development of an evaluation report	Project Manager's time Stakeholders time Service Providers and Agency staff Computer access	Survey/questionnaire Data analysis results Project Report Project Poster Final Article	Knowledge of the feedback from agencies regarding any improved client outcomes in accessing health services.	Predictive information about factors that influence use of Protocols available for use by Service Providers and Agencies.	Potential for increased improved client outcomes in accessing health services.
To make recommendations to improve CBD Homelessness Health Access Protocols Project.	INW PCP Executive Officer INW PCP Project Coordinator Service Providers and Agency staff in CBD who provide services for Melbourne's homeless population.	Development of an evaluation report based upon recommendations to improve the CBD Homelessness Health Access Protocols	Project Manager's time Stakeholders time Computer access	Project Report Project Poster Final Article	Knowledge for agencies, how to improve the implementation and service delivery by reviewing current practice.	Baseline information about agencies that may benefit from implementing the Protocols.	Possible improved improve access to primary health care and mental health services for people affected by homelessness within the Melbourne CBD

Appendix. 4. Gantt Chart

#	Step	Date Start	Date Finish	6/05	13/05	20/05	27/05	3/06	10/06	17/06	24/06	1/07	8/07	15/07	22/07	29/07	5/08	12/08	19/08	26/08	2/09	9/09	16/09	23/09	30/09	7/10	14/10	21/10	28/10	4/11	11/11	18/11	25/11
1	Literature Review (Ongoing)	9/2	13/11	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	
		14/5	13/11	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	
2	Stakeholder Meetings (Ongoing)	-	13/11	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	░	
		14/5	13/11		▓	▓						▓					▓				▓	▓			▓			▓	▓			▓	▓
3	Title and Summary Due(19/03)	9/2	19/3	░																													
		14/5	28/5	▓	▓	▓	▓																										
4	Develop Data Collection Tool(30)	5/3	2/04	░																													
		14/5	28/5	▓	▓	▓	▓																										
5	Write Human Ethics App(14 d)	12/3	2/04	░																													
		14/5	28/5	▓	▓	▓	▓																										
6	Human Ethics App Draft Due(2/4)	12/3	2/04	░																													
		14/5	28/5	▓	▓	▓	▓																										
7	H. Ethics App Revisions(29)	9/4	30/4	░																													
		14/5	28/5	▓	▓	▓	▓																										
8	Human Ethics Application Due	9/4	30/4	░																													
		14/5	28/5	▓	▓	▓	▓																										
9	Written Permission Sponsor Org	1/4	30/4	░																													
		14/5	28/5	▓	▓	▓	▓																										
10	Develop Budget(13days)	1/4	7/5	░																													
		14/5	28/5	▓	▓	▓	▓																										
11	Develop Comms Plan(13 days)	1/4	7/5	░																													
		14/5	28/5	▓	▓	▓	▓																										

#	Task	Start	End										
12	Develop RiskM -& Eval plan(13)	1/4	7/5										
		14/5	28/5										
13	Develop Project Proposal(14)	1/4	7/5										
		14/5	28/5										
14	Project Proposal Due(07/05)	1/4	7/5										
		14/5	28/5										
15	Finalise agreement sponsor org	1/4	30/4										
		14/5	28/5										
16	Learning Agreement Due(30/4)	1/4	30/4										
		14/5	28/5										
17	Provide draft survey to EO	1/4	7/5										
		14/5	28/5										
18	Provide final survey to EO	30/4	31/5										
		14/5	28/5										
19	Submit to FHEC	29/5	29/5										
		29/5	29/5										
20	Receive feedback from FHEC	17/6	17/6										
21	Draft memo response to FHEC	17/6	04/7										
22	Practice setting survey monkey	01/7	02/7										
23	Meeting with Sponsor	02/7	02/7										
24	Revise draft on survey monkey	02/7	04/7										
25	Advise Sponsor, when finished updating the survey	02/7	04/7										
26	Revise PIS as per FHEC memo	02/7	04/7										

#	Task	Start	End
27	Draft invite letter, provide important details to be included and send email to Sponsor	02/7	04/7
		02/7	04/7
28	Sponsor to review, revise and PCP the Invitation letter	02/7	04/7
		02/7	04/7
29	Sponsor provided the Invitation letter on INW PCP letterhead	02/7	04/7
		02/7	04/7
30	Prepare FHEC memo response, PIS and Invite letter	02/7	04/7
		02/7	04/7
31	PDF merge the Memo response	02/7	04/7
		02/7	04/7
32	Send Memo response to FHEC	02/7	04/7
		02/7	04/7
33	Wait to rec FHECs response	04/7	9/7
		04/7	97
34	Ask PHE5ALS staff estimated timeframe to receive FHEC response	02/7	04/7
		02/7	04/7
35	Email link to survey monkey to Sponsor	04/7	05/7
		04/7	05/7
36	Sponsor will test the survey internally – the link and proof read the content by the Admin Officer	04/7	05/7
		04/7	05/7
37	Prepare a stakeholder list, of agencies to send the survey to for the Sponsor	04/7	05/7
		04/7	05/7
38	Finalise survey monkey	8/7	15/7
		8/7	16/7

#	Task	Start	End
39	EO arrange letter distribute	8/7	15/7
		8/7	15/7
40	EO to distribute survey (3 wks)	8/7	2/8
		16/7	16/8
41	Follow up with reminder emails	8/7	2/8
		16/7	16/8
42	Data collection completed	8/7	2/8
		16/7	16/8
43	Documentation completed	8/7	2/8
		16/7	16/8
44	Perform Documentation Audit(14	22/7	2/8
		19/8	23/8
45	Data entry (21 days)	8/7	2/8
		23/8	27/8
46	Perform Data Analysis(14 days)	2/8	7/8
		23/8	27/8
47	Interpret Data Analysis Results(7)	2/8	7/8
		23/8	27/8
48	Schedule Stakeholder Meetings(7	2/8	7/8
		2/9	6/9
49	Meet with stakeholders(7 days)	2/8	7/8
		2/9	6/9
50	Prepare Presentation learning set	1/7	30/07
		1/7	30/7
51	Project presentation to learning	30/7	30/07
		30/7	30/7
52	Document recommendations(14)	1/7	14/08
		1/7	28/8
53	Develop Interim Proj.Report(14)	1/7	14/08
		1/7	28/8

#	Task	Start	End
54	Interim Project Report Due	1/7	14/08
		1/7	28/8
55	Write reflective Report(21 days)	1/7	27/08
		1/7	10/9
56	Reflective Report Due	1/7	27/08
		1/7	10/9
57	Develop Poster(40 days)	27/8	10/10
		28/8	10/10
58	Poster abstract submitted	27/8	02/10
		28/8	16/9
59	Poster presentation to learn set	8/10	08/10
		8/10	8/10
60	Refine Poster/Presentation(2 d)	8/10	10/10
		8/10	10/10
61	Poster uploaded to LMS	8/10	10/10
		8/10	10/10
62	Poster printed(7 days)	8/10	10/10
		8/10	10/10
63	Develop poster presentation(30)	27/8	15/10
		27/8	15/10
64	Poster delivered LTU City Campus	15/10	15/10
		15/10	15/10
65	Poster presentation completed	Oct	Oct
		Oct	Oct
66	Develop project report(31 days)	1/10	13/11
		1/10	13/11
67	Write final report for submission	1/10	13/11
		1/10	13/11
68	Finalise final report	1/10	13/11
		1/10	13/11

69	Final Project Report Due	13/11	13/11																											
		13/11	13/11																											
70	HEC final report/prep doc storage	1/11	20/11																											
		1/11	20/11																											
71	Final article submittedassessment	1/11	13/11																											
		1/11	13/11																											
72	Develop presentation INW PCP	1/11	20/11																											
		1/11	20/11																											
73	Present results to INW PCP	1/11	29/11																											
		1/11	29/11																											

Appendix 5. Budget and Resources.

The funding required for this proposed project is $17,263. This amount includes funds for staffing, computer access, printing costs and sundries. All resources will be funded privately by the project manager as part of their postgraduate studies and as such no further funding will be sought. Please see budget below for further details.

Resource	Base Cost	Quantity	When	Initial BudgetedValue	Progress@ 15wks	Final Budget	Funding Source
Staffing costs							
Project Manager	$40.53	12hr per week	26 weeks b/w Wk 19 - 48	$12,480	$7,295.4	$12,480	Donated in-kin by Project Manager
Total staff on-costs (20%)	$40.53	N/A	Wk 19 – 48	$2,496	$1,248	$2,496	Donated in-kin by Project Manager
Subtotal Personnel			Wk 19 – 48	**$14,976**	**$8,543.40**	**$14,976**	
Program Costs							
Office	N/A		Wk 19 – 48	N/A	N/A	N/A	Donated in-kin by Project Manager
Telephone/Fax/Mobile cost	$83 p/mth	7	Wk 19 – 48	$581	$332	$581	Donated in-kin by Project Manager
Internet cost	$88 p/mth	7	Wk 19 – 48	$616	$352	$616	Donated in-kin by Project Manager
Stationary/Printing	$40 p/mth	7	Wk 19 – 48	$280	$160	$280	Donated in-kin by Project Manager
Travel Expenses (petrol/car)	$30 p/mth	7	Wk 19 – 48	$210	$120	$210	Donated in-kin by Project Manager
Poster printing	$100	1	14.10.2013	$100	Not yet	$100	Donated in-kin by Project Manager
Subtotal Program Cost			Wk 19 – 48	**$1,787**	**$964**	$1,787	
Capital Costs (including equipment)							
Laptop (depreciation)	$300	1	Wk 19 - 48	$300	N/A	$300	Donated in-kin by Project Manager
Printer/Scanner	$200	1	Wk 19 - 48	$200	N/A	$200	Donated in-kin by Project Manager
Subtotal Capital Costs			Wk 19 – 48	**$500**	**N/A**	$500	
Totals for project duration			Wk 19 - 48	**$17,263**	**$9,507.40**	$17,263	Donated in-kin by Project Manager

Note:

Project Manager (Health Professional Services - Public Sector - Victoria Award 2003, Allied Health Senior Clinician, VC4, $40.53 per hour

Appendix. 6. Key Stakeholders and Impact

The table below highlights the key stakeholders, their interests and potential impact on the project, both positive and negative, are identified, with management strategies deemed necessary are below. For a list of service providers and agencies relevant to each sector.

Stakeholder	Internal/ External	Interest	Effect	Power	Likelihood	Capacity	Needs	Management Strategies	Frequency	Potential Impact on project
INW PCP Executive Officer	Internal	High	Enabler	High	Certain	N/A	Project deliverables Communication	Agreed proj. plan Verbal Written progress report	Reviewed monthly and prn Weekly and prn Fortnightly	Increased personal workload, potential to impact on reputation, could benefit from useful outcomes
INW PCP Project Coordinator	Internal	High	Enabler	High	Certain	N/A	Project deliverables Communication	Agreed proj. plan Verbal Written progress report	Reviewed monthly and prn Weekly and prn Fortnightly	Increased personal workload, potential to impact on reputation, could benefit from useful outcomes
Support Services Agencies	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required, During data collection	Increased personal workload, Benefit from further knowledge and information from the evaluation report, ensure Protocols and practices are embedded and adhered to
Mental Health Services Agencies	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required, During data collection	Increased personal workload, Benefit from further knowledge and information from the evaluation report, ensure Protocols and practices are embedded and adhered to
Dental Services Agencies	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required, During data collection	Increased personal workload, Benefit from further knowledge and information from the evaluation report, ensure Protocols and practices are embedded and adhered to
General Health Services Agencies	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required, During data collection	Increased personal workload, Benefit from further knowledge and information from the evaluation report, ensure Protocols and practices are embedded and adhered to
Drug and Alcohol Services Agencies	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required, During data collection	Increased personal workload, Benefit from further knowledge and information from the evaluation report, ensure Protocols and practices are embedded and adhered to
Emergency Assistance – Hospital/Acute Agencies	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required, During data collection	Increased personal workload, Benefit from further knowledge and information from the evaluation report, ensure Protocols and practices are embedded and adhered to
CBD Health and Homelessness Alliance	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required,	Could benefit from useful outcomes
CBD Health and Homelessness Working Group	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required,	Could benefit from useful outcomes
Key Access Points	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required,	Could benefit from useful outcomes
Guide to Accessing Services	Internal	Medium	Enabler	Med	Likely	Yes	Communication	Verbal/Written	As required,	Could benefit from useful outcomes

Appendix 7. Risk Register

When	Description of risk	Consequence	Initial assessment			Mitigation Strategies	Action taken	Subsequent assessment			Outcome/Future Action
			Probability	Impact	Risk Rating			Probability	Impact	Risk Rating	
Prior to project	Project not approved by human ethics committee	*Resubmit ethics to La Trobe and INW PCP Executive Officer*	*Unlikely*	*Moderate*	*Medium*	*Adjust project timelines to suit shortened timeframes*	*Revise Ethics Application*	*Rare*	*Minor*	*Low*	*Not needed, remove risk*
						Adjust project scope to suit shortened timeframes	*Revise Ethics Application*				*Not needed, remove risk*
Prior to project	*Unwanted feelings of distress by participant*	*Personal distress*	*Possible*	*Minor*	*Medium*	*Participant Information sheet that lists potential outcomes to ensure informed consent*	*Revised PIS*	*Rare*	*Minor*	*Low*	*Approved by Ethics committee on 08.07.2013*
						Careful wording of questions	*Revised questionnaire*				*Approved by Ethics committee on 08.07.2013*
						Resource support mechanisms eg counselling	*Counsellor services organised*				*Not needed to date, continue to monitor*
Prior to project	Project fails to achieve interim timeframes/budget on process evaluation	*Adjust scope or quality of the project to ensure completion within timeframes.*	Possible	Minor	Low	*Adjust scope or quality of the project to ensure completion within timeframes.* Seek increased support from sponsor.	Student to work on the project over the weekend, and take A/L day from work in order to make sure report is complete	Rare	Minor	Low	*Not needed, remove risk*

When	Description of risk	Consequence	Initial assessment			Mitigation Strategies	Action taken	Subsequent assessment			Outcome/Future Action
			Probability	Impact	Risk Rating			Probability	Impact	Risk Rating	
Prior to project	Sponsor withdraws support	*No project*	*Possible*	*Major*	**High**	*Ensure appropriate stakeholder management to maintain support.*	*Ensure appropriate stakeholder management to maintain support.*	Rare	Minor	**Low**	*Not needed, remove risk*
Prior to project	Data unable to be extracted from survey questionnaires	*Delay in report findings and interpretation of results*	*Rare*	*Extreme*	**Extreme**	*Adjust timeframes and scope to accommodate*	*Ensure appropriate stakeholder management to maintain support.* *Seek support from sponsor.* *Extract data manually*	Possible	Major	**Medium**	*Ensure appropriate stakeholder management to maintain support.* *Seek support from sponsor.* *Extract data manually* *Adjust scope of project to reduce amount of data required to be extracted.*
Prior to project	Quality of documentation within survey of insufficient quality for analysis	*Unable to provide quality report findings and recommendations*	*Possible*	*Major*	**High**	*Alter data collection tool to accommodate varied data quality to guarantee analysis is possible.*	*Revise survey*	Possible	Major	**High**	*Survey revised with Emily in July 2013, finalised by15th July and distributed.*
Prior to project	Insufficient resources available for documentation	*Difficult to report findings*	*Unlikely*	*Moderate*	**Medium**	*Allow adequate time in plan if PM is to complete individually*	*Ensure appropriate stakeholder management to maintain support/resources available*	Unlikely	Minor	**Low**	*Not needed, remove risk*
Prior to project	Stakeholders work to block project success	*Not able to produce project report*	*Unlikely*	*Minor*	**Low**	*Monitor stakeholders*	*Manage stakeholder interests*	Unlikely	Minor	**Low**	*Not needed, remove risk*
Prior to project	Project findings become less important due funding/staffing	*Unsure*	*Unlikely*	*Minor*	**Low**	*Review and adjust objectives of project to benefit changed context*	*Monitor*	Unlikely	Minor	**Low**	*Not needed, remove risk*

MEMORANDUM

FACULTY OF HEALTH SCIENCES

To:	**Lindsay Carey – Department of Public Health**
Student:	**Kyriaki Petridis**
From:	**Chair, Faculty Human Ethics Committee**
Reference	**FHEC13/123**
Title:	**Evaluating the CBD Health and Homelessness Access Protocols Project**
Date:	**8 July, 2013**

The chair of FHS FHEC has evaluated your application as of negligible risk, and has approved the project without review.

As a negligible-risk project (see http://www.latrobe.edu.au/research-services/assets/downloads/HEC_Guidelines%202012.pdf section 6.2 and 6.3), you are not required to submit annual and final reports, but you are required to maintain auditable records of the project.

Please note that the Informed Consent forms need to be retained for a minimum of 5 years. Please ensure that each participant retains a copy of the Informed Consent form. Researchers are also required to retain a copy of all Informed Consent forms separately from the data. The data must be retained for a period of 5 years.

Owen M Evans, PhD
Chair
Faculty Human Ethics Committee
Faculty of Health Sciences