Service Integration Initiative Guidelines, Specifications and Requirements

December 2024

Queensland Government

Contents

1 Context

These Guidelines outline the framework and service particulars for the delivery of Service Integration Initiative (SII) funding to auspice Service Integration Facilitators (SIF) to improve integration of multi-agency responses for people with complex needs that assist them to obtain and sustain housing and support to improve their life outcomes.

1.1 Underpinning approaches to service integration initiative

It is expected that the SII will be underpinned by the following approaches:

- Housing first – refer to *Homelessness Program Guidelines, Specifications and Requirements* for details.
- Duration of need - refer to *Homelessness Program Guidelines, Specifications and Requirements* for details. In the context of SII, this means that a service integration plan should not be closed until a household has achieved a sustainable housing and support outcome or has disengaged.
- Collective impact.
- Service integration initiatives principles and pillars.

1.1.1 Collective impact

This approach provides a collaborative platform in which to develop effective place-based change mechanisms designed to address complex social issues through a highly participatory actioning process. In order to create such an environment, five conditions must be met (*Figure 2*);

- *Common agenda:* All those involved have a shared vision for change which includes a common understanding of the issue(s).
- *Continuous communication*: Open communication across all stakeholders to build trust, reinforce mutual objectives and create motivation.
- *Shared measurement system*: Consistent measurement of data across all locations.
- *Mutually reinforcing activities*: Whilst respecting local knowledge, influence and experience, activities are coordinated and aligned to a central action plan.
- *Backbone function*: Provision of support and coordination to all stakeholders.

1.1.2 Service integration initiative principles and pillars

SII Principles

Person-centred

- Informed and planned around the needs and preferences of the individual with consideration for the individual's experiences, culture, and capability.
- Individuals are supported in demonstrating their right to self-determination and considered a central, active member of the service integration process.
- Service systems are responsive to individuals and cohorts.

Place-based

- Integrated service approaches are designed and operated at the local level.
- Local decision making about the needs, care and support of individuals.
- Highly collaborative, bringing together and leveraging local expertise and resources across community, non-government, government and private sectors.
- Service system wide integration and collaboration of local services that responds to and addresses local needs.

Outcomes-focused

- Captures and analyses meaningful client outcomes.
- Driven by quality sustainable outcomes for clients, rather than client quantity.
- Service system contributors working toward shared outcomes for the individual.
- Recognising the complexity of measuring outcomes in human services and including qualitative data and collaborative approaches to understand data.

Evidenced-based

- Informed by empirically supported assessments and responses in the day-to-day support of individuals.
- Practice will be both informed by evidence-based approaches and contribute to the development of evidence-based approaches.
- Approaches that consider professional ethics and practice, as well as the personal and cultural values and judgements of individuals that are being supported.

Continuous improvement

- A culture of continuous improvement, embedded in operations and governance.
- Systems and processes will be reviewed regularly to ensure contemporary, evidence-based practice methodologies are in place.
- Supports workforce capability building opportunities and the development of tools and resources to implement continuous improvement across Queensland.
- Promotes collaboration between and within service systems to support continuous quality improvement and improve client outcomes.

SII Pillars

Alliance at the local level

- Each location brings together a cross-sector alliance of committed community services and agencies that as a collective will provide multi-disciplinary responses for individuals with complex needs.
- The alliance tailors service systems responses to individual and cohort needs and is focused on designing a system that delivers sustainable client outcomes.
- The alliance uses a 'no wrong door' style approach during the referral process.
- The alliance works together to identify and respond to local individual and service sector needs with the aim of improving service delivery and outcomes for clients.
- The alliance actively supports the co-design, implementation and continuous quality improvement of local integrated services approaches.

Sustaining outcomes

- Actively contributes to housing outcomes and broader socio-economic outcomes to support tenancy sustainment.

- Short, medium and long-term client outcomes are measured, and appropriate follow-up mechanisms are in place to ensure the sustainability of outcomes.
- Led by a holistic view of the needs identified by the individual and with respect for the individual's experiences, culture, and capability.
- Reducing inflow of repeat service users and increase in sustainable, person-centred outcomes.
- Addresses service system gaps and implements service system improvement to support tenancy sustainment for individuals and / or for cohort, where a cohort service system response is appropriate.

Collaborative impact

- Collaboration across the local service system and with other key stakeholders.
- Working with and building on established local mechanisms and services.
- Engaging with specific service domains to address issues at the local level.
- Local promotion of Service Integration Groups to optimise engagement.
- Open and consistent communication.
- Action orientated learning: Build – Measure – Learn.

2 Associated guidelines

The Service Integration Initiative Guidelines, Specification and Requirements are a subset of the *Homelessness Program Guidelines, Specifications and Requirements* - refer to *Homelessness Program Guidelines, Specifications and Requirements* for details.

3 About service integration initiative

3.1 Program logic

Refer to the *Homelessness Program Guidelines, Specifications and Requirements* for the Program Logic for the Homelessness Program.

3.2 Service integration facilitators

SIFs develop systems and processes to underpin an integrated service system response including establishing and maintaining productive partnerships across all sectors and supporting service integration planning for people with complex needs who are referred to a Service Integration Group (SIG). Please note that service integration plans are for the coordination of support from multiple agencies and services and are not case management plans which should be developed by the agencies providing direct work with people.

SIFs are funded to facilitate SIGs, support services to implement integrated responses and progress service system strengthening opportunities. SIFs work across the service system with funded and non-funded services as well as all levels of government to improve outcomes for people with complex support needs. This includes identifying broader local needs and service system gaps and working collaboratively with government and non-government agencies to address these.

3.3 Service integration groups

SIGs are formal groups which exchange information, services, ideas, opportunities, learn and share experiences while building connections of mutual benefit and reciprocity between individuals, groups, and agencies through place-based networking. They work together to provide integrated responses to achieve outcomes for individuals and to identify and address service system improvements.

SIGs also bring together front-line staff from across the regional service system to develop service integration plans for people with complex needs experiencing or at risk of homelessness which require multi-agency response.

SIGs include an alliance of multi-disciplinary services and agencies which are categorised by service domains in the Client Management System Care Coordination Module (CMS). A full list of service domains is at Appendix 1.

Elements of success for SIGs includes deliberate facilitation, active participation, collegial input and professional advice, clear and concise information, documentation of clients, active follow-up and implementation in-between meetings, ability for off-line case conferences, review and feedback, intentional escalation, capacity building and workforce development. See Appendix 2 for more details.

3.4 Backbone support

The backbone role provides support, advice and assistance to housing and homelessness networks and SIGs operating across Queensland, including capability building, development of standard inputs, enabling and facilitating a consistent data collection approach and the leading the state-wide action research for the SII.

3.5 Service categories and service users

People accessing services in the context of the Homelessness Program are specified within two broad service user groups including:

1. People who are experiencing homelessness or at imminent risk of homelessness; or
2. People who are housed but at risk of homelessness.

See more details in the *Homelessness Program Guidelines, Specifications and Requirements*.

The SII funding is provided for the following service category, service type and services user group as detailed in the *Homelessness Program Guidelines, Specifications and Requirements*:

- Service Category: Service System Support and Development.
- Service Type: ST12 Coordination/Network Development.
- Service User Group: SU3550 Generalist. (The target group for SII are people with complex needs who require multiagency responses to achieve a sustainable housing outcome).

3.6 Geographic catchment

As defined in each auspice agencies Service Agreement and Funding Schedule (3.7 Service deliverables).

Refer to the *Homelessness Programs Guidelines, Specification and Requirements*.

3.7.1 Outcomes and targets

The below outcomes and targets have been developed to provide guidance on the department's expectations for the service integration planning function of SIG to be supported by the SIFs.

It is recommended that:

- all active clients have a service integration plan in place.
- households remain in service integration for their duration of need to achieve a sustainable housing outcome, unless their service integration plan is closed due to disengagement.
- households have an exit plan when their service integration plan is closed, unless their service integration plan is closed due to disengagement.

Service category	Outcome measurement		
	Outcome	**Outcome measure**	**Annual target**
Client outcomes	Households resolve the issues that impede accessing or maintaining housing.	**CC01** – Number of and percentage of active households whose records were closed during the reporting period who had a service integration plan in place.	Minimum 90% (from CMS)
	Households are housed at the end the service integration planning support period.	**CC02** - Number and percentage of active households whose records were closed during the reporting period who achieved a sustainable housing outcome.	Minimum 60% (from CMS)
	Households have exit plan at the end the of service integration planning support period.	**CC03** – Number and percentage of active households whose records were closed during the reporting period who had an exit plan in place on exit.	Minimum 60% (from CMS)

3.7.2 Outputs and targets

Service category	Service type	Output measure	Annual target
Service system support and development	Coordination/Network development.	CC04 - Households assisted.	Number of households per year provided with service integration planning.

3.7.3 Calculating and reporting outcomes and outputs

Services are required to deliver a minimum number of funded outputs and meet outcome targets for clients. These are expressed as minimum outcome and output targets. The counting rules for these targets are detailed at Appendix 3.

4. Service delivery requirements

SII services must adhere to the statements identified in this section which form part of the contractual requirements in a service agreement with the Department of Housing and Public Works (the department).

4.1 Service integration facilitator role

SIFs provide local assistance to strengthen existing and emerging SIGs. A copy of the SIF Role Description is at Appendix 4 and are funded as full-time positions as per Social and Community Services Level 6. SIFs do not work directly with clients or case manage clients but work at the system level to support improved coordination and integration of multiagency responses for people experiencing complex support needs. This includes service system strengthening and supporting SIGs to create service integration plans for the duration of need until people referred to a SIG achieve a sustainable housing outcome, with broader supports being implemented on an ongoing basis as needed.

SIFs and their auspice organisations must work collaboratively with the backbone support role, including but not limited to workforce development planning and the development and use of commons tools and resources for SII. SIFs must also ensure that data related to households referred to a SIG and service system improvement data is entered and maintained on the CMS to support six month and annual reporting.

4.2 Client informed consent

SII services must conform with Commonwealth and State Laws and Regulations related to the collection, management and sharing of personal information for the purposes of service integration planning and consider using deidentified information where possible to protect client privacy.

4.3 Service integration

Service integration is a mandatory service approach for all SIFs and SIGs must provide initial service integration planning, monitoring and review and exit planning for all referred households. The SIF has secure access and use of CMS and will capture the following mandatory service integration process and related data:

- referral/entry into service integration.
- service integration plan development.
- service integration plan reviews.
- sustainability Assessment.
- planned or unplanned exit points.
- exit planning – exit planning template at Appendix 5.
- outcomes achieved.

Referral forms should be completed and submitted by the service referring people to a SIG at a reasonable time before each SIG meeting to be presented and considered by the SIG. In most cases, it is reasonable for the SIG to require the referring agency to complete intake and assessment of clients they are referring prior to referral, to understand the additional supports that may be required. The referral to a SIG should not limit or delay referrals to other services as required outside of scheduled SIG meetings.

The facilitated development, implementation, monitoring and reviewing of service integration plans is vital in tracking the journey of a client(s) within the service integration process, reporting outcomes and providing meaningful real-time data on the local service system's responsiveness to households and certain cohorts requiring specific interventions.

4.4 Service system strengthening

A SIF must work at the service system level to support service system strengthening and identify and respond to local service system gaps, trends and emerging issues. This is done through engagement in local networks including SIGs, to strive to facilitate and broker local solutions:

A SIF must:

- create or support existing systems and processes to underpin an integrated service response, including governance arrangements, terms of reference and mechanisms to support greater service integration and collaboration.
- establish and maintain productive partnerships with and across government, and non-government service sectors, to ensure effective communication, negotiation and information sharing to address the needs of people who are experiencing homelessness or at risk of experiencing homelessness with complex support needs requiring multi-agency responses and to improve service system responsiveness.
- analyse and report on client and service system data to understand trends and service systems gaps.
- work with sector partners to resolve issues and improve local service system design.
- ensure systems and processes enable the evaluation of outcomes and impacts of service integration approaches and potential improvements/refinements.

4.5 Accessibility

Refer to the *Homelessness Programs Guidelines, Specification and Requirements*.

4.6 Client practice

Refer to the *Homelessness Programs Guidelines, Specification and Requirements*.

4.7 Reporting requirements

This section outlines the data collection and reporting requirements for all providers.

4.7.1 Data collection and evaluations

Agencies funded under the SII must:

- meet all data collection requirements as notified by the department from time to time, including (without limitation) the requirement to ensure CMS data is fully completed and up to date monthly to support reporting, real-time data and improvements. Reporting templates have been developed and incorporate reporting on the outcomes, outputs and other measures defined in these guidelines (Sections 3.7.1, 3.7.2 and 4.7.4). CMS data reports will be generated centrally by the department for SIF analysis and sharing locally.
- agree to the backbone support and the department using deidentified client data for reporting and evaluation of the SII.
- participate, as requested by the department, in all performance monitoring and evaluation processes including briefing the Regional Director of the department in the local area on a regular basis to support broader service system improvements and departmental understanding of current service system issues for people requiring multi-agency responses.
- adhere to the CMS Policy as provided by the department.

4.7.2 Data systems

The department has implemented the CMS which is an electronic database used to collect client and service system data, and for creating and monitoring service integration plans for clients.

Service Providers must capture data to support the service integration planning for clients and capture client and service system data through the CMS.

4.7.3 Case studies

Funded services are required to provide a minimum of four case studies each year including:

- The Provision of a minimum of one case study every six months that demonstrates household experiences and outcomes.
- Provision of a minimum of one case study every six months that demonstrates improved integration of service delivery across government and community services or measures or initiatives that address identified local needs, gaps or emerging issue.

The case study guide is provided at Appendix 11 and includes a case study consent form.

4.7.4 Performance reporting

Providers are required to report to the department the following measures from CMS in addition to reporting against the outcome and output targets at Section 3.7.

Other outcomes measures
Number and percentage of households with closed support periods who disengaged and reasons for disengagement.
Number and percentage of households with closed support periods with one of more complex service needs unmet and percentage of these households who were considered to have achieved sustainable housing.
Number and percentage of active households with support periods greater than three months from commencement of a service integration plan with housing needs unmet.
Number and percentage of active households with support periods greater than six months from commencement of a service integration plan with other support need (excluding housing) service needs unmet by service domain.
Number and percentage of active households with service needs unmet due to no service available in locations by service domain.
Number of active households who are repeat users, excluding households whose support periods were closed due to disengagement.
Number of active households who are repeat users, whose support periods were closed due to disengagement.
Throughput measures
Number of households referrals.
Number of households referrals by pathway and service domain.
Number of active individual clients.
Number of active households, by construct (singles, couples, families with dependent children).
Number of active households based on housing situation on referral.
Average and range of the length of time of support periods for households.
Level of enduring needs of active households.
Level of enduring needs not assessed for active households.
Number of households with a closed support period and sustainable housing outcome.
Number of households with a closed support period and an exit plan is in place.
Number of households with a closed support period and supports were coordinated as a part of Service Integration.
Number of households with a closed support period and on-going supports.
Number of households with a closed support periods by tenure.

Demographic measures
Number of lead clients identifying as Aboriginal and Torres Strait Islander.
Number of lead clients identifying as being from Culturally and Linguistically diverse backgrounds.
Number of lead clients with a disability.
Number of lead clients identifying as a veteran.
Number of lead clients by gender.
Number of lead clients by age.
Number of lead clients identifying as being affected by DFSV.
Number of lead clients identifying as being affected by problematic gambling.
Number of lead clients identifying as being affected by problematic alcohol and other drug use.
Number of lead clients identifying as being affected by hoarding and squalor.
Number of lead clients transitioning from custodial arrangements or previously incarcerated.
Number of lead clients transitioning from foster care or child safety residential placements.
Number of lead clients identified as 'Know by Name'.
Number of lead clients identifying as LGBTQI+.
Service system measures
Number of agencies and services actively participating in service integration groups in each location, and the participation rate of each agency or service.
Number of service integration projects the SIFs have led to support service system strengthening.
Number of service integration projects the SIFs have participated in led by others to support service system strengthening.
Number of service domains covered through the participation of the agencies and services.
Other measures
Provision of a minimum of one case study every six months that demonstrates client/household experiences and outcomes.
Provision of a minimum of one case study every six months that demonstrates improved integration of service delivery across government and community services or measures or initiatives that address identified local needs, gaps or emerging issues.

4.8 Governance

Service providers must actively participate in state-wide governance of SII and provide leadership of local governance.

The department and the backbone support provide the state-wide governance groups for the SII and oversight of measures delivered as part of SII and auspice agencies must be active participants of these groups as outlined in the terms of references (ToRs) for such groups.

Local SIGs are governed and driven at the local level. Each SIG should be supported by a Place-Based Response Team or a steering group to promote transparency and accountability related to practice and processes. Local governance groups are bound by local ToRs and group membership commitment.

Local governance groups should identify opportunities to improve the delivery of person centred and integrated services for people with complex needs. It should broker local service system solutions and develop improved pathways for people with complex needs and work at the service system level to address issues and challenges at

the local level or escalate these to the state-wide governance groups either through the auspice organisations or the Regional Director.

4.9 Continuous improvements

Building on the underpinning approaches to service delivery at Section 2, funded agencies will support build, measure and learn approaches at the local level and state-wide level and continuous improvements in relation to practice and reviewing, refining and updating process.

Funded agencies must also work collaboratively with the department and the backbone support action research activities and to implement state-wide improvements, with consideration for the local context where appropriate. The action research activities of the backbone support role and the department may include the requirement for funded agencies to participate in surveys, interviews and focus groups conducted by the backbone support role.

5 Contact information

For further information contact your Contract and Partnership Officer.

6 Document control

Document owner	Director, Homelessness Programs
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2	04/12/2024	Updated to reflect name change of key roles	Senior Program Officer, Homelessness Programs, Housing and Homelessness Services	Director, Homelessness Programs, Housing and Homelessness Services

7 Appendix 1: Service integration group - service domains

SIG include an alliance of multi-disciplinary services and agencies which are categorised by service domains in the Client Management System Care Coordination Module (CMS) as listed below, and which may be updated from time to time in system.

- Homelessness Service - Specialist Homelessness Service
- Homelessness Service - DFV Specialist Homelessness Service
- Homelessness Service - Non-SHS
- Homelessness Service - Reintegration Services - Correctional
- Housing Service - Public Housing Product
- Housing Service - Private Market Products
- Housing Service - Community Housing Provider
- Health Service - Mental Health
- Health Service - Drug and Alcohol
- Health Service - Indigenous
- Health Service - General
- Health Service - Aged Care Service
- Family Service - Child Safety
- Family Service - IFCC / FACC
- Family Service - IFS
- Youth Service - Youth Justice
- Youth Service - Exiting Care
- Youth Service - General
- Other Support Service - Financial and Budgeting Support
- Other Support Service - Legal Service
- Other Support Service - Education, Training and/or Employment Service
- Other Support Service - Disability support (NDIS assessment) Service
- Other Support Service - Disability Service
- Other Support Service - Centrelink
- Community Service - Domestic and Family Violence (Not SHS)
- Community Service - Aboriginal and Torres Strait Islander Services - General
- Community Service - CALD Service
- Community Service - Self Care and Living Skills
- Community Service - Basic Needs (food etc.)
- Community Service - Social Relationships and Isolation
- Community Service - Drug and Alcohol
- Community Service - General
- Community Service - Migrant Support
- Community Service - Advocacy Service

8 Appendix 2: Glossary of terms

Term	Meaning
Client	A client is a member of a household who is supported with a service integration plan.
Lead Client	The lead client is the main client of the household whose details are entered in full into CMS.
Household	A household includes singles, couples, families and other shared household arrangements. A person is considered a member of a household if they would be required now or in the near future to live with the lead client, and for at least one night per week for shared custody arrangements.
Support period	The support period is the total period of time a household has an active service integration plan.
Sustainable housing outcome	A household has achieved safe and secure housing and has learnt or re-learnt capabilities to sustain the housing (internal resources and agency), whilst also having the necessary services and supports available and engaged (external resources). For example, the household has outcomes demonstrating more than just safe and secure housing. Housing is stable for a sustained period, with other needs met and enduring needs having a plan for ongoing support from the local service system. It is therefore encouraged that households remain active in-service integration after achieving safe and secure housing to ensure that the housing is stable and other support needs are working effectively to support sustainable housing.
Safe and secure housing	Secure housing is where a household either has security of tenure or where a client/household is provided with housing that is secure and ongoing in another person's rental or owned home (such as living with extended family or in a family home). In addition, any housing arrangement should be safe in terms of the livability and free from violence or harm.
Service Integration Plan	A Service Integration plan is a plan for how multiple agencies and services will support a client in an integrated and coordinated way, recognising the interdependence of their service offerings to support sustainable housing outcomes for people with complex needs. Service Integration plans are developed and reviewed at SIG meetings and must be recorded in the CMS.
Lead Agency/Service	A lead agency/service may be the referring agency/service or main agency/service identified by a SIG as lead for the client and first point of contact for a SIF between meetings in relation to the client. A SIG and a SIF will maintain collective responsibility for the service integration plan and this should not sit with one lead agency to coordinate.
Exit planning	On closing a client's service integration plan a SIF must complete an exit plan and attached it to the CMS, except where a client has disengaged and it is not possible to develop an exit plan. The exit plan will provide the lead agency and SIG with details of the ongoing support a SIG have committed to for the household and a readily available plan to stand up if the household becomes unstable and needs an immediate coordinated service system response in future.
Referring Service	The service which initially refers a client to a SIG and completes the referral form providing the initial data to put onto the CMS.
Deliberate facilitation	Facilitated discussion, planning and decision making.

Term	Meaning
Active participation	From agencies directly involved in assisting the household, specialist experts, broader experience, ideas and suggestions from all participants to augment the emerging plan.
Collegial input and professional advice	Eliciting collegial support and professional advice to address barriers and progress positive outcomes. Planned referrals for people who are identified as having complex support needs and/or requiring a multi-agency response. Referrals can also be intended to seek collegial input for a situation that remains complex or where progress is difficult.
Clear and concise information	Presenting relevant information to engage other agencies.
Documentation	Progress for clients and of outcomes is documented.
Active follow-up and implementation in-between meetings	Agencies involved in assisting clients remain highly autonomous in-between SIG meetings ensuring appropriate follow up and connections are made in progressing actions within the agreed service integration plan.
Ability for off-line case conferences	Where a situation requires a focused discussion on just one person or household usually involving only the agencies directly involved and a SIF.
Review and feedback	Progress is reviewed at subsequent meetings. Case reviews to understand elements of success and what impacted situations where success was not achieved. Intentional celebration and reporting of success.
Intentional escalation	Intentional escalation to leaders and managers of situations that remain seemingly intractable or where a systemic barrier prevents a solution.
Capacity building	A SIG develops skills, practice, confidence and shared understandings that support implementation. Front-line people are more supported and confident in their contribution to solutions and that these insights and skills are transferrable to other situations.
Workforce development	The workforce is supported to extend practice and develop broader ways of thinking about and doing the work. This can be helped by a considered framework of questions that both help understand the situation as it is and generate possibilities for future situations that have not yet been defined. Just as in client interventions, the framework of questions is designed to achieve appreciation for the strengths and capabilities of practitioners while also inviting them to expand their horizons about what might be possible. A repertoire of questions will include: • Situation clarifying questions including questions that invite additional perspectives on what is happening and why (focused on the past and present). • Questions that clarify possible initiatives or interventions (future focused). Questions that build on possible initiatives and create new possibilities, ideas and opportunities (future focused).
Sustainability Assessment	Engaging directly with the client(s), this assessment will be conducted by a service integration stakeholder engaged in ongoing direct transitional/sustainment support and provided back to the SIF to capture in the CMS. Assessment of sustainable outcomes should be conducted every 3 months from the period of transition until this is no longer required. To support the sustainment assessment process, services should use and/or can be provided access to the following: • An outcomes-focused psycho-social assessment tool. • A sustainability assessment survey.

Term	Meaning
Disengagement	If a household has not been contactable for a sustained period they can be considered as disengaged. A person may also advise that they no longer want to be supported by a SIG when their housing need and other support needs have not been met and they can be considered as disengaged.
Enduring Need	A household is experiencing ongoing need which requires either short, medium or long-term support from housing or other agencies and service to sustain housing.
For additional terms, refer to Glossary of terms *Homelessness Programs Guidelines, Specification and Requirements*	

9 Appendix 3: Counting rules for performance measures

Outcome measures	Counting rule	Example only
CC01 – Number of and percentage of active households whose records were closed with a service integration plan in place.	The number of households whose records moved from active to closed during the counting period who had service integration plan in place. AND Express the number above as a percentage of the total number of households whose client records moved from active to closed during the reporting period.	At the end of the reporting period there were 25 households whose client records who moved from active to closed during the counting period. Of these, 20 were households had a service integration plan in place. Of the total of 25 households, the percentage that achieve this outcomes measure were 20 clients or 80% of clients.
CC02 - Number and percentage of active households whose records were closed who achieved a sustainable housing outcome.	The number of active households whose records were closed during the counting period who on exit achieved a sustainable housing outcome. AND Express the number above as a percentage of the total number of active households whose records were closed during the reporting period. Please note that the CMS has the option to choose sustainable housing outcomes based on the SIFs discretion with consideration for the sustainable housing outcome definition in the glossary of terms and only based on housing situations which can be considered safe, secure and sustained.	At the end of the reporting period there were 25 active households whose records were closed. Of these, 20 households were exited with a sustainable housing outcome. Of the total of 25 households with closed records, the percentage that achieve this outcomes measure were 20 clients or 80% of clients.
CC03 - Number and percentage of active households whose records were closed who had an exit plan in place on exit.	The number of active households whose records were closed during the reporting period who on exit had an exit plan uploaded into CMS.	At the end of the reporting period there were 25 active households whose records were closed. Of these, 20 were households exited had an exit plan uploaded to CMS. Of the total of 25 households, the percentage that achieve this outcomes measure were 20 clients or 80% of clients.
Output measures	**Counting rule**	**Example only**
CC04 - Households assisted.	Count the number of households assisted including all in progress or closed household during the reporting period.	NA

Note Counting rules for other measure at Section 4.7.4 are under development.

10 Appendix 4: Role description Service Integration Facilitator

Position	Service Integration Facilitator
Level	SCHADS 6
Term	*<org to add>*
Organisation	*<org to add>*
Reporting to	*<org to add>*

Strategic overview

The Coordinated Housing and Homelessness Response (CHHR) is improving and strengthening the collaboration and integration of housing, homelessness and broader service system responses to reduce homelessness in Queensland. The CHHR includes a state-wide backbone of support for housing and homelessness networks along with Place-Based Response Teams and the Service Integration Initiative, delivered in key locations across Queensland.

The Service Integration Initiative is building the capacity of new and existing Service Integration Groups through funding local Service Integration Facilitators in all existing Service Integration Initiative locations and Queensland Shelter's provision of the state-wide backbone of support. The backbone role provides training, data analysis and reporting, resources, tools and practice support to the facilitators. Service Integration Groups are working to improve the integration of multi-agency response for people with complex needs to assist them to obtain and sustain housing and support and improve their life outcomes.

The additional resources to these regions provided by the department is strengthening the network support and service integration practices.

About this role

This role will provide local assistance to strengthen existing and emerging Service Integration Groups to provide person-centred and place-based service integration planning for people with complex needs and improve integration of service system response for this cohort.

The role does not involve direct client case management and provides support to sector partners to facilitate service integration plans and improved service system responses.

The ideal candidate will be a senior officer with a proven track record in engagement and community development as well as an excellent understanding of the drivers and solutions to homelessness. The preferred candidate will also understand how to support people and organisations to strengthen practice and build collective capacity and capability in supporting people experiencing with complex support needs.

Duties

Collaboration, engagement and facilitation

- Establish and maintain productive partnerships with and across government and non-government services to support improved client outcomes and service system improvements for people experiencing homelessness or at risk of homelessness with complex needs.
- Actively support Service Integration Groups to develop and maintain systems and processes to enable integrated service responses for clients with complex needs, including local governance arrangements and where agreed with the Service Integration Groups, taking on the role of secretariat for these groups.
- Ensure client and service system data is maintained in the required client management system to enable the timely reporting of client and service system data.
- Provide analysis of client and service system data to understand trends, service systems gaps and work with sector partners to improve local service system design to improve whole of service responses for people with complex needs.
- Produce high quality written and verbal reports that support accountability and continuous improvements.

- Prepare comprehensive reports and case studies which provide in depth and broad analysis and to demonstrate outcomes to government funders.
- Actively engage in other local networks and groups to support broader service integration work, including providing regular updates to these networks and groups on the work of the Service Integration Group, client outcomes, and opportunities for service system improvements.
- Adopting collective impact principles, Service Integration Facilitators will collaborate and constructively engage with the backbone support in relation to research activities and participate in governance and other meetings organised by the backbone support in relation to service integration.
- Identify learning and development needs and engage with Queensland Shelter to bring learning experiences to the region, including promoting local capability building opportunities offered by the backbone support.
- Actively work towards the sustainability of networks and structures including with the Housing Service Centre/s and regional staff, that support regional capacity.

<organisation to add any WHS / organisational duties>

Key criteria

1. Proven track record and results in successful engagement and community development including engagement skills across diverse agencies with diverse service delivery models and specialised roles that are complementary but different.
2. Senior practice experience in housing and homelessness sectors and a detailed understanding of the needs of people experiencing of at risk of homelessness and experience driving local service system improvements to improve client outcomes.
3. Skilled communication including clear and effective verbal reporting and a very high standard of written reporting
4. Experience working with diverse groups in a facilitation role.
5. Experience in contributing to workforce development and capability.
6. Ability to use software applications including client management systems to a high standard.

Other requirements

1. A criminal history check is mandatory.
2. Driver’s licence.

11 Appendix 5: Exit planning template

Service Integration Initiative **Exit Plan**	***Name:*** ***Date of birth:*** ***Gender:*** ***Address:*** ***Phone:***
Lead Agency	
Links to other government agencies and supports	*For example, Mental Health, NDIS ….* If appropriate, have linkages to specialist Aboriginal and Torres Strait Islander services been considered? ☐ Yes ☐ No ☐ N/A Comments:
[Insert name]'s Service Integration Plan goals	1. 2. 3. 4.
Participant and support provider agreement	Has this exit plan been discussed with the client? ☐ Yes ☐ No Client Signature: _____ Date: ___ / ___ / ___ Copy of plan given to client? ☐ Yes ☐ No Date: ___ / ___ / ___

Exit plan and follow up
Situation at exit (Service Integration participant's achievements/changes): • • •
Enduring needs/potential future challenges: • • •

Current and future supports			
Type of Support	**Duration of Support**	**Support Agency**	**Contact details**

12 Appendix 6: Guide to writing case studies, consent form and template

Background information

The case studies complement the quantitative data provided through the periodic performance reporting process. The case studies can provide a much richer picture of the complexities, challenges and achievements of clients who are experiencing homelessness.

Case studies are a valuable tool for:

- understanding service integration approaches and client pathways.
- understanding how Service Integration Groups (SIG) are supporting service system strengthening.
- demonstrating the barriers and challenges of improving local service system responsiveness for people who are homeless or at risk of homeless who have complex needs and required coordinated multi-agency responses.
- demonstrating the benefits or outcomes of Service Integration Initiative funding.
- reflective practice in documenting an organisation's experiences, results, best practice and lessons learned and identifying ways to improve service integration in place.

Purpose of the case studies

The department will use the case studies to inform monitoring of the performance of funded services and the development of contemporary service integration approaches for people who are experiencing homelessness or at risk of homelessness.

Requirements and further guidance

Funded services are required to provide a minimum of four case studies each year including:

- The Provision of a minimum of one case study every six months that demonstrates client/household experiences and outcomes, including:
    - the clients experience while being supported by the funded service.
    - the outcomes achieved for the clients and their households, including housing and other supports.
    - the SIG role in supporting that outcome.
    - any gaps or challenges in relation to being able to achieve a sustained outcome for the client.
    - learnings of what the SIG might need to do differently or try to replicate in future.
    - learning in terms of local service system strengthening or the role and impact of the SIG.
- Provision of a minimum of one case study every six months that demonstrates improved integration of service delivery across government and community services or measures or initiatives that address identified local needs, gaps or emerging issue.

Use of information and consent

Case studies may be published in departmental reports. However, this would not be done without specific agreement from the relevant provider.

Providers must ensure clients give consent for de-identified information provided by them to be used to develop a case study and what this information will be used for.