

Thriving and On Track

Program Playbook

A practical guide for primary health networks (PHNs), state and territory health and education departments, and early childhood and allied health partners adapting a community-embedded model of early intervention and support for healthy child development.

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phn
BRISBANE SOUTH

An Australian Government Initiative



Developed by

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Acknowledgments

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Acknowledgement of Traditional Owners

Baugull nyungai Gurrumba bigi Maroomba biggee

We acknowledge the Traditional Custodians of the land on which we live and work, and of the many different nations across the wider Brisbane south region.

We pay our respects to the Elders, past, present and emerging, as the holders of the memories, the traditions, the culture and the spiritual wellbeing of the Aboriginal and Torres Strait Islander peoples across the nation. We acknowledge any Sorry Business that may be affecting the communities as a whole.

In the spirit of reconciliation, partnership and mutual respect, we will continue to work together with Aboriginal and Torres Strait Islander peoples to shape a health system which responds to the needs and aspirations of the community.



About this playbook

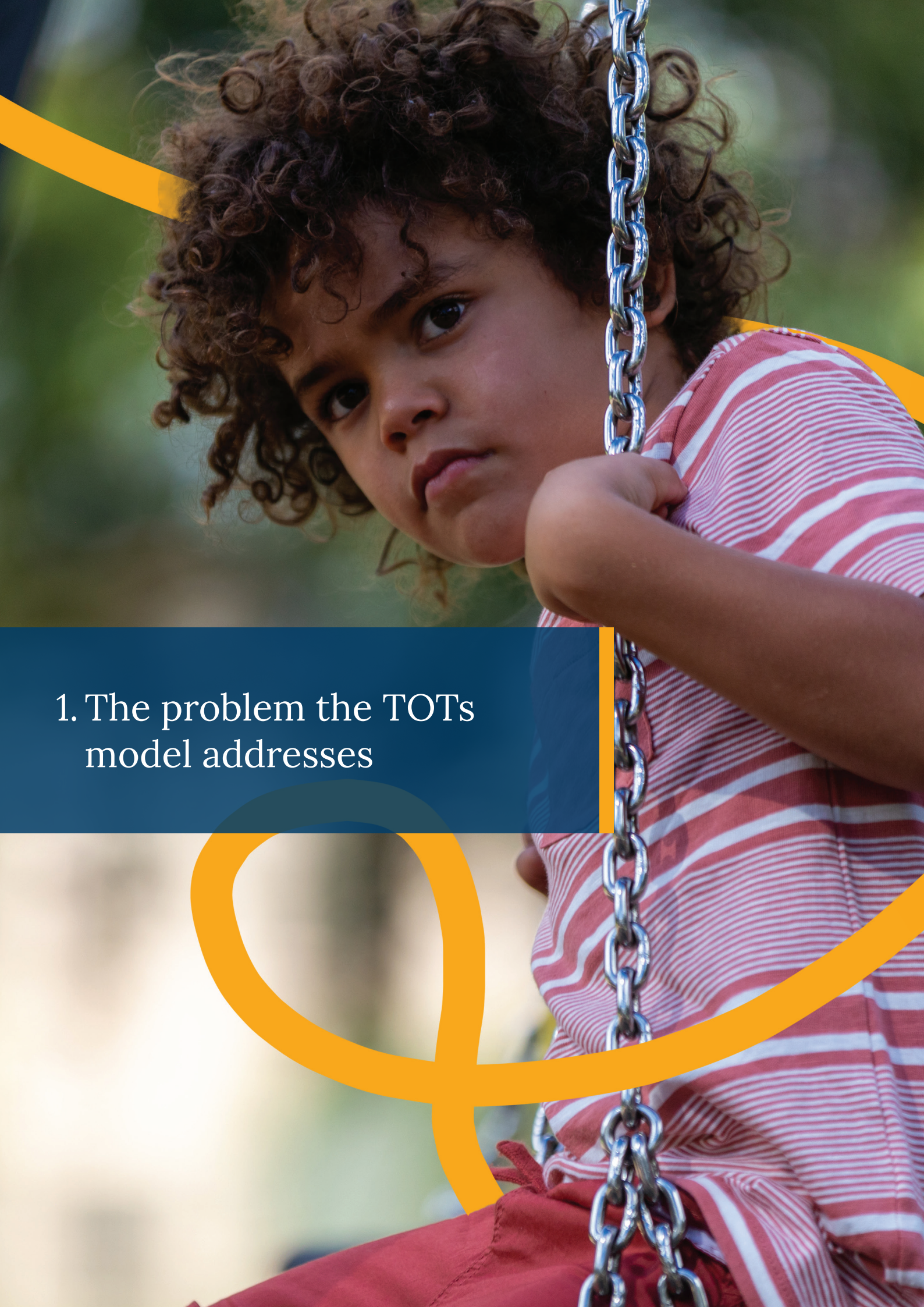
This playbook describes the Thriving and On Track (TOTs) model of care—a place based approach to early childhood developmental support implemented across diverse community settings in South East Queensland over 7 years. It is written for the organisations that could adopt and adapt the model in their own regional jurisdictions: primary health networks (PHNs), hospital and health services (HHSs), state and territory health and education departments, and early childhood and allied health partners.

The guide explains the evidence base underpinning the model, describes how it works in practice, and presents local examples of how it has been adapted to meet the needs of different priority population communities. It is especially relevant as governments move towards models of early childhood support that are easier to access in the places children live, learn and play—the direction reflected in reforms such as the Australian Government’s Thriving Kids initiative.



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1. The problem the TOTs model addresses

Some children fall behind before anyone has the chance to help them.

For many families with young children, the gap between when a developmental concern first appears and when it is identified and acted upon can stretch months or years. During that window, the child's brain is developing rapidly and opportunities for early support and intervention to help the child to meet developmental milestones are being missed.

When the Thriving and On Track (TOTs) program first brought child health nurses into early childhood education settings to assess children flagged through screening, only a small fraction—6%—had presented to child health services in the previous year. In other words, the TOTs program was reaching children and families who had not yet connected with child health services through the usual pathways.

The 3 interconnected challenges driving developmental gaps for children:

01 Developmental concerns go undetected in everyday settings

The people who spend the most time with young children—early childhood educators, playgroup leaders, family day care providers—often notice signs of developmental delay before anyone else. But without training, confidence, or a clear referral pathway to act on, those observations rarely translate into early support for those children and their families. Many concerns only surface when children enter formal schooling, by which time significant developmental time has passed and optimal windows for successful early interventions prior to schooling may have been missed.

02 Families face barriers to accessing services

Even when a concern is recognised, the pathway to receiving appropriate support is rarely straightforward. For families navigating language barriers, limited health literacy, geographic isolation, cultural mistrust of formal services, or other complex social circumstances, accessing specialist assessment and allied health support can feel prohibitively difficult. The services exist, but they are not always within reach of the families who need them.

03 Early childhood educators are under-recognised as trusted community and health connectors for the children in their care

Early childhood education and care (ECEC) settings represent one of the most consistent points of contact with children aged 0 to 5 and their families. Yet the ECEC workforce is rarely integrated into health and developmental support systems. Strengthening this workforce's capacity to identify and respond to developmental concerns is one of the most valuable investments available to health and education systems.

~1 in 4

Queensland children
developmentally vulnerable
in at least one domain
(AEDC 2024)

18-26%

of children at risk or
vulnerable across AEDC
domains in Logan
and Inala

0-5yrs

the period of fastest
brain development,
when early support
is most effective

Why the early years matter

The first 5 years of life represent the most critical period of brain development. Neural connections form at a rate that will never be matched again. Experiences during this period—including timely identification of and response to developmental challenges—shape cognitive, social, emotional and physical outcomes across the life course.

Early intervention during this window is significantly more effective, and significantly less costly to the health and education system, than remediation at school age or beyond.

2. What is the TOTs model of care?



Thriving and On Track (TOTs) is a place-based early childhood development program that brings developmental screening, educator capability building, and coordinated access to health services into the everyday settings in local communities where families, parents and carers are already present.

The model operates on a straightforward premise: if families cannot easily navigate their way to services, services should navigate their way to families. TOTs embeds early identification and support into community settings—ECEC centres, playgroups and community hubs—where families already have trusted relationships and regular routines.

Established in 2019, TOTs is a cross-sector collaboration between Brisbane South PHN, Children’s Health Queensland, Department of Education, early childhood education centres, Griffith University and several other community partners. It has been delivered across the Logan and Inala areas of South East Queensland over 7 years, providing a substantial evidence base of a success program model from which other jurisdictions can draw.

The model is deliberately described here as a set of system and community level design principles and components. It is not a fixed program. That is what makes it portable: the principles hold constant, while the delivery is assembled to fit each region’s communities, workforce and existing service system. Sections 3, 10 and the appendices set out which elements are essential and which are designed to be adapted locally.

2.1 What the TOTs model is designed to do

The TOTs initiative aims to:

- identify developmental concerns earlier, in settings where children are already known and comfortable
- build the confidence and capability of early childhood educators and community hub staff to recognise concerns, have respectful conversations with families and connect children to support
- equip families, parents and carers with the understanding, guidance and practical support they need to act on developmental concerns
- bring child health nurses and allied health professionals into community settings, reducing the access barriers families face
- strengthen referral pathways and coordination across health, education and community services
- create lasting workforce capability in a place-based system—so benefits are legacy based and extend beyond individual children to the settings and communities where they grow up.

2.2 How the TOTs model fits within a broader system of care

TOTs does not duplicate or replace existing health and developmental services. It improves the earliest stage of the system by strengthening early identification and support to educators and community hub staff to respond to developmental concerns, building parent and carer confidence to do this too, and ensuring that the right referrals are made to the right services at the right time for children to receive timely, wrap-around care and support to thrive before age 5.

A model suited to the direction of early childhood policy

Across Australia, early childhood policy is moving towards support that is easier to access in the everyday places children live, learn and play—with earlier identification, coordinated services, and investment in the workforce around the child. National reforms such as the Australian Government’s Thriving Kids initiative reflect this direction.

TOTs is a practical expression of that approach. It is not a concept awaiting a pilot; it is a working model, refined over 7 years and independently evaluated twice, that delivers early intervention and support for young children and their families in familiar, community settings. That makes it a model other regions can adapt as they design their own responses to this shared policy direction.

The fit with Foundational Supports is particularly close. Thriving Kids proposes a new tier of support for children with low to moderate support needs for developmental delay or autism, delivered closer to home and outside the NDIS. That describes precisely the cohort TOTs reaches, and the way it already works by identifying concerns early in everyday settings, building the capability of the adults around the child, and connecting families to the right level of support without creating a parallel system.

The TOTs model goes beyond describing what Foundational Supports might look like in theory—it shows what they already look like in practice. While the specific funding mechanisms and administering arrangements for Thriving Kids are still being settled between governments, what is clear is that the design intent of the reform and the design logic of the TOTs model are aligned and point in the same direction.

For the current policy and funding context relevant to a specific jurisdiction or audience, see the accompanying stakeholder summaries, which are updated as arrangements are confirmed.



3. How the TOTs model works

TOTs brings together 4 interconnected service components, delivered in community settings in an integrated and flexible way. Not every component operates in every centre—the mix is matched to consider each setting’s needs, the local workforce, and available resources—but every participating centre receives at least one form of support.

3.1 The 4 service components

01 Educator training and capability building

Early childhood educators in participating early childhood education centres (ECECs) and community hubs (offering playgroups) receive structured training to have conversations with families about their child’s development. This builds educator’s capacity to recognise signs of developmental concern, engage in supportive conversations with families, and apply targeted strategies in everyday practice. The goal is not to turn educators into health professionals—it is to make them confident, capable partners in early identification and support.

02 On-site developmental screening and assessment by a child health nurse

Where an educator’s observations or a conversation with a family surface a developmental concern, structured developmental screening is conducted by a child health nurse within the child’s familiar setting—the ECEC centre or community hub/ playgroup they already attend. This reduces the anxiety and logistical barriers associated with unfamiliar clinical environments and tends to produce more accurate observations because children and families are at ease. Families receive clear, accessible information about results and a supported pathway to next steps. Co-located within the familiar ECEC or community hub setting, the child health nurse conducts the secondary developmental screen and develops a care plan at the point of family engagement—so families who might not proactively seek out an appointment can easily access the same expertise and support without navigating an unfamiliar system.

03 Allied health support in community settings

Allied health professionals—including speech pathologists, occupational therapists and other developmental specialists—provide support within participating sites and community hubs. This brings specialist input earlier in the identification process, reduces waiting times, and helps educators and families understand and respond to a child’s specific needs. For many families—particularly those from culturally and linguistically diverse backgrounds—this community-provided, culturally safe support meets a need that other funded pathways do not reach. This allied health integration is identified as an area of opportunity to further enhance and scale TOTs, to see the full potential of the program in providing holistic, wrap-around supports to children and families.

04 Navigation and coordinated access to healthcare and support services

For many families, knowing what services exist is only half the challenge—understanding how to access them, removing barriers and providing continuity of care is where the system often fails families—particularly those that are more vulnerable. TOTs provides active navigation support, helping families understand their options, engage with referral pathways, and maintain ongoing connection to services.

3.2 How the TOTs model is funded and delivered

A defining—and replicable—feature of TOTs is that it is a home-grown solution to a local problem. It has been seeded and existed through funding from local partners and philanthropies. It has not relied on a single funding stream or provider. Instead, it has braided together complementary, place-based contributions from local partners, philanthropy and the available service system to create a sustainable, locally responsive model. Jurisdictions adapting the model should expect to assemble a similar mix from the funding and provider landscape available to them.

This braided structure spreads investment, draws in workforce that a single provider could not deliver alone. It is one of the clearest lessons for partners weighing how to resource a comparable model.

Underpinning the funding model is an equally important asset: a genuine cross-sector partnership and localised governance. TOTs brings together health and education sector partners—including, Brisbane South PHN, Children’s Health Queensland, the Queensland Department of Education, and other community organisations—around a shared responsibility for children’s development in the shared region. The 2021 independent evaluation of TOTs found this health–education partnership to be the single most important enabler of the program’s success, and one whose benefits extend well beyond TOTs itself. For any jurisdiction setting out to deliver coordinated early childhood support, it is the relationship that has to be built first.

3.3 What workforce capacity building involves in practice

‘Capacity building’ approaches and outcomes are specific and well defined under the TOTs model. TOTs team members, drawn from early childhood teaching and allied health backgrounds, support early childhood educators through training and coaching focused on:

- increasing educator knowledge and confidence around early child development
- sharing their observations and insights about children’s development with their families engaging in sensitive, respectful conversations with families about a child’s development within community hubs and early childhood education settings
- broadly understanding early child development and the educator’s role in supporting them
- applying strategies and classroom accommodations to promote child development broadly in the classroom and support children with additional needs.

This professional development is delivered through 3 reinforcing modes:

1. formal professional learning sessions;
2. real-time modelling alongside educators in the classroom; and
3. ongoing coaching and follow-up, including help with referrals.

The combination of all 3 modes of professional development, rather than a one-off training with reference materials, is what shifts everyday practice and is grounded in adult learning theory, motivational interviewing, and a strengths-based approach that builds from where each educator and centre is already at.

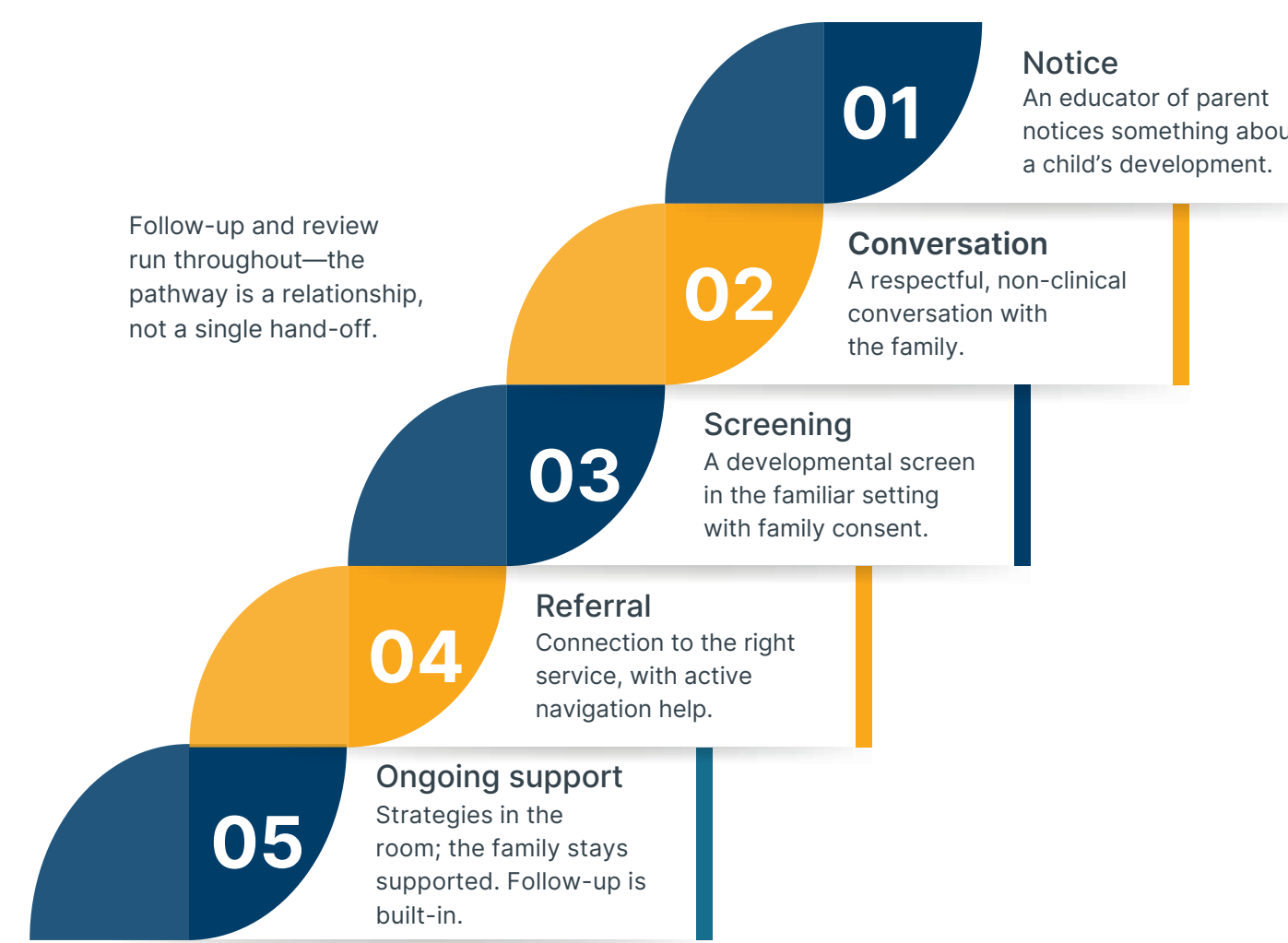
3.4 The pathway from concern to support

The components come together as a single, repeatable journey—one that stays consistent in shape while remaining flexible at every step to suit the child, the family and the setting. A centre first connects with the program, directly or by referral. A TOTs team member then works with educators to understand the setting and agree how support will be delivered locally. Capacity building follows, through training, in-classroom modelling and ongoing coaching.

Where a concern is identified, the child is connected to a child health nurse appointment in the centre, to allied health support in a community hub, or to a specialist referral.

Finally, feedback from educators, families and partners informs the next cycle, and the relationship continues rather than ending after a single visit. The diagram below shows this flow.

Alongside this journey, allied health professionals are embedded as part of the holistic team in community hubs, so that families can access information, intervention and navigation support in the one familiar setting.



3.5 Design principles



What makes TOTs distinctive is its exact combination of design principles that run through every element of delivery, connecting early education and health professionals to deliver coordinated support to children and families in familiar settings.

Six principles do this work. All 6 principles applied in combination, and not any single component in isolation, are what give the model its consistent effectiveness across very different communities.

- **Place-based delivery.** Support is brought into the settings families already use and trust, rather than delivered in clinical or unfamiliar environments that families must find their own way to.
- **Relationship-centred practice.** The model builds on the trusted relationship between families and educators or community hub staff. These trusted relationships are often the most powerful bridge a family has to link into the health system.
- **Strengths-based and capacity-focused.** The model builds the confidence and capability of families, educators and community members, rather than positioning them as passive recipients of a service.
- **Workforce capability building.** Investment in educators and community hub staff creates lasting workforce capacity that stays in the system—transmitted between settings through workforce movement, extending the benefit well beyond the children the local program reaches directly.
- **Flexible, adaptive design.** The model is tailored to local community needs, the available workforce and cultural context. It is deliberately not intended to be applied uniformly—the same ingredients are combined differently in each place, tailored to the local needs and systems challenges.
- **Integrated, not duplicative.** TOTs strengthens existing systems—improving the quality and timing of access to services that already exist—rather than building parallel structures or services alongside them.

The TOTs 'ingredients', and why their flexible combination is key to the model's success

It is tempting to read the 4 components as a checklist—a set of services a region installs and switches on. That is not how the model works, and it is not where its value lies. If a health program is a recipe for better outcomes, consider the 4 components as ingredients and the 6 principles are the method. What closes the gap for children is not the presence of every ingredient in every centre, but the judgement to combine the right ones, in the right measure, for the community in front of you.

This is what the local examples in Section 7 show in practice. In culturally and linguistically diverse communities, the embedded allied health team member relationship and a culturally aligned navigator do the heaviest lifting. In a First Nations context, the same capability is brought alongside community-controlled leadership rather than in place of it. Within the ECEC context, where there can be high staff turnover, the weight shifts onto lasting educator capability. Same ingredients; different recipe. The constant is the principles; the variable is the mix.

That adaptability is also what makes the model a natural fit as a Foundational Support. A national reform cannot prescribe one delivery model for communities as different as inner-city Logan, the Moreton Bay islands and remote Australia. It needs an approach whose core holds steady while its delivery flexes to place—reaching children with developmental delay or autism and low to moderate support needs early, in the settings they already are, and connecting them onward before a concern hardens into longer-term disadvantage by school age. That is exactly what this model is built to do.





4. Evidence and outcomes

TOTs is unusual among community early intervention programs in having been independently evaluated twice, 5 years apart. This gives partners and funders a rare view of both the model's early impact and its sustained value as it matured.

- Siggins Miller (2021): An external review during the program's first full years of rollout, focused on access, implementation and cross-sector coordination.
- Griffith University (2025): A qualitative case study evaluation of the capacity building model, drawing on focus groups with 19 stakeholders across Logan and Inala.

Together they tell a consistent story: in its early years the model demonstrably improved access for children who were not otherwise reaching the system; by its mature years it had embedded lasting capability in educators and centres. The outcomes summarised below are drawn from these evaluations. The program reach figures are from Brisbane South PHN program records and are presented separately for clarity.

4.1 Early impact: improving access (Siggins Miller, 2021)

The first independent evaluation examined the program during its 2020–21 rollout, when it offered developmental checks to children in a narrower age band across several Logan and Inala communities. Its central finding was that TOTs was reaching children the system had been missing.

The figures below relate to that early-rollout period and should be read as foundational evidence of the model's access value, not as a measure of its current scale.

1,393

children completed PEDS developmental screening in their early childhood centres (Aug 2020 – Apr 2021)

~88-89%

of eligible centres chose to engage with the program across the first 2 rounds

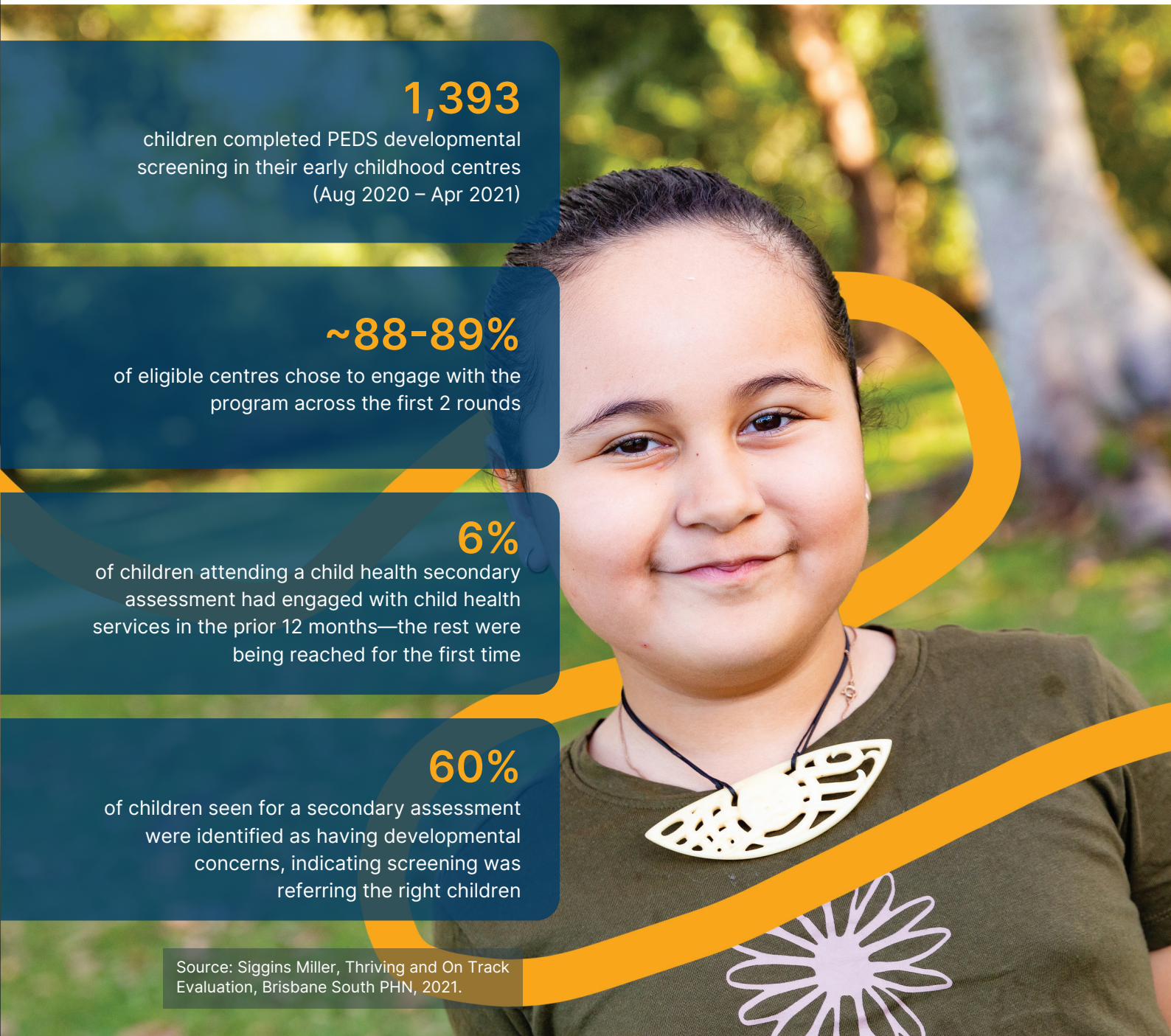
6%

of children attending a child health secondary assessment had engaged with child health services in the prior 12 months—the rest were being reached for the first time

60%

of children seen for a secondary assessment were identified as having developmental concerns, indicating screening was referring the right children

Source: Siggins Miller, Thriving and On Track Evaluation, Brisbane South PHN, 2021.



4.2 Program reach and outcomes (FY25)

The following figures are from Brisbane South PHN program data for the 2024–25 financial year (July 2024 to June 2025) and reflect the model at its current scale across Logan and Inala.

143

early childhood education centres across Logan and Inala, of which 80% receive some form of support from the model (55% engaged, 25% being supported to engage)

370+

educators trained to have early, supportive conversations with families about development—71% reported the training increased their awareness of their role a lot

340+

educators provided with allied health capacity building—100% reported increased knowledge of child development and 98% felt more confident in the area targeted

285

children seen by a child health nurse in their early childhood centre—9% identified as First Nations and 20% as culturally or linguistically diverse

172

families supported to access allied health intervention in community hubs—of those surveyed, 100% reported increased awareness of their child's needs and 94% intended to use strategies at home

~500

estimated early, supportive conversations with families about their child's development each year, across participating ECEC centres and community hubs

4.3 Outcomes for educators

- Increased knowledge and confidence in recognising and responding to developmental concerns
- Improved ability to initiate and sustain supportive conversations with families about child development
- More confident and consistent use of targeted developmental strategies within everyday teaching practice
- Stronger understanding of available services and more effective relationships with health and allied health professionals
- Sustained capability that continues to benefit children and families beyond direct program involvement

TOTs reaches children the system was missing

Of the 285 children seen by a child health nurse through the Brisbane South PHN program in FY2025, only 8% had presented to child health services in the previous 12 months. The large majority of children were being reached for the first time—consistent with the 6% access finding from the 2021 evaluation, providing the clearest evidence that the TOTs model surfaces need that would otherwise go unidentified.

“In practice they're doing some mentoring and coaching in a similar way that I would as well, because they take on board the context here and the philosophy we have too.

ECEC educator, Griffith University evaluation (2025)

Source: Brisbane South PHN program data, Financial Year 2025. The figure for early, supportive conversations is a program estimate; under current delivery, all ECEC centres across Logan and Inala are supported as they are ready, and exact counts are not collected.

4.3 Outcomes for educators

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- Improved ability to initiate and sustain supportive conversations with families about child development
- More confident and consistent use of targeted developmental strategies within everyday teaching practice
- Stronger understanding of available services and more effective relationships with health and allied health professionals
- Sustained capability that continues to benefit children and families beyond direct program involvement

4.4 Outcomes for families

- Becoming more proactive about voicing developmental concerns for children
- Increased uptake of referral pathways and engagement with follow-up services
- Feeling more prepared to respond when educators raise concerns and more heard and supported during those conversations
- Stronger, more trusting relationships with educators
- Improved access to relevant, tailored resources and strategies to support their child
- Feeling informed of the next steps to support their child

4.5 Outcomes for children

- Earlier identification of developmental concerns during the most critical period of brain development
- Faster referral for developmental assessment and delivery of tailored support and early interventions—reducing the gap in time taken between concerns first being raised and when support services are accessed.
- More tailored support within ECEC settings, delivered by confident, well-informed educators
- Access to culturally safe and responsive allied health support

4.6 Outcomes for the system

- Improved referral quality and timing across health, education and community services
- Stronger cross-sector relationships between early childhood educators and health professionals
- Earlier engagement with services, reducing pressure on higher-acuity intervention later
- A more supported and capable ECEC workforce that acts as an effective first point of contact for the child health and developmental support system

5. Easing workforce pressure

“Before, I was sort of just searching here, there and everywhere trying to find everything for them—whereas now, having TOTs, it’s kind of like a one-stop shop.

ECEC educator, Griffith University evaluation (2025)

Independent evaluation

Ziegenfusz, S., Dunstan, K., Burkitt, T., Graham, L., & Siyambalapitiya, S. (2025). Evaluating the Thriving and On Track Initiative: A Qualitative Case Study Evaluation of Capacity Building for Early Childhood Educators. Griffith University, Gold Coast.

The evaluation focused on the capacity building dimension of the model—how educator training translates into changed practice, improved family engagement, and better developmental outcomes for children. Its findings validate the model’s core design logic and provide a basis for replication in other regional contexts. The full report is publicly available on the Brisbane South PHN website.

The biggest question about scaling early childhood support is not whether it is worth doing—it is who will do it.

Child health nursing and allied health are already stretched, with long waitlists in many communities. A common and reasonable concern is that more screening simply generates more referrals than the system can manage. This concern deserves a direct answer.

The TOTs experience suggests the model is designed to ease pressure on the existing workforce rather than add to it. The central insight is this: screening in familiar settings does not create new demand—it surfaces existing unmet need earlier, when it is simpler and less costly to respond to. The 2021 independent evaluation found that the large majority of children reaching a child health assessment through TOTs had not engaged with child health services in the prior year.

The need for early childhood developmental support required by many young children, their families, carers and educators was already there; the model made the scale of this need visible to the system.

5.1 Supporting the child health nursing workforce

- TOTs is intended to identify needs earlier and share the work more evenly, so that clinical time is spent where it adds the most value TOTs delivers:
- educators trained to recognise developmental concerns are able to make earlier, better-informed identifications, improving the quality and timing of referrals into child health
 - on-site screening in the child’s familiar setting gives nurses clearer, more accurate information to work from
 - warm, supported referrals—with active navigation behind them—reduce the time clinicians spend following up families who might otherwise disengage
 - shared care pathways help keep nurses focused on clinical work rather than service navigation
 - earlier identification often reduces the likelihood of concerns escalating into more complex cases that consume more clinical time later, while recognising that some children will need ongoing support despite early identification and intervention.

5.2 Supporting allied health capacity

- A frequent worry is that screening means more referrals and longer waitlists. The model is designed to work the other way, by improving how children are matched to the right level of support:
- A tiered approach means specialist allied health intervention is sought for the children who most need it, while lighter-touch support is met within the setting.
 - In-setting coaching allows allied health professionals to build educators’ capability across a whole room.
 - Short-term, early intervention is intended to reduce the number of children who later need longer or more intensive therapy.
 - Better-quality referrals, informed by educator observation and screening, give allied health teams clearer information to triage and prioritise.

5.3 A more coordinated, holistic system of care

Beyond any single workforce, the model is intended to reduce the fragmentation that drives avoidable workload across the system: less duplication of assessment across educators, GPs, child health nurses and allied health; better information flow so families are not repeatedly re-assessed; and active family navigation that reduces the non-clinical load on clinicians. These are the same coordination gains the 2021 evaluation identified as among the program’s most durable benefits.

TOTs also complements other Queensland reforms strengthening the early childhood workforce, including investment in child health and child development staffing under Putting Queensland Kids First. As a working, place-based model with cross-sector governance already in place, it offers a practical foundation on which such investment can be deployed.

These are design intentions borne out by early evidence rather than fully quantified outcomes; establishing the workforce impact over time is one of the measurement priorities set out in this playbook. But the direction is clear: a model that builds capability where children already are, and coordinates the services around them, is part of the answer to workforce pressure—not a new source of it.

6. Known challenges and how the model responds



Brisbane South PHN believes a credible health program model is honest and open about what is hard to achieve. The independent evaluation identified 6 factors that shape how well TOTs capacity building works in any given setting. Partners considering the model should plan for these from the outset rather than discover them in delivery.

Relationships and rapport take time

Strong, trusting relationships between TOTs team members and educators are essential—and they cannot be assumed. Barriers are usually about educator capacity: burnout, complex personal circumstances, or limited initial openness. The response is to invest in relationship-building deliberately, with consistent, approachable contact, before asking educators to change their practice.

Staffing constraints inside early childhood education centres

Staff-to-child ratios limit how much time educators can spend in TOTs sessions, and competing priorities and tight budgets can deprioritise external initiatives. The response is to advocate for protected time and to design support that fits around, rather than competes with, the demands of the room.

High staff turnover

Turnover makes continuity and sustained relationships difficult. The partial upside the evaluation observed is that educators who move often carry TOTs knowledge to new centres, extending reach—but the model still needs orientation tools for new staff and resource-continuity plans to hold the gains.

Continuity within the TOTs team

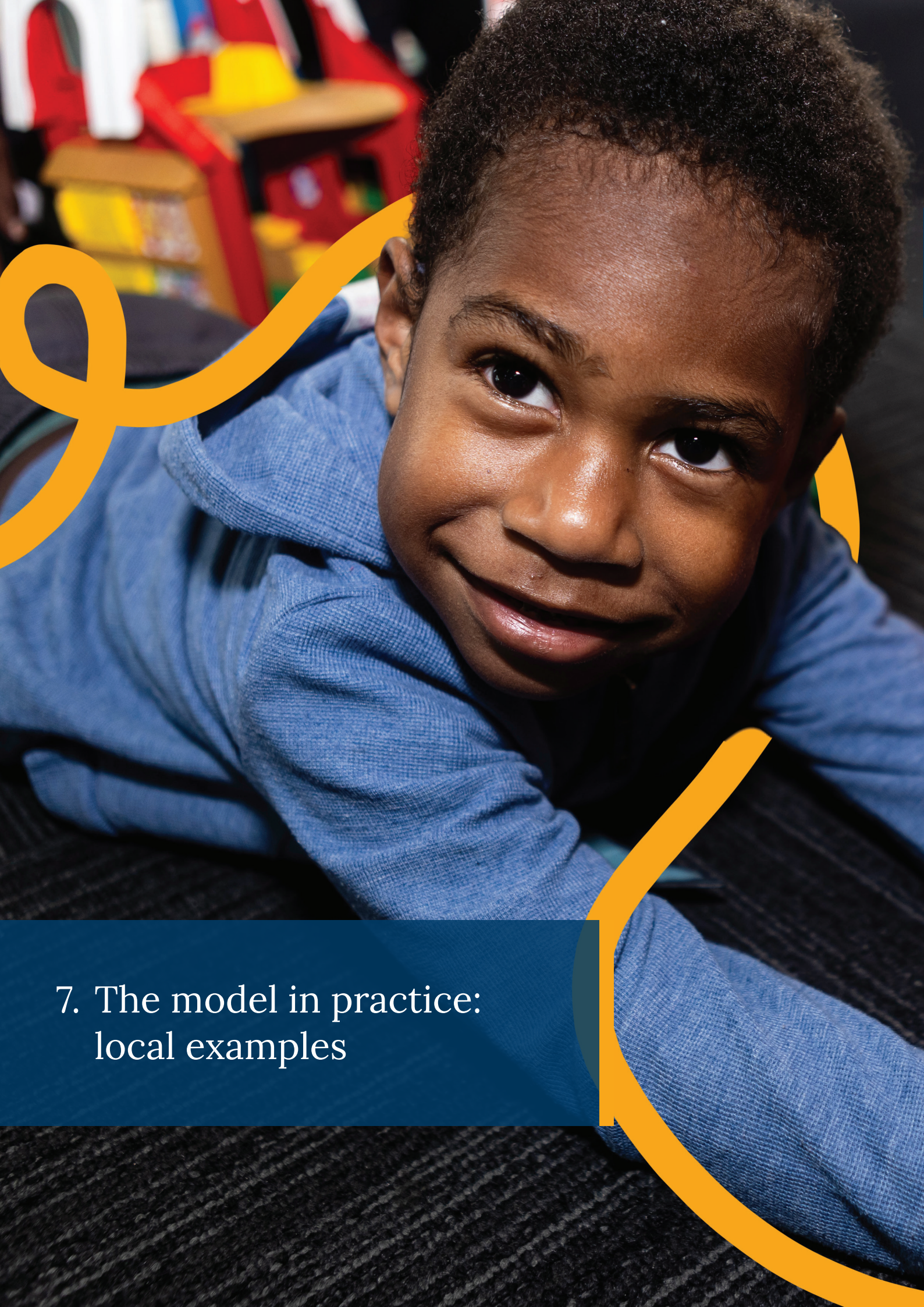
Impact is strongest where the same TOTs team members work with a centre over time, allowing follow-up and a deeper understanding of children's needs. Centres with long-standing involvement report smoother implementation. Consistency of staffing on the delivery side matters as much as on the centre side.

Relevance and timing of support

Educators engage most when professional development and resources are directly applicable to their current challenges; generic or poorly timed materials are a barrier. The response is to co-design and regularly refresh bespoke resources with educator input.

Family follow-through beyond the centre

The hardest barrier sits outside the centre: families missing appointments or not yet being ready to discuss concerns. This limits follow-through even when early identification works well. TOTs responds with proactive service navigation support and has trialled a dedicated Child Health Champion role to help families overcome practical barriers such as transport and appointment timing, and to lift the uptake of the services children are referred to. This role was trialled rather than embedded consistently and is one option jurisdictions may consider. Other complementary engagement strategies such as home visits, co-designed parent and carer resources and informal family events also help build the trust that appointment follow-through often depends on.



7. The model in practice: local examples

One of the most significant features of TOTs is its demonstrated capacity to adapt to the needs, strengths and characteristics of different communities. Over seven years it has been applied across a range of settings and priority population contexts—each requiring a tailored approach while maintaining the core design principles. The following examples illustrate how this flexibility has worked, and what each demonstrates for other jurisdictions.

Example 1:

Culturally and linguistically diverse communities—Logan and Inala



Community context

Logan and Inala are among the most culturally and linguistically diverse communities in Queensland. Families from Pacific Islander, African, South Asian, Southeast Asian and Middle Eastern backgrounds live alongside long-established Australian communities. Many are recently arrived, speak English as a second or third language, and have limited prior experience with Australian health and education systems.



The challenge

For families from culturally and linguistically diverse backgrounds, standard approaches to screening and referral often fail at the first point of contact. Formal clinical settings can feel unfamiliar or intimidating, written communications may not be accessible, and cultural understandings of child development, disability and help-seeking vary significantly. Engagement through conventional outreach is consistently low.



How TOTs was applied

TOTs embedded developmental support directly into the community hubs and ECEC centres these families already attended. Educator training was tailored to include culturally responsive communication. Allied health and child health nurse services were co-located in familiar settings, and navigation support was provided through referral processes, including in languages other than English where appropriate.



What it demonstrated

Participation among families from culturally and linguistically diverse backgrounds in TOTs-participating settings was substantially higher than is typically seen in clinic-based or outreach models. Embedding services in trusted environments—with known community hub staff and educators as the first point of contact—proved a critical enabler, and family satisfaction was consistently high across cultural groups.



Transferable lesson

Trusted relationships and familiar settings drive engagement more powerfully than service availability alone. In diverse communities, the community hub staff or educator relationship is often the most important bridge between families and the health system.

Example 2:

First Nations communities—Bullang Jarjums partnership, Logan



Community context

Logan has a significant and growing First Nations community, including Aboriginal and Torres Strait Islander families from across Queensland and beyond. Like many First Nations communities, Logan families have a complex and often painful history of engagement with formal health and government services. Trust must be earned, not assumed—and culturally safe practice is not optional.

The challenge

Standard early intervention models, however well-intentioned, frequently fail to achieve meaningful engagement with First Nations families. Approaches that do not centre cultural safety, community self-determination and First Nations leadership tend to reproduce the very barriers they seek to address. The risk of causing harm—through culturally inappropriate practice or deficit narratives—is real.

How TOTs was applied

TOTs partnered with Gunya Meta, a non-profit First Nations organisation led by and for the Logan community, to support the Bullang Jarjums program—a Child Health Pathways initiative providing early intervention for First Nations children aged 0 to 3 within a culturally safe playgroup. TOTs connected children and families to free speech pathology services i, delivered with the cultural leadership of the Gunya Meta team. Gunya Meta led the cultural and relational dimensions; TOTs provided the developmental health infrastructure.

What it demonstrated

The model is strengthened by operating through a community-controlled delivery partner. Engagement was higher, trust was deeper, and outcomes were supported by a relational foundation that a PHN or health service alone cannot build. The model’s flexibility enabled genuine co-delivery rather than top-down service imposition.

Transferable lesson

In First Nations community contexts, cultural self-determination is not a constraint on the model—it is a design feature. Bring TOTs’ developmental health capability alongside community-controlled leadership, not instead of it.

Example 3:

Geographically isolated communities—Southern Moreton Bay Islands



Community context

The Southern Moreton Bay Islands (SMBI)—Russell, Macleay, Karragarra and Lamb Islands—present a distinctive set of access challenges. Families live on islands accessible only by ferry, with limited service infrastructure and no on-island specialist health or allied health services. Many residents experience socioeconomic disadvantage, and isolation compounds limited services.

The challenge

Conventional early intervention models assume a level of geographic accessibility that simply does not exist in island communities. Families cannot easily attend mainland appointments, providers do not routinely visit, Standard outreach approaches do not translate.

How TOTs was applied

TOTs adapted delivery to the constraints of the SMBI context; health professional visits were structured around ferry schedules and community routines. The model’s emphasis on building lasting community capability—rather than relying on recurring specialist visits—was particularly well-suited to this local community context where ongoing specialist access is inherently limited by its geographic isolation.

What it demonstrated

The TOTs model is viable in geographically isolated settings, but requires genuine adaptation to local logistics rather than a scaled-down version of the suburban model. Investment in community capability proved to have even higher relative value here, because it created something lasting where visiting services could not.

Transferable lesson

In isolated communities, workforce capability building is not just a design principle—it is the primary mechanism through which the model creates sustainable impact. A model that builds lasting local capacity is far more valuable than one that depends on ongoing external input.



8. Why the model lasts: sustainable, embedded community support

For partners weighing investment in replication, the most important evidence is not what happens while the TOTs team is in the room—it is what remains after. The evaluation found clear, early signs that the model builds lasting capacity rather than dependency.

Capacity stays in the centre or hub

In centres with longer TOTs involvement, directors and educators have begun sharing strategies and learnings with other staff—peer-to-peer support that signals the model is becoming embedded in the culture of the centre, not just the practice of individuals. Educators increasingly make independent observations rather than relying on directors, and feel confident to have sensitive conversations, reducing the burden of difficult conversations that directors once carried alone. In community hubs, the allied health support embedded in the holistic hub programs has built the capacity of parents and carers to understand their child's developmental presentation and advocate for their needs.

Capacity travels

Even ECEC centre staff turnover—ordinarily a barrier—can extend the model's reach, as educators carry TOTs knowledge and strategies into new centres. The capability is portable in a way that a visiting service is not. Within community hubs, parents and carers are building the capacity of others to respond to and promote children's development.

Building the future workforce

The student-led speech pathology clinic serves two purposes at once: delivering care to children today while training the allied health workforce of tomorrow in a community-embedded model of practice. This is a structural contribution to long-term system capacity that few early intervention models offer.

“ That ah-ha moment, when you're working with an educator and you see it click—that's when you know it will outlast us being there.

ECEC educator, Griffith University evaluation (2025)



9. Common questions

Will this duplicate services that already exist?

No. TOTs is explicitly designed to improve access to existing services, not to create parallel ones. Its role is to strengthen the earliest stage of the system—identification, family engagement and referral quality—so children and families are more effectively connected to services that already exist. The child health nurses and allied health professionals working within TOTs do so as part of their existing roles; the model changes where and how they engage, not what they provide.

Will this increase the workload of early childhood educators?

Educator feedback consistently indicates that TOTs does not feel like an additional burden—it feels like the right support for work educators are already trying to do. The training equips them with language, skills and confidence to act on concerns they were already noticing but felt ill-equipped to address. Its practical, embedded nature means it complements educators' existing practice under the Early Years Learning Framework rather than sitting alongside it. That said, implementation should be sensitive to workforce capacity, and genuine partnership—not top-down imposition—is essential. The model recognises the skills and expertise of the ECEC sector workforce in walking alongside children and families in the early childhood period.

Will families engage, particularly those who are hard to reach?

The evidence is clear: families engage at significantly higher rates in familiar settings with trusted providers than through clinic-based or outreach approaches. The educator and community hub staff as trusted intermediary is not incidental—it is the core mechanism. For communities where trust in formal services has historically been low, this relational approach has been particularly powerful, as the First Nations and CALD examples show. The honest caveat is that family follow-through beyond the centre remains the model's hardest barrier, which is why active navigation is built in.

How long does it take to establish the model?

Timelines vary with local context, existing infrastructure and the readiness of ECEC partners. Brisbane South PHN's experience suggests meaningful capacity building can be established within the first 6 to 12 months, with referral-pathway improvements developing as relationships strengthen. The model is built progressively, starting with a small number of sites and expanding as experience accumulates. Expect the first year to look different from the third.

Does the model work in rural and remote contexts?

Yes—with appropriate adaptation. The Southern Moreton Bay Islands (SMBI) adaption demonstrates viability in geographically isolated communities. In these contexts the emphasis on building lasting community capability becomes even more important, because it creates identification capacity that does not depend on regular specialist access. The key is genuine adaptation to local logistics—not applying an urban model at reduced scale.

What does it cost, and what does it require to set up?

TOTs is designed to integrate with existing workforce and service infrastructure rather than require significant new resourcing. The primary investments are educator training, the co-location of child health nurses and allied health professionals, and program coordination. As Section 3.2 describes, the TOTs model overseen by Brisbane South PHN braids together complementary contributions rather than relying on a single funding stream or provider. **Specific funding requirements for the TOTs model will naturally vary depending on the local context and scale of its implementation. Brisbane South PHN is available to discuss its implementation experience in detail upon request.**



10. Adapting the TOTs model for local contexts

TOTs is evidence-informed but not prescriptive. Its design principles are consistent; its delivery is flexible. The following reflect what Brisbane South PHN has learned about the conditions that enable success, and the decisions each jurisdiction will need to make for itself.

10.1 What is non-negotiable

- Delivery in settings families already use—not in clinical or unfamiliar environments
- Genuine investment in educator capability—not just awareness raising, but practical skill building with ongoing support
- Active navigation support—not just referral, but supported connection to services
- Strong relationships between health professionals and ECEC settings—built over time, not assumed
- Cultural responsiveness—tailored to the specific community context, not applied uniformly

10.2 What can be adapted

- The specific settings used—ECECs, community hubs and playgroups, or other community touchpoints
- The health professionals co-located within settings—depending on local workforce and priority needs
- The training content and delivery format—adapted to local ECEC workforce characteristics
- The funding and provider mix—braided from what is available locally (see Section 3.2)
- The referral pathways and service connections—based on what exists in the local system
- The cultural and language adaptations—specific to the community served
- The scale and pace of rollout—starting small, learning, and expanding

10.3 What Brisbane South PHN has learned from 7 years of delivery

- **Start with the relationship, not the service.** The most important early investment is building genuine partnerships with ECEC settings and community hubs—understanding their context, respecting their expertise, and establishing trust before asking them to change their practice.
- **Educator training needs follow-up.** One-off training is not sufficient. Sustained improvement requires ongoing support, access to health professionals for consultation, and opportunities to reflect on experience.
- **Navigate actively, not passively.** Providing a referral is not the same as supporting a family through it. Active navigation—checking in, following up, problem-solving barriers—is what turns referrals into actual service access.
- **Measure what matters to the community, not just what is easy to count.** Numbers on educators trained and children screened matter—but so does qualitative evidence of changed practice, family confidence, and stronger cross-sector relationships.
- **Be honest about what takes time.** Cross-sector relationships, changed workforce practice and genuine community trust are built slowly. Plan for it.



11. Next steps

Brisbane South PHN is committed to sharing what has been learned through 7 years of TOTs implementation. We welcome conversations with primary health networks, hospital and health services, state and territory health and education departments, and early childhood sector partners exploring how community-embedded early intervention can be strengthened in their regions.

11.1 What Brisbane South PHN can offer

- Detailed implementation insights and lessons learned from diverse community contexts
- Access to the Griffith University evaluation report and supporting program evidence
- Guidance on educator training approaches, referral pathway design, and program coordination structures
- Discussion of how the model can be adapted to different regional contexts, population needs and service infrastructure
- Connection with delivery partners—early childhood organisations, health professionals and community groups with experience of the model

11.2 Suggested first steps for interested partners

- Read the full Griffith University evaluation report, available on the Brisbane South PHN website
- Map existing early childhood service infrastructure in your region and identify potential community settings
- Identify the priority population communities where developmental access challenges are most acute
- Consider the workforce and partnership landscape—which ECEC providers, health services and community organisations might anchor a local implementation, and how a braided funding mix could be assembled
- Contact the TOTs team to discuss your context and explore what a local adaptation might look like

Get in touch

We are happy to share our TOTs implementation experience, connect you with relevant resources, and support your thinking about how community-embedded early childhood developmental support can work in your region.



12. Supporting resources

- **Evaluating the Thriving and On Track Initiative: A Qualitative Case Study Evaluation of Capacity Building for Early Childhood Educators**—Griffith University / Brisbane South PHN, June 2025.
bsphn.org.au/images/child-youth-families/evaluating-tots_a-qualitative-case-study-evaluation-june-2025.pdf
- **Thriving and On Track (TOTs) program information**—Brisbane South PHN.
bsphn.org.au/community-health/child-youth-and-families/thriving-and-on-track-tots
- Thriving Kids Advisory Group Final Report—Australian Government.
- **Thriving and On Track Evaluation: Brisbane South PHN—Final Report**—Siggins Miller, 2021 (the first independent evaluation; available from Brisbane South PHN on request).
- Gunya Meta—Bullang Jarjums program information—gunyameta.org
- Australian Early Development Census National Report 2024—Australian Government Department of Education.



13. Glossary

The following is a list of key terms and abbreviations used in this TOTs program guide. The definitions provided are for a general audience and reflect common usage in the Australian early childhood and primary health context.

AEDC

Australian Early Development Census. A national data collection, conducted every 3 years, that measures how children are developing across 5 domains by the time they start school.

Allied health

Health professionals other than doctors and nurses—in this model, primarily speech pathologists and occupational therapists—who support children's development.

CALD

Culturally and linguistically diverse. Describes people and communities with a range of cultural backgrounds, languages and experiences of migration.

Capacity building

Equipping educators, families and community staff with the knowledge, confidence and tools to support children's development, so that capability remains in the setting over time.

Child Health Champion

A navigator role trialled within TOTs to help families overcome practical barriers—such as transport and appointment timing—and to increase the uptake of the child health and developmental services children are referred to.

Child health nurse

A registered nurse with specialist training in the health and development of young children and the support of their families.

Developmental screening

A brief, structured check to identify children who may benefit from further assessment or support. In this model, screening is conducted in familiar community settings with family consent.

ECEC

Early childhood education and care. Includes long day care, kindergarten, family day care and similar settings for children aged 0 to 5.

HHS

Hospital and Health Services. A state-governed statutory body that delivers public hospital and community health services within a defined region; the natural partner alongside a PHN in adapting a model such as TOTs in their shared regional boundaries.

EYLF

Early Years Learning Framework. Australia's national framework guiding the practice of early childhood educators.

Foundational Supports

A new tier of support, established under the Australian Government's Thriving Kids strategy, for children with developmental delay and/or autism with low to moderate support needs and their families, to be delivered by state and territory governments with Commonwealth funding.

PEDS® / PEDS-R®

Parent's Evaluation of Developmental Status (and its revised edition). A validated developmental screening tool that draws on parents' observations of their child.

PHN

Primary Health Network. One of 31 regional, non-profit organisations that help to commission and coordinate primary health services across Australia with Commonwealth funding.

Place-based

An approach that delivers support within the everyday settings where families already gather, rather than requiring them to travel to clinical or unfamiliar environments.

SLCN

Speech, language and communication needs. Difficulties a child may experience in understanding or using language and communicating with others.

Thriving Kids

An Australian Government strategy and reform recognising that the period from conception to age 8 is foundational to lifelong health, learning and wellbeing, and establishing Foundational Supports for young children.

TOTs

Thriving and On Track. Brisbane South PHN's place-based early childhood developmental support program, the subject of this playbook.



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15. Appendix

Appendix A.

Implementation readiness checklist

This checklist is provided as a supportive prompt for partners scoping a local adaptation of the model. It is not intended as a prescriptive sequence—the TOTs model is designed to start small and grow. Instead, it lists the conditions that Brisbane South PHN's experience suggests matter most for successful program implementation.

1. Community and need

- ✓ AEDC and local data reviewed to identify communities with the highest developmental vulnerability
- ✓ Priority population contexts understood (e.g. CALD, First Nations, geographically isolated)
- ✓ Community settings identified where families already gather (ECEC centres, playgroups, hubs)

2. Partnerships and governance

- ✓ ECEC providers engaged as genuine partners, with time allowed to build trust before changing practice
- ✓ Health and allied health partners identified for co-location in community settings
- ✓ Community-controlled organisations engaged where First Nations or culturally specific delivery is required
- ✓ Governance and information-sharing arrangements agreed across sectors

3. Funding and workforce

- ✓ A braided funding mix scoped from available Commonwealth, state and territory sources (see Section 3.2)
- ✓ Workforce identified for capacity building delivery (allied health, early childhood, or student-led)
- ✓ Protected time for educators to engage in TOTs activities advocated for and planned

Delivery and evaluation

- ✓ Capacity building content and delivery modes adapted to the local workforce (training, modelling, coaching)
- ✓ Referral pathways mapped to services that exist in the local system
- ✓ Active navigation support resourced—not just referral, but supported follow-through
- ✓ Mechanisms in place to monitor educator practice, family engagement and child outcomes over time
- ✓ Measures of sustainability included (peer sharing, independent use of tools and strategies)

Appendix B.

TOTs co-investment proposal outline (minimum viable model) – Children’s Health QLD HHS, Brisbane South PHN and IDAC/Philanthropy partners

This document details the resourcing, reach and cost per year to deliver a minimum viable model for TOTs within ECECs and 8 community hubs across 7 suburbs within a local council area. TOTs is currently delivered in the areas of Inala, Browns Plains, Eagleby, Yarrabilba, Logan Central, Kingston and Marsden. TOTs is a proven model and provides targeted capacity-building, screening and early intervention support for families, educators, community hubs in responding to mild to moderate developmental delays.

Role	Responsibilities	FTE	Reach/yr	Cost/yr ¹
TOTs Manager	Operational management of TOTs in BSPHN	0.8FTE		\$162,000
TOTs Operations and Evaluation Coordinator	Commissioning of providers Monitoring of deliverables	1.0FTE		\$108,000
TOTs Program Coordinators	Engagement of ECECs Training of educators, follow up support and capacity building Community and partner relationship	1.6FTE	1FTE = 45 ECECs 350+ educators 2000+ children Includes low support, high support to ECECs	\$216,000
Child Health Nurses	Secondary developmental screening and are planning Onward referrals	0.8FTE	0.8FTE = 300 children	\$129,600
Child Health Admin	Scheduling, ASQ processes	0.5FTE		\$54,000
Allied Health support	Broad messaging to families Soft entry education and family capacity building sessions Short-term intervention in community hubs including capacity building of hub staff Short-term intervention in ECECs Early childhood educator capacity building	4.5FTE	1000 families approx. (offered all TOTs ECECs) 500 families approx. 150+ children 8 hubs 200 children (children with delay) 100 educators approx. 20 ECECs	\$593,000
Total				\$1,262,600

¹ Includes 10% staffing on-costs and 8% organisational costs, calculated for financial year 2024-2025.

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