Barnardos Australia's Submission on OOHC Costs and Pricing Review Draft Terms of Reference

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For over 100 years Barnardos Australia (Barnardos) has been a leading child protection charity, providing support to 15,000+ children and families across New South Wales (NSW) and the Australian Capital Territory (ACT) each year. This includes up to 1,200 children placed in Barnardos out-of-home care (OOHC) per annum.

Barnardos provides evidence driven foster care programs based on planned child outcomes, with discrete and specifically trained managers, case workers and teams. Barnardos OOHC programs and planned child outcomes are closely aligned to previous and current NSW legislation, specifically the *Children and Young Persons (Care and Protection) Act, 1998*.

Barnardos OOHC comprises:

- Temporary Family Care (children entering care on NSW Children's Court Interim Orders)
- Kinship Care
- Open Adoption (for non-Aboriginal children)
- Permanent Care (children on NSW Children's Court Orders for Parental Responsibility to 18 years of age).

Barnardos is the only NSW non-government organisation (NGO) to hold a Deed of Delegation on the Exercise of Aspects of Parental Responsibility for Children and Young People under the Minister's Responsibility, agreed in 2007 and renewed ongoing since that time.

Barnardos demonstrates strong experience and collaboration in previous OOHC costings analysis by NSW government – including Unit Costs 2006 (Ernst and Young), OOHC Cost Modelling 2010 (Boston Consulting Group); and internationally (see Ward, H., & Holmes, L. , 2008, Calculating the costs of local authority care for children with contrasting needs. *Child and Family Social Work*, 13(1), 80–90). In light of this combined practice and efficiency costing experience, Barnardos respectfully provides the following suggestions for consideration within the Draft Terms of Reference for the forthcoming Review.

- Consideration of costs related to OOHC placement outcomes for children, specifically the evidence-based caseworker skills required and associated remuneration, and caseload size (the latter directly impacting quality of care for children and young people via impact on child visitation rates)
- Complexity of analysis of 'true costs' within the current NSW OOHC funding environment, specifically that DCJ and some NGOs (including Pty Ltd companies) are operating outside the PSP contract environment
- 'Hidden' OOHC costs within DCJ Psychological and Specialist Services which provide intensive programs for foster carers however sit outside DCJ OOHC budgets and currently within the budget of the Office of the Senior Practitioner
- DCJ costs related to excessively high rates of staff turnover (including OOHC staff replacement costs)
- Utility analysis of the Child Assessment Tool (CAT) which is not evidence-based, subject to 'override' provisions, and a payment method essentially unrelated to the actual costs of caring for a child in foster care
- Specifically include children and young people living with disability and complex health needs as a standalone category for calculating efficient and benchmark costs

- Cost of developing culturally appropriate Care Plans (including for Aboriginal and Torres Strait Islander and culturally and linguistically diverse children and young people), which are not static and require amendment over time based on the ongoing and expanding cultural needs of the child
- Consideration of court related and legal system costs, including legal representation for NGOs when differences of professional opinion arise in relation to proposed child Care Plans
- Unanticipated costs for example additional administrative requests by government
- Costs related to family finding and cultural lineage
- Incentives for targeted recruitment of carers for children and young people with complex trauma related needs, and associated treatment requirements
- Cost of leaving care plans and transition to independent living and
- Costs related to child safety related compliance and regulation, specifically reportable conduct.

Attached to further assist please find:

1. Barnardos' research in conjunction with Monash University and The University of Melbourne (Tregeagle and others, Worker time and the cost of stability, *Children and Youth Services Review*, 2011)
2. Development of outcomes based contracting for OOHC and other human services provision (Ernst and Young for NSW Government, 2015).

Please also note that since 2012 Barnardos has undertaken detailed annual actuarial data analysis by independent firm PFS Consulting (PFS Consulting - PFS Consulting), in relation to costs and outcomes for children in Barnardos OOHC. These reports can be made available on meeting request, with possible connection to the PFS Managing Director.

Thank you for the opportunity to submit these comments to the Review of OOHC Costs and Pricing Draft Terms of Reference. Barnardos is looking forward to participating in this important piece of work as initiated by NSW Government.

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Worker time and the cost of stability

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ABSTRACT

This paper investigates the time caseworkers spend supporting long-term foster care and adoption placements. Undertaken in Australia through collaboration between university and non-government agency researchers, the 'Cost of Support Study' tracked the hours that caseworkers spent supporting twenty-seven children and their carers over a nine month period.[3] The placements were part of a 'Find-A-Family' program for 'hard to place children', many of whom had previously experienced multiple placement breakdowns. The program has a history of 78% stability on the first placement (over the young person's time in the program) and 93% by the second, with the type of support provided by this accredited agency's program detailed here. The weekly worker diaries reveal an average of 3 hours 32 minutes of worker time per week per placement; however wide variation is apparent in the time given to each placement, and depends on the characteristics of the child involved. Further, the resources required to support each placement are found by multiplying worker hours by the hourly cost per worker, using New South Wales government costings. The paper contributes to the important debate regarding the link between worker time and stability in care, by deepening our understanding of the costs involved in providing high quality support and supervision of casework.

1. Introduction

Stability of foster care placements is generally considered an important factor for understanding the poor outcomes that are too common for children and young people who have spent long periods of time in out-of-home care. Breakdowns in foster care or adoptive placements can be traumatic to the children and carers, as well as financially expensive for the community (O'Neill, 1997). While a precise definition of 'stability' is elusive, concern at the damage to children brought about by the instability of placements has been an important area of social work research (Christiansen, Havik, & Anderssen, 2010; Jackson & Thomas, 1999). While some children need to move placements due to 'policy' concerns such as reuniting with siblings or being placed with kin (James, 2010), unplanned placement moves are described as leading to childhood stress, emotional pain and trauma, decreased attachment and emotional and behavioral disorders, difficulty forming positive relationships, increased foster care cost and carer distress (Pecora, 2010). Children themselves complain of the loss of personal belongings, self-esteem and 'personal power', as well as reporting the tendency to 'withdraw' and disconnect from adults (Unrau & Day, 2010).

Most recent research regarding the factors associated with instability has focused predominantly on the characteristics of the child, the carer household, or the different types of care, such as residential or foster care (Barber & Delfabbro, 2003; Jones, 2010; Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007). Factors such as placing siblings together, worker continuity (Pecora, 2010), worker skills, foster parent assessment and retention (Jones, 2010) are also acknowledged as factors that can assist stability. This paper aims to contribute to the debate on the factors leading to the stability of a placement by exploring the time spent by workers in support of the placement. These findings on worker time provide increased understanding of the resources needed by an agency to provide a particular level of stability.

2. Background

Over recent years, social work researchers have become increasingly interested in the costs of services (Allphin, Simmons,

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[3] The research also tracked the time taken by carers for tasks related specifically to the placement — i.e. above and beyond 'ordinary parenting'. See full report of the research at http://www.buseco.monash.edu.au/ebs/pubs/reports/cost-of-support-final-report.pdf; and Research Report Summary (O'Neill, Tregeagle, Forbes, Cox, & Humpheys, 2010). Further papers on the carer findings and the methodology itself are in preparation.

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& Barth, 2001; Selwyn, Frazer, & Quinton, 2006; Selwyn, Sturgess, Quinton, & Baxter, 2006). Particular interest has focused on the comparison of one practice option with another, to understand where funding may be inadequate, and to anticipate the future costs of running a program. Initially undertaken for administrative purposes, this area of research has more recently begun to link data with outcomes such as stability in care (see for example, Beecham & Sinclair, 2007).

A major difficulty in comparing studies involving stability relates to the different aspects of stability considered. Stability rates are subject to varying degrees of precision owing to the length of time used to estimate the underlying rates; for example, in some studies rates are assessed over a ten year time-frame (Delfabbro, Jeffreys, Rogers, Wilson, & Borgas, 2009), in others over five years (DHS, 2003). Stability rates themselves are an important outcome measure for long term foster care programs as they gauge a program's overall ability to establish supported care for children within their foster families. However, to be measured precisely stability rates should be assessed over a long period of time, as they are based on information collected regarding the duration of placements. Further, information must be amalgamated over different children, with individual situations having relatively little impact on the overall rate.

In this study, the impact of worker support on individual placements is explored, with stability referring to the absence of placement disruption over the study period. This is particularly meaningful in the context of a program with well established stability rates, because the context of stability overall is already established. The aim in this study is to explore detailed information about the amount of time that workers spend on different types of placements and the types of activities that are most important to maintaining those placements within the program. In particular, the variation between different types of children and their placements is of interest, to help understand the way that the program is able to respond to the needs of individual placements over time.

A few studies, in other policy areas, have hinted at the significance of the time workers spend with children and carers, but this has not been the primary focus of research. For example, we know from studies exploring foster carer motivation that interest in maintaining a placement is greatly affected by the adequacy of support and information available from agencies (Brown & Bednar, 2006). Increasing numbers of foster carers say that they stop fostering because they do *not* receive the support and positive recognition that they need (Rindfleish, Bean, & Denby, 1998). Administrative data from the US Child and Family Services Review also identifies stronger stability outcomes related to casework visits to foster parents and children (Sudol, 2010). Also, research directly with foster children has identified that the actions and attitudes of workers affect their experience of foster care. Children and young people report that placements break down when they are not able to get an adequate response from workers, resulting in a lost opportunity to improve the placement (Christiansen et al., 2010). Foster children cite the lack of attention and support they receive from statutory child protection staff and report not being able to trust staff, who, for example, visit infrequently or fail to supply promised transportation (Mathiesen, Jarmon, & Clarke, 2001).

In the area of costing, there have also been some anecdotal findings about the link between worker time and the stability of a placement. For example, adoption rates are higher in programs with greater staffing and resources (UK Department of Health, 1999). Improved short-term stability for children in care is noted following increases in government funding in the United Kingdom (UK) subsequent to changes in legislation (Jackson & Thomas, 1999, p. 31). The 'number of case managers allocated to clients' is noted as an important indicator of stability in Australian foster care (DHS, 2003, p. 64), and a lack of contact between children and workers is seen as a significant factor in placement instability (Gilbertson & Barber, 2004). However, more direct research into worker time and agency resources is needed.

Costing studies have generally taken one of two approaches to calculate the cost of services (Beecham, 2004). The first, a 'top-down' approach, divides the total budget by service output. In contrast, a 'bottom-up' approach analyses actual costs and processes associated with individual placements or service areas (Beecham, 2004; Selwyn, Frazer, & Quinton, 2006). Top-down approaches have been used in Australia (SCRGSP, 2010) and the UK to calculate the cost of care and adoption (Selwyn & Sempik, 2010). However, top-down costing is poor at establishing comparative costs. The bottom-up approach has been used in the UK to anticipate the cost of placements before they commence (Ward & Holmes, 2008). However, in practice bottom-up studies typically draw their data from focus groups well after the work has taken place, and therefore the accuracy of such data is suspect since it relies on the somewhat distant memories of the participants, an approach known to be fraught with errors (Conrath, Higgins, & McClean, 1983). One recent exception is the work of Holmes, Westlake, and Ward (2008) which used 'event records' (workers completing time diaries) for 15 children to arrive at cost estimates of particular placement processes. The authors note, however, that only four workers completed three months of data recording and that the average completion length was far shorter at 26 days.

This paper contributes to the important, but inchoate debate on the link between worker time and stability in care using a robust bottom-up methodology, where workers regularly record the actual time and type of activity undertaken to support a placement. We present a detailed analysis of worker time and costs associated with the delivery of a long term foster care program which has an accredited level of quality and established high rate of placement stability. In addition, the amount of support provided to placements is explored across various placement characteristics, including the age of the child, the intention to proceed to adoption and the time in care.

3. The cost of support study

3.1. The study site

In Australia, out of home care (OOHC) is the responsibility of state governments and each state therefore has its own range of relevant legislation and policies. There is also a strong non-government sector which provides much of the actual OOHC work, funded mainly by the relevant state government. This paper describes a research project which took place in the state of New South Wales, Australia, over nine months within 2008–09 and within the context of a non-government agency that has operated for over twenty-five years. Conducted within the Barnardos Australia Find-A-Family (FAF) program, a specialist permanency program that takes children separated from their families by the court until the age of 18 years, the study was undertaken to look at the cost of providing support to, and therefore facilitating stability in, long-term foster care and adoptive placements. In the FAF program, children either stay in long-term foster care or may be adopted, with the agency having full case-management responsibility (that is workers do not share decision-making with the statutory workers during the placement). The program specializes in 'hard to place' children and was the first program to receive government accreditation in Australia. The program is independently audited each year by the New South Wales Office of the Children's Guardian (www.kidsguardian.nsw.gov.au) in relation to policy, education and health assessment, record keeping, assessment, training of workers and carers, supervision and governance. All workers use the internationally recognized *Looking After Children* (LAC) case management system, developed in the UK in 1990s and adapted for Australia in 1997 by the LACPROJECT Australia (Cheers & Morwitzer, 2008) to establish agreed levels of regular assessment in a

range of areas (e.g. health, education, relationships) and to facilitate the ongoing review of each child's progress. Further information is available regarding the long term outcomes for children in the FAF program (Fernandez, 2006, 2008, 2009).

A general description of the program is provided here to allow greater understanding of the costed model of care. FAF is based on the Barnardos UK family finder program, and provides care for children who have either experienced multiple disruptions in foster care, or are babies or toddlers with complex family backgrounds who have no possibility of returning to their birth parents' care. FAF specializes in placing large sibling groups and children who require culturally specific placements as these are children who frequently have the greatest difficulty being placed. Based on the NSW government's criteria for additional placement funding,[4] over two thirds of the children have behavior described as either very difficult (30%), or extremely or extraordinarily difficult (38%).

Adoption is the care plan for up to half of the children in the program and the average age at legal finalization of the adoption is 10 years. In keeping with the Secretariat of National Aboriginal and Islander Child Care guidance (SNAICC, 2008) and Aboriginal cultural views on adoption, FAF would not normally accept an Aboriginal child into care, and adoption would only be considered in consultation with Aboriginal communities and elders.

The FAF program operates under the New South Wales Children (Care and Protection) Act 1997, and each child has finalized Children's Court Orders committing them to care until age 18. Parents have rights to seek revisions of these Orders. However, under separate adoption legislation, children can also consent to their own adoption after the age of 12 years.

The FAF program has a history of 78% stability on the first placement (over the young person's time in the program) and 93% by the second; see Fig. 1. Given the special needs and challenging nature of the children, the FAF stability rates appear to be high. These rates were calculated using over twenty-three years of records, and relate to the entire period of involvement for all children in the program (children remain with the program until adoption or 'aging out' of the program).

Although difficult to provide direct comparisons, as few studies focus on stability for the subgroups of very damaged children who have been in the care system for a long time, it is clear that the FAF figures are impressive. US data shows an average of 3.2 placements per child with a median length of stay of 15.3 months in a Californian study of the general foster care population, showing that 77% of children had three or more placements (Pecora, 2010). An Australian study demonstrated that almost 80% of a particular comparison group had experienced seven or more previous placements (Delfabbro et al., 2009). In another Australian study conducted over a five-year period of the general foster care population, children and young people experienced an average of 3.4 foster placement changes, and 23% had five or more placements (DHS, 2003, p. 59).

FAF has well established principles of practice, based on the available research literature regarding children's attachment and poor outcomes in traditional out of home care. On entry into the program, children and young people generally enter a 'bridging placement' for 12–18 months (not counted in this study as a permanent placement), until child specific recruitment efforts result in an appropriate family being found. Due to their critical attachment needs, children under the age of three are usually placed directly with an adoptive family and are not associated with such individualized recruitment procedures. Note that for these young children, an adoptive family is often much easier to recruit. The child's introduction to the placement usually takes place gradually, over a number of visits, and unrelated foster children are rarely put together in one placement (Ingley & Earley, 2008).

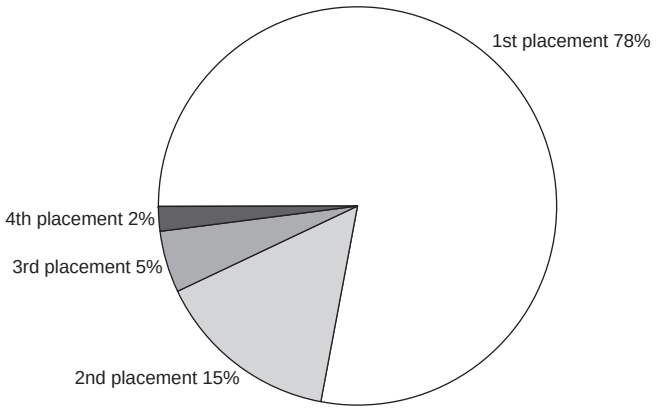

Fig. 1. Stability rates for placements in Barnardos FAF Program, October 1984–February 2008 (N = 365). This is the rate at which children found a permanent family, or who exited the program to adoption or independent living, in their first or subsequent permanent placements.

Case workers have daily to weekly contact with children at the beginning of placement in order to establish the arrangement. Support remains in place on an ongoing and 'as-needed' basis. Active age-appropriate participation by the child or young person in decision making is strongly encouraged and birth family engagement with the children is generally ongoing, including after an adoption. Workers monitor placements regularly and support is offered to carers to avoid small issues threatening the placement. Carers have access to their twenty-four hour 'on call' phone numbers. Supervision and ongoing training are provided for carers as soon as a child is placed, alongside other practical support structures (counseling, education, health) which help to resource long term placements, particularly those for children and young people with very difficult behaviors. This support, supervision and ongoing training are seen as necessary for the maintenance of a high quality service, both to children and their carers.

3.2. Study method

This article reports on the findings from research based on diary records maintained by workers relating to the support provided for twenty-seven children in the FAF program from November 2008 to August 2009. A blank copy of the diary page used for data collection is included in the Appendix A. The research was funded by a philanthropic organization (The Ian Potter Foundation) and ethical clearance was gained through the University of Melbourne Human Research Ethics Committee and confirmed by the Monash University Human Research Ethics Committee.

At the outset of the study, twenty-five placements were selected through a purposeful sampling design, where five placements from each of five different groups were selected, representing a broad range of placement characteristics. The five pre-determined study groups were:

- *Adolescent group*: young people thought to be vulnerable to instability due to being in adolescence, aged between 12 and 16 years;
- *First Year group*: children and young people in their first year of placement;
- *Unstable group*: placements where staff members were concerned about the stability of the placement at the commencement of the project;

[4] There are four categories of NSW government funding, ranging from Care (ordinarily difficult), Care+1 (very difficult), Care+2 (extremely difficult) to Care +2+ (extraordinarily difficult).

- *Stable group*: placements considered to be in a 'stable/average' category, viewed as a control group;
- *Adoptive group*: pre-adoptive placements, where the placement was intended to proceed to adoption, and although thought to be stable, could potentially require greater levels of worker time because of the care plan.

The five individual placements selected within each group were chosen at random, subject to ensuring that workers were not unduly burdened with multiple placements and also where carers were willing to participate.

In addition to the original sample of twenty-five placements, placements for two further children were added partway through the study when it was apparent the placements were stressed and therefore vulnerable to disruption. It was felt that it was important to get data on potential disruptions to compare with previous studies in the area (O'Neill, 1997). These two placements are referred to as the *Imminent Risk group*.

Each week for nine months, the workers recorded the hours of work completed each day (in 15 minute blocks), indicating the category of activity undertaken, for each placement in the study. Consistent administrative follow up was provided, resulting in only 2.3% of days where data was not recorded. Managers were also asked to detail, on a weekly basis, any time spent on placements involved in the study as, in addition to routine supervision, they provide additional support when difficulties arise within a placement or when a worker is away on leave. Manager time is therefore treated as a separate category within the worker data.

The subsequent costing of time was undertaken using the NSW Government costing data, which importantly includes all overheads and non-client related time.

3.3. Worker costs

Costs calculated from the study represent the cost of the hours provided by workers and are based on an hourly rate provided by the FAF funding body (NSW Department of Community Services) for the 2008/9 year. The cost of each Full Time Equivalent (FTE) notional worker position has been determined by the funding body at $163,480 *per annum*.[5] This figure does not include carer payments or contingency payments which cover such costs as additional education, health and recreational activities. The calculation is reproduced in Table 1 for completeness, and to allow adaptation of the formula to other times or local conditions.

The hourly rate associated with Table 1 is calculated for a 38 hour week, with 207 days available for work (365 days excluding weekends, public holidays, recreation and sick leave and training), resulting in 1626 hours available per worker, per year. Included in the activities are non-client related work such as general team meetings, supervision and administration.

Barnardos Australia managers reported that they view this formula as a good approximation of the FAF program costs. When considering the costing formula, it should be noted that the workers in this study did not undertake recruitment of foster carers (this is done by specialist officers), however this is included in the hourly rate. Also, Barnardos workers have full legal responsibility for the children and are not involved in liaison with statutory workers or involved in court preparation. They also only work 140 hours over a four week period, with time off in lieu enforced for any time spent with work at night or weekends. All workers hold a four year undergraduate degree in social work or psychology, while some also hold a Master's degree in these areas.

Table 1
Cost of FTE notional caseworkers in out of home care in Australian dollars, from costing manual for child and family services in New South Wales 2008–9 'Out of Home Care Services', Department of Community Services (www.community.nsw.gov.au, accessed 1/4/2009). Note that non-client related data is included in this costing.

Caseworkers — indicative unit cost per FTE	Low range	High range	Indicative cost
Unit labor costs (per FTE)			
Caseworker base salary	$47,900	$58,540	$53,220
Direct supervisor allocation	$10,390	$12,690	$11,540
Admin and other indirect support allocation	$18,670	$22,810	$20,740
Salary oncosts	$13,370	$16,340	$14,851
A. Total unit labor costs	$90,330	$110,380	$100,350
Unit non-labor costs (per FTE)			
Motor vehicle			$13,240
IT/computer			$4920
Telecommunications			$1310
Stationery/postage/printing			$1610
Depreciation and equipment maint.			$1960
Staff training			$3630
Accommodation			$10,360
Corporate overheads & other			$26,100
B. Total unit non-labor costs	$56,820	$69,440	$63,130
Total loaded cost per FTE (A + B)	$147,150	$179,820	$163,480
Labor cost factor			61%
Non-labor cost factor			39%
Total available hours			1626
% of time — non client related			20%
Service hours available			1301
Cost per direct client hour	$113.1	$138.2	$125.6

3.4. Calculation of the average hours per day

A key objective of the research was to calculate the cost of support for a worker per week (or correspondingly, per day), and hence we investigated the average number of hours per day for each placement over the study period. As well as direct client contact, the hours included phone calls, letters, supervision, meetings and travel time — i.e. anything related to the child or placement. The total hours recorded on the diary sheets relating to an individual child or young person was divided by the total number of working days available.[6] A large proportion of workers are employed part-time, with varying flexible working arrangements in place. However, as the amount of work for each worker is managed by the total number of cases in a worker's caseload, the number of available days during the study was *not* adjusted to reflect the nominal employment fraction of the worker. It would be expected, therefore, that the average number of hours per actual working day would be higher on average for a part-time worker than for a full-time worker, if all other factors were the same, simply because the same level of support is expected in fewer days per week. Hence, we interpreted the average number of hours per day as being representative of a nominally full time worker.

3.5. Characteristics of the children and young people in the study

The twenty-seven children and young people who participated in the study comprise about 15% of all children in the FAF program. Twelve male and fifteen female children and young people were associated with the study, with six children aged less than 5 years, five aged 5–9 years, eight aged 10–14 years and eight aged at least 15 years at the start of the study. These characteristics represent a relatively even spread of gender and age across the population of children in the program.

[5] All dollars quoted are Australian dollars. On 4 November 2010 the US and Australian dollar were virtually equivalent. (Reserve Bank of Australia, http://www.rba.gov.au/statistics/hist-exchange-rates/index.html, downloaded 5 November 2010.)

[6] Public holidays and days of annual leave were excluded.

Participants were identified[7] as having special needs according to the four categories used by the NSW funding body:

- Ten rated within the 'Care' category, with behavior defined as 'ordinarily' difficult for foster care;
- Eight rated as 'Care +1', with behavior classed as 'very difficult';
- Six rated in 'Care +2' having 'extremely difficult' behavior; and
- Three rated as 'Care +2+', with 'extraordinarily difficult' behavior.

Seventeen children in the study were therefore designated as having special behavioral or medical needs, with up to six identified health issues (average 1.7) at the time of entry into the FAF program. The most common problems were Attention Deficit Hyperactivity Disorder (ADHD) and mental health problems. Twelve children required extra assistance with their education, nine were reported to be performing at or above average educationally and six were in childcare or pre-school with no reported developmental delays.

The children and young people had been in care (with Barnardos or previously with another agency, as of 1 January 2009) for an average of 6.2 years, including the current placement. Prior to the current placement, together the children had been in 105 placements with an average of 3.8 placements each and with a range of one to eight placements each. Nine had a care plan of long-term care with adoption, one was moving to independence and the remaining care plans were for long-term foster care (this proportion is also broadly representative of the program as a whole).

The most usual contact arrangement with birth families in the FAF program is four contact visits each year, however contact arrangements vary widely, with two children in the study having no contact with any family member and one having twelve visits per year. In addition to contact with the birth mother, visits with fathers, extended family and previous carers are also facilitated. Fourteen of the participants in the study had active contact with siblings. Twenty-four children/young people had siblings in alternative placement situations, including some other foster care placements or with birth family members. Eight of the children were placed with their siblings, but five of these also had other siblings living elsewhere.

3.6. Limitations of the study method

Like all research studies there are limitations as well as strengths in the methodology that has been used. A number of issues need to be taken into account:

a) The study sample is small. In taking five cases from each category there may be children in the sample who are atypical in each of the categories.
b) There was some variability in the compliance with diary entry by workers. Regular follow up and feedback by researchers and managers supported a high level of compliance, but of course this does not ensure 'perfection', with 2.3% of diary days missing.
c) The choice of participants was initially randomly chosen from the designated categories, but subsequently on which dyads of workers and carers were most likely to keep diaries accurately. It is therefore possible that the most conscientious carers were included in the study.
d) There may have been a 'research effect', as there were no disruptions in the nine month period for this group of children and young people. However, we note that there were some 'threatened' disruptions, as well as two disruptions (from the study group) within a few months following the end of the study period.

[7] Identification of special needs and payment categories is a negotiated process between the placement agency and the NSW Department of Community Services prior to the agency accepting the child for placement.

Despite these limitations, we believe that the study data retains a high degree of accuracy and leads us to have confidence in the resulting findings.

4. Results

The findings of the study are presented in terms of worker average hours, by study group, by activity, and according to a selection of placement characteristics. Worker costs are also included, by study group and placement characteristics.

4.1. Worker average hours per day per placement

A total of 3282.85 hours of work, including hours recorded outside of normal working periods, was recorded by the workers. These hours were collected from the 4637 working days associated with the twenty-seven cases over the entire research period, resulting in an average of 0.71 hours, or about 42 minutes of worker time, per day per placement in the study. Due to the stratified sampling design, a simple average across cases need not represent the overall worker average time for the Barnardos FAF program. However comparing the care difficulty rating proportions in the sample against those in the overall Barnardos FAF program in 2008, this average figure may be considered as representative of the overall worker average time per day for all placements in the FAF program.

Across the twenty-seven placements, workers spent on average 3 hours 32 minutes per child per five day week during the study. However, the average time hides the large differences in individual worker average time per placement, which were found to range from 16 minutes per day to 79 minutes per day. These individual times also varied according to the category of placement.

4.2. Worker time by group

Worker average time for each study group was obtained by totaling the hours for all workers within the relevant group, and then dividing by the number of cases within the same group. From Table 2 it is evident that the Imminent Risk, First Year and Unstable groups were associated with the highest levels of worker time. In particular, the worker average per day time for the First Year group was more than *twice* the average time from any of the Adolescent, Adoptive or Stable groups.

The above is not meant to suggest that the remaining three groups (Adolescent, Adoptive and Stable groups) did not require significant support, with each requiring an average of just under a half an hour per day. The worker average time was slightly higher in the Adolescent group than for either the Adoptive group or Stable group, and in all cases the average number of hours per worker per day can vary considerably even within the same study group.

In addition to the differences in average levels of support both between and within groups, every individual case required a variable amount of support over time. On many days the worker time was much greater than the daily average would suggest, and correspondingly there were also days when time spent was negligible. Fig. 2 displays the daily hours recorded for one particular placement,

Table 2
Summary of worker average hours, per placement, per day, for each study group, and over all placements in the study.

Group	Imminent risk	First year	Unstable	Adolescent	Adoptive	Stable	All
Average hours per study day	1.32	1.01	0.91	0.49	0.47	0.46	0.71
Number of cases in group	2	5	5	5	5	5	27

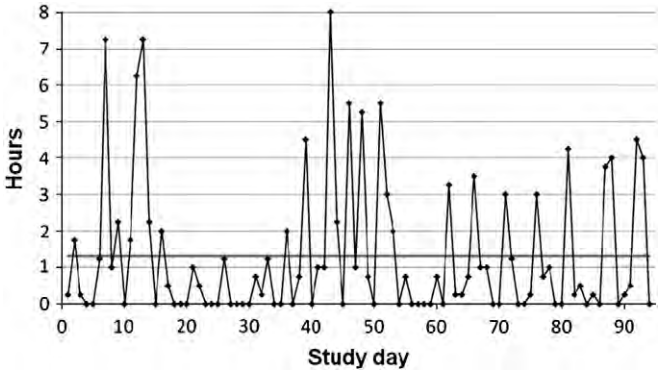

Fig. 2. Worker hours per study day for a placement. This figure shows an example of variability in hours of worker support over consecutive study days for case #1 in Imminent Risk group. The total recorded hours of worker support provided for this case over the study period is indicated by the sequence of connected dots. The corresponding average hours per study day associated with the case is 1.32 hours is indicated by the solid line. Note that 'study days' includes all days when records were recorded for placement, and does not include weekends or public holidays.

associated with the Imminent Risk group, over the days recorded during the study. The ebb and flow of worker support shown is indicative of that found in all placements in the study, despite the differences in the overall level of support required for each.

The average number of years that the children in the study were placed in any care program does vary somewhat per group, and this may have some impact on the overall findings. However, the pattern is not entirely obvious, with the First Year group having the shortest period in care (as of 1 January 2008) and the Unstable group having the longest period in care, on average. The two cases at Imminent Risk of disruption during the study had periods of care in any program less than the overall average of 6.3 years for all children in the study. This is coupled with the fact that the least demanding placements, apart from those in the Unstable group, tend to be associated with children who have been in care for slightly longer periods. A similar result applies when considering the length of time in the FAF program only; see Table 3.

4.3. Worker time by activity

Over 80% of the total hours recorded[8] may be attributed to the following eight main worker activities:

- Contact with foster carers/adoptive parents (18.9%)
- Administration — case notes, reports, etc (16.3%)
- Contact with child/ren only (13.0%)
- Contact with carers/children together (10.2%)
- Manager hours (9.4%)
- Work with birth family (6.7%)
- Access arrangements and supervision — birth parents (4.7%)
- Adoption related work (4.4%).

The percentages indicated above are found by taking the total hours associated with the relevant activity for all workers in the study over all days, and dividing that by the total number of hours reported by all workers on all days, on any activity. Other categories that required less than 4% each of the overall worker time included supervision, access with birth siblings or other family members, educational issues, health or counseling issues, internal meetings or meetings with other agencies.

However, the relative percentage of time required by workers for various activities was not constant for each study group. Table 4 details the percentage of time workers within each group spent on each of the same eight activities. The first column details the categories of activity investigated. The second column gives, in descending order, the overall percentage of time over the study period for the activity listed in the first column. In the subsequent columns, the percentage of time that workers within the group (indicated by the column heading) spent on the nominated activity, relative to all of the time recorded for that group, is given. This layout enables the reader to identify the top eight activities in terms of worker time overall, as well as how demanding that particular activity is relative to the individual study groups. For example, while time with carers or adoptive parents is of relative importance for all groups, as it ranks as requiring the highest overall time across the study and accounts for at least 15% of time in all groups, this activity is only associated with the highest proportion of time recorded for the First Year, Unstable and Adolescent groups. Similarly, while time spent on adoption related matters ranks as only the eighth most time consuming activity overall, it is understandably the most time consuming activity for the Adoptive group, and is a relatively important activity for the Stable group.

Other specific findings relating to the relative importance of various activities by group include:

- The top four activities accounted for nearly 60% of worker time. Notably, three of these four activities deal directly with the children or their carers.
- The top five activities overall accounted for over 80% of the Imminent Risk group worker time. In addition, no time was spent by this group on either access with any relationship, adoption related work, or meetings with other agencies over the period of the study.
- The findings of both the Unstable and Adolescent groups were quite similar to the First Year group, albeit with relatively more time spent with children by themselves. For both of these groups, adoption related work dropped to a very small percentage of each group's overall time.

Table 3
Average number of years of care in any foster care program (row 2), and average number of years in specific FAF program (row 3), for children in each study group and overall.

Group	Imminent risk	First year	Unstable	Adolescent	Adoptive	Stable	All
Time in any program	5.0	3.1	9.0	7.6	5.5	6.6	6.3
Time in FAF	3.5	1.0	7.7	7.5	4.2	5.4	5.0

Table 4
Top eight worker activities, overall and by group. Group percentage times for overall top eight activities ranked according to the percentage of time on activity relative to the total hours recorded during the study across all participants within the group. The 'Total top 8 for group' shown in the bottom row of the table denotes the total percentage of the relevant group's time spent on these eight categories only.

Worker activity	All	Imminent risk	First year	Unstable	Adolescent	Stable	Adoptive
Carers/adoptive parents	18.9%	17.8%	15.2%	21.5%	24.1%	17.3%	14.7%
Administration	16.3%	13.8%	14.2%	18.2%	15.1%	17.9%	15.3%
Children only	13.0%	25.8%	9.5%	17.4%	17.1%	6.3%	1.0%
Carers/children together	10.2%	8.5%	13.0%	7.6%	10.1%	10.1%	9.3%
Manager	9.4%	14.8%	13.4%	6.5%	11.4%	15.4%	10.0%
Birth family	6.7%	3.7%	6.3%	4.1%	4.9%	8.9%	13.5%
Access — birth parents	4.7%	0.0%	6.3%	4.5%	3.9%	3.7%	7.0%
Adoption related	4.4%	0.0%	2.1%	0.7%	1.3%	10.4%	17.3%
Total top 8 for group	83.6%	84.4%	79.8%	80.4%	87.9%	90.1%	88.1%

[8] These eight categories of activity represent 83.7% of all hours reported for all placements over the study period.

- Six of the top eight activities accounted for over 80% of the Stable group's time. A similar result was found for the Adoptive group.

It is apparent that workers do shift activity priorities according to the needs of individual placements. It seems that a great deal of time is spent on cases within their first year, with an emphasis on working with the children and their carers. Significant time is also spent on the birth family in terms of support by the worker and access to the children. Then, when placements are more stable, relatively more time is spent on adoption-related work.

4.4. Worker time and placement characteristics

In this section, the relationship between worker average hours per day and gender, age, health, and other placement characteristics known at the start of the study is explored. No claims are made regarding cause and effect of worker time and the characteristics of the children, and the research process considered factors only one at a time. With the relatively small number of cases and other limitations of the study, the possibilities to explore interactions of this type are limited, and do not provide adequate scope to determine statistical significance. They nevertheless point to some trends in the data.

- Cases involving male children were slightly more demanding of worker time, with an average of 45 minutes per day, compared with an average of 38 minutes per day for workers relating to cases involving female children.
- The average time per day spent by workers was the lowest (an average of 33 minutes per day) for cases involving children in care under the age of 2 years, and the highest (49 minutes per day) for cases involving children in the 3–5 year age group. As the children get older, worker time per case declines, on average, with children aged 6 to 11 years of age associated with 45 minutes of worker time per day and children aged 12 years or older in the study associated with 40 minutes per day.
- There is not an obvious pattern between worker demand and the number of health issues identified at the start of a placement; however worker time is higher, on average, for cases associated with more difficult care categories. Placements with children in the 'Care' and 'Care +1' categories were associated with an average of 37 and 38 minutes of worker time per day, respectively, whereas placements with children in the 'Care +2' category were associated with 49 minutes per day, and placements with children in the 'Care +2+' category were associated with 56 minutes of worker time per day.
- The demand for worker time is lower for placements with a long term foster care plan leading to adoption, than for placements with a long term foster care plan without adoption. Worker time on placements with long term foster care leading to adoption averaged only 34 minutes per day, whereas worker time with long term foster care placements not associated with adoption averaged 47 minutes per day during the study.
- Worker time appears to decline the longer the child has been in any care program. If a child was within the first two years of care, the placement required an average of 53 minutes per day from the worker, whereas if the child had been in care more than two years, but less than five years, the placement required an average of 43 minutes. Placements where the child had been in care more than five years averaged only 38 minutes per day from the worker.
- Considerable worker time is spent during the first year of the FAF program to establish the placement as well as to attend to a wide range of medical and social issues, resulting in an average of 64 minutes per day. We believe that the benefit of intensive work within the first year is that the overall level of time spent in subsequent years is reduced, with only 30 minutes spent on average over the second, third and fourth year in the program. However some years later support levels do gradually appear to increase, with 36 minutes the average worker time per day spent on placements where the child has been in the program for between five and eight years, and 41 minutes per day averaged by workers for placements having been stable in the program for nine years or more. We speculate that this finding may be representative of either more complex long term placements that do not result in adoption and/or could be due to the young people preparing to leave care.
- Worker time is marginally lower, at 39 minutes per day on average, for placements without respite support, than for placements with respite support, averaging 43 minutes per day. This may reflect the tendency for placements with a more difficult care category to receive respite support.
- The range of worker experience levels (based on years of experience within Barnardos, together with salary levels) for those in the study was mixed, with ten novice workers, nine more experienced workers and seven senior workers.[9] However, all workers completed the same case management system documentation (LAC) and each had the same level of supervision (monthly one-two hours with their immediate supervisor). Average time per placement per day for the novice workers was 45 minutes, more experienced workers spent 47 minutes, and senior workers spent 35 minutes.

4.5. The cost of worker time

Having obtained the average daily levels of worker time associated with each of the twenty-seven cases in the study, the average daily costs were obtained. These were calculated by multiplying the average number of worker hours per day by $125.60 (see Table 1), resulting in an average daily cost per placement of $88.92, corresponding to about 0.71 hours (or 42 minutes) per day. However, as noted in Table 2, large variation in worker time per day exists by group, and hence the group average costs vary in a corresponding way, as shown in Fig. 3.

Similarly, we find a large difference in worker average cost for long term placements associated with a plan for adoption as compared with those without adoption, as shown in Fig. 4. This figure may reflect the fact that placements need to be stable before an adoption care plan is put into action. However, it also shows that the commonly held view that adoption work remains time intensive, compared with other long term placements in this program, is not supported by the study data.

Fig. 5 shows the average cost per day, per worker, relative to the number of years the child or young person has spent in any care program. This figure demonstrates that the worker average cost per day is relatively highest in relation to placements in the first two years in any care program, and tends to decline the longer the child is in care.

5. Discussion

The Cost of Support research has confirmed much of the 'practice wisdom' of adoption and foster care workers. Using a robust 'bottom-up' methodology, the research has produced accurate time and cost findings for placement support in an organisation with a known level of stability in care. We have demonstrated that the cost of this kind of work is considerable, especially given the fact that work to recruit carers was not included in the study. In addition, we have demonstrated that both workers (and carers) are able to maintain an intensive 'diary' methodology over an extended period of time, contributing significantly to accuracy in costing. This builds on the

[9] As the worker changed over during the study in the remaining placement, this case was excluded from the worker experience analysis.

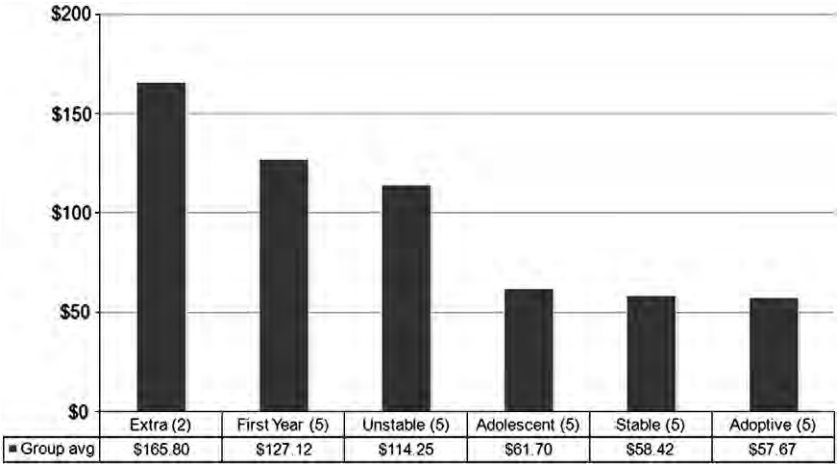

Fig. 3. Average cost per day, by group. Here the worker average hours per day for the cases within each group are multiplied by the representative cost of $125.60 per hour. The number of cases in each group is given in parentheses following the group label in the table.

work of Ward and Holmes (2008), who used a focus group methodology to arrive at estimates of time and costs; and subsequently Holmes et al. (2008), who used a more limited 'event record' methodology.

There are two major issues which have become increasingly apparent to the researchers and the Barnardos staff over the course of the study. Firstly, variability is a key issue, which is apparent throughout the sample — i.e. it is not restricted to placements requiring higher levels of support. The study has shown that placement agencies need to allow for considerable variability in worker time:

- In terms of age, gender and previous time in care.
- During a child's placement journey — with little worker support needed at some times and significant amounts at other times;

Between children in a similar category — even in a group of children of similar age and placement background, some will need far greater support than others.

Secondly (and related to variability), although the required level of support can be anticipated to some degree (e.g. for first year placements), it is difficult to predict which children and placements will need 'spikes' of support, or when these will be needed, or what kind of support will be appropriate. Similarly, placement disruptions are hard to predict. Five children in this study were initially chosen because their workers considered that their placements were potentially unstable and yet all of these placements were intact at the end of the research. Two other children, whose placements were in difficulty, joined the study partway through the nine months and yet neither of these placements disrupted before the end of the study (although one of these disrupted some months later).

Variability and unpredictability mean that placement agencies need to have enough staff hours and flexibility to be able to respond quickly to crises and requests for support.

The study showed that a significant amount of worker time is involved in supporting first year placements and unstable placements (inclusive of the initial 'Unstable Group' and the 'Imminent Risk Group'). We could speculate that the intensive support provided in the first year, as well as to subsequently unstable placements, leads to a greater degree of stability than has been reported in other research.

The costing model, independently developed and based on both salary and non-salary factors, is one that could be adapted for other countries or agencies. Ultimately it may be possible to compare

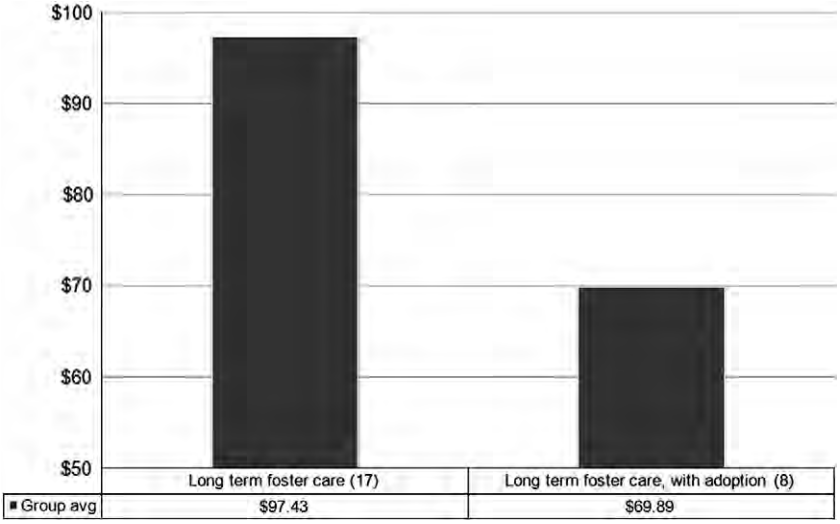

Fig. 4. Average cost per day, by care plan. Here the worker average hours per day for the cases within each category are multiplied by the representative cost of $125.60 per hour. The number of cases in each category is given in parentheses following the category label in the table.

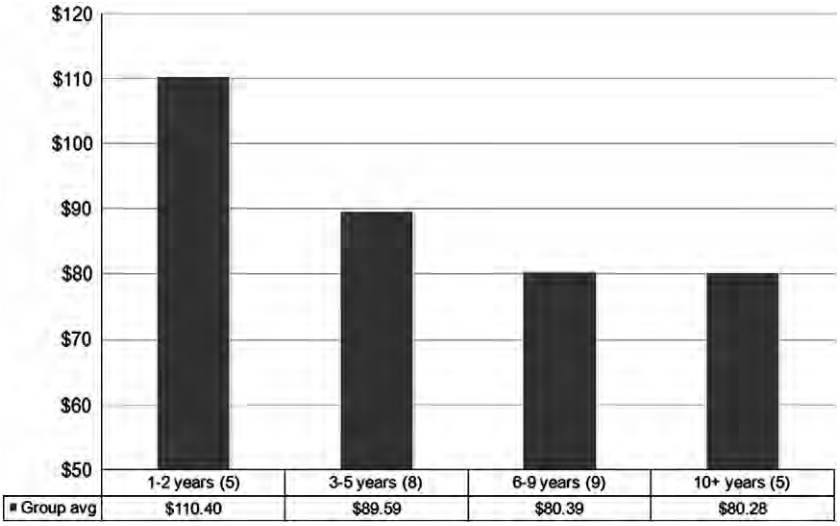

Fig. 5. Average cost per day, by time in any care program. Here the worker average hours per day for the cases within each care duration group are multiplied by the representative cost of $125.60 per hour. The number of cases in each care duration category is given in parentheses following the category label in the table.

findings with other services with different program structures, costing formulae and stability rates.

6. Conclusions

This paper contributes to the debate on the factors leading to stability of a placement by detailing the level of worker support provided to individual placements within a program that has an established high rate of stability. By using a diary method over a relatively lengthy period of nine months to track the time and activity of workers of twenty-seven separate placements in the FAF program, detailed information regarding the level of support provided to different types of placements and the types of activities that are most important to maintaining those placements within the program were obtained. From this approach, a greater understanding is gained regarding the relative frequency of various worker activities, and the financial resources required to sustain a placement.

The study found that workers spend the highest proportion of their time on contact issues with carers and potential adoptive parents, administration related to the child, interaction with children, and contact with carers and children together. Other time was spent on work with the birth family, organizing visits and work related to adoption. In addition, the characteristics of placements associated with higher than average support requirements are explored, providing insight into the factors that contribute to the variability in support needs found within the study. The research findings, along with the detailed description of the study program, methodology and the inclusion of the costing formula, will enable other programs to compare their practice, outcomes and costs.

Role of the funding source

This research was supported by The Ian Potter Foundation, 'The cost of support in long term foster care and adoption' project grant. The Ian Potter Foundation did not play any role in the study design; nor in the processes of collection, analysis or interpretation of data; nor in the writing of any reports or articles; nor in the decisions related to submission of papers for publication in any journal.

Appendix A. The cost of support in foster care and adoptive placements — caseworker weekly recording chart

Child: XY (code to be kept by agency). Week: Mon 1st>Sun 7th.
Please record in 15 minute blocks DAILY.

Worker time (incl. face to face time, phone calls and travel) spent with/on:	Monday 1st	Tuesday 2nd	Wednesday 3rd	Thursday 4th	Friday 5th	Weekend Sat 6th/Sun 7th	Total
Foster carers/adoptive parents only							
Child/ren only							
Carers/children together							
Education issues — schools, tutoring, etc							
Legal issues — specify e.g. consultation with lawyers, Court, etc							
Adoption related work							
Birth family							
Access arrangements and supervision — parents							
Access arrangements and supervision — siblings							
Access arrangements/supervision — other (e.g. extended family, previous carers)							
Health issues							
Counseling issues							
Internal meetings							
Meetings with other agencies — DOCS, etc							
Supervision/consultation							
Administration — case notes, reports etc							
Other							

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Summary report: Development of outcomes based contracting for out of home care and other human services provision

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6 November 2015

Summary report: Development of Outcomes-Based Contracting for Out-of-Home Care and other Human Services Provision

Dear Clare,

I am pleased to provide you with this report that summarises our engagement: *Development of outcomes-based contracting for Out-of-Home Care (OOHC) and other human services provision* in NSW.

Purpose of the report and restrictions on its use

The purpose of our report is limited to the objectives set out in our scope of work agreed 15 May 2015, and additional scope agreed on 10 June 2015 and 9 September 2015, and should not be used for purposes other than:

- Providing evidence of best practice in outcome-based contracting to inform a preliminary consideration of the approach to the re-contracting of out-of-home care (OOHC) services.
- Identifying key issues for the design and implementation of outcome-based elements in contracting for OOHC in NSW to support the desired outcomes for children and young people in care, and the OOHC system.

This report may only be relied upon by the NSW Government, pursuant to the terms and conditions outlined in our scope of work referenced above. We accept no liability for any loss or damage which may result from reliance on any research, analysis or information so supplied. EY disclaims all liability to any party other than NSW Government for all costs, loss, damage and liability that the third party may suffer or incur arising from or relating to or in any way connected with the provision of the report to the third party. If others choose to rely in any way on the report, they do so entirely at their own risk. The report should be read in its entirety with reference to both the scope and the limitations outlined in this letter and in the report.

Any commercial decisions taken by NSW Government are not within the scope of our duty of care. In making such decisions, the NSW Government should take into account the limitations of our scope of work and other factors of which NSW Government should be aware from sources other than our work.

Limitations of our work

In undertaking the project, a number of limitations and constraints have influenced the content of our report. These limitations include:

- Reliance has been placed on publicly available desktop research and data provided by FACS and NSW Treasury, supplemented by consultation and representations made by international practitioners and key stakeholders. These data and representations have not been independently verified or validated by EY. EY does not accept any responsibility or liability for independently verifying any information we have obtained, nor do we make any representation as to the accuracy or completeness of the information.

- The content of the report is, by necessity, limited and qualified to reflect the limited time available to undertake the report, the terms of reference as set out in the NSW Treasury's Request for Proposal and agreed in the 'Project Overview', and the reliance being placed on information provided by key stakeholders. The scope of our analysis has been limited by data availability in some areas.

- EY was asked to conduct a limited market sounding of nine providers, and the two peak bodies: the Association of Children's Welfare Agencies, and the Aboriginal Child, Family and Community Care State Secretariat. The report assumes their views are representative of the broader market. However if this is not the case, the content of the report may be impacted. EY has relied on the views represented in the limited market soundings and has not independently verified them.

- EY was not asked to conduct benchmarking or other quantitative analysis of the unit price for OOHC services, nor has it modelled any of the payment or incentive options in terms of their impact on the NSW budget or individual providers.

- Finally, EY has not provided legal advice in respect of the current contracts or the recommended approach described in the report.

Please contact me if you have any questions about the contents of the report.

Yours sincerely

[redacted]

Amanda Evans
Partner

Table of contents

1. Introduction

This report summarises the key messages and findings of EY's engagement regarding the application of outcomes-based contracting to out-of-home care (OOHC) services.

1.1 Objectives, scope and methodology

The aim of this paper is to:

- Incorporate research of existing outcome-based contracting elements from any sector that are relevant to OOHC contracted care, and draw lessons for the design and implementation of outcome-based elements in contracting for OOHC in NSW.
- Identify the critical success factors for implementation of outcome-based contracting, including how to support a viable and competitive provider market given that existing providers are at varying stages of sophistication and readiness.

EY conducted a review of agreed national and international case studies of outcome-based contracting, and conducted a qualitative analysis of the current OOHC system in NSW, drawing on global evidence in both the OOHC sector and wider human service areas. The project was conducted over a 10 week period, and was primarily desktop research based. However, our work has also been informed by:

- interviews with nine market participants and two peak bodies
- interviews with NSW Government staff members
- interviews with international specialists
- interviews with EY sector practitioners, and
- data supplied by the Department of Family and Community Services (FACS) and NSW Treasury.

1.2 Context: why outcomes-based contracting for OOHC?

1.2.1 NSW OOHC current state

In NSW, just over half of statutory OOHC is delivered by government funded and accredited non-government organisations (NGOs). As of May 2015, 7,344 NGO placements were funded by the NSW Government, representing 56 per cent of total funded statutory OOHC placements, with the remainder delivered by the NSW Government.[1]

In July 2016, the NSW Government's current OOHC service contracts expire. The contracts are funded on an activity basis, i.e. providers are paid for the number of nights a child is in care. This has allowed the Government to understand the costs of delivering OOHC services, and to monitor and control costs. However, it has also meant that the focus of the contracts and system management has been on activity, rather than children's outcomes. In this context, the Government is interested in moving from contracts focused on activity to outcomes focused contracts, which have more potential to support better life outcomes for vulnerable children and young people in care. Any future outcomes-based contracts would aim to put children at the heart of the contracting system, and support the Safe Home For Life goals of achieving permanent, safe, stable homes for children and young people.

[1] FACS *NSW OOHC Transition Summary FY14 - FY15 Transition Progress May 2015* viewed 9 July 2015 <http://www.community.nsw.gov.au/docswr/_assets/main/lib100045/jul13-may15_transition_dashboard_snapshot.pdf>

1.2.2 Moving to outcomes-based contracting

The NSW Government has already taken significant steps towards the development of an outcomes focused OOHC service system. The transition to non-government service provision, based on a consistent unit price, has laid the groundwork. In parallel, the NSW Government has initiated two outcome-based pilots of social impact bonds in the child protection system.

The OOHC system already focuses on child outcomes in other ways. The NSW Office of the Children's Guardian (OCG) provides quality assurance of OOHC providers against the *NSW Standards for Statutory Out-of-Home Care* (NSW Standards). The OCG assess providers against a range of criteria which are linked to high level objectives. For example, the objective of Standard 1 is that "The rights of children and young people are the primary focus for their care."[2] Finally, the NGOs who provide OOHC services implicitly have the interests of children at heart. Many of the providers we spoke to during the course of the project already have systems in place to measure individual child outcomes, or are developing or acquiring those systems.

However, while outcomes for children are the focus of providers and many of the people working within the system, the current contracts and the way they are currently administered do not allow scope to identify and reward providers who are doing an outstanding job. Further, since the contracts are focused on OOHC delivery, they do not incentivise performance, or provide dedicated funding streams associated with planning and implementing permanency pathways. This is in contrast to a number of case studies discussed in this summary, particularly Illinois, which has a performance oriented model.

Moving to outcomes-based contracting for OOHC will require changes to the service specification in the contracts, and investment in the measurement of a targeted number of OOHC system performance metrics. Further, it will require a shift to a funding model that puts the outcomes for children, rather than delivery of bed nights, at the centre of the system.

While outcomes-based contracting for human services is in its infancy worldwide, outcomes-based contracts have the potential to achieve strong results over the long term – using a mix of incentives and levers to drive performance outcomes and value for money. The shift to outcomes-based contracting includes risks, such as the risk of creating perverse incentives through inappropriate design. The international evidence suggests that the shift must be undertaken in stages, with close collaboration between service providers, government and carers, and careful consideration of the needs of children at every step.

1.3 A guide to the summary report

Chapter 2	Summarises the lessons from the research phase of the project.
Chapter 3	Describes the NSW OOHC system at a high level, and summarises issues identified through interviews and market soundings.
Chapter 4	Sets out a suggested long term vision for the sector, and potential approach to the next re-contracting round.
Appendix A	Summarises EY's 'Commissioning Lifecycle' which is used to frame chapter 2.

[2] NSW Office of the Children's Guardian *NSW Standards for Statutory Out-of-Home Care* 2013 page 2

2. Lessons from the international experience

2.1 Major findings from the research

In most sectors around the world, 'genuine' outcomes-based contracting is in its infancy, and in most cases has either only been trialled on a small scale (e.g. social impact investment pilots) or is a small component of the overall funding arrangements.[3] This is particularly the case in human services, which typically involves complex service systems, multiple funding streams and outcomes which are hard to define and measure. Nevertheless, many of the case studies demonstrated promising early results. Where pilots have not been successful, there are still important lessons, for example, about system design and measurement. Programs included in our research are shown in table 2.1 below.

Table 2.1 – Case studies included in the research

Program	Jurisdiction	When launched
Children's Centres	UK	2011
Department for Work and Pensions Innovation Fund – 10 Social Impact Bonds	UK	2011
Drug and Alcohol Recovery Pilots	UK	2011
London Homelessness Social Impact Bond	UK	2012
Newquay Pathfinder for Integrated Care	UK	2012
Transforming Rehabilitation Program	UK	2013
Whanau Ora (Healthy Families)	New Zealand	2014
Job Services Australia	Australia	1996
The Work Program	UK	2011
Workforce Investment Act	US	1998
UK health programs – composite case study	UK	Varied
US health systems – composite case study	US	Varied

The major lessons described in this chapter have been categorised against the four quadrants of EY's Strategic Commissioning Framework, summarised at Appendix A. The four quadrants are: client needs, defining and designing services, delivering services, and assessment.

2.1.1 Client outcomes

The commissioning of services should place the client or 'end-user' of the system at the heart of service design and delivery. There were three key learnings from the research in relation to outcomes for clients, which are set out below.

- Define the outcomes early and collaboratively: the most successful examples of outcomes-based contracting had a core focus on defining client outcomes at the start of the process, through deep consultation, or a 'co-design' process, with clients, providers and other stakeholders.
- Have an upfront investment in measurement – what gets measured gets done: the research demonstrates the importance of having a robust and analytically sophisticated approach to

[3] 'Genuine' outcomes based contracting could be defined as contracting models where the majority of service delivery payments are at risk, based on the achievement of final outcomes.

outcomes measurement, balanced with manageable reporting requirements. There needs to be an evidence base linking individual measures to the achievement of longer-term outcomes. Critical success factors for setting outcome measures included:

- Establishing appropriate measures
- Establishing the counterfactual
- Understanding the extent to which providers can influence the outcome
- Calibrating data collection and publication requirement
- Investment in independent assurance of data quality and performance
- Measuring and tending to overall market health/performance

- Demand analysis is critical: the research shows that careful and detailed analysis of client characteristics, volumes and current service experience are critical to ensure that the service system is designed around clients' needs and that providers are paid flexibly and according to need (i.e. level and type of service required). The latter is particularly important in outcomes-based payment systems, where a failure to compensate providers sufficiently for the costs of working with high need clients can lead to 'parking' (i.e. ignoring 'difficult' cases) and/or 'cream skimming' (i.e. focusing on achieving performance targets by focusing on 'easy' cases), and create financial stress for providers.

2.1.2 Design

Once client need and demand is well understood, the services, funding and commercial approach should be designed around those needs. The key lessons from the research in respect of designing services are described below.

- Clear, upfront design of roles and responsibilities are critical: large scale outcomes-based contracting programs have all entailed extensive system design to determine the purchaser/provider split and the respective roles and responsibilities of system managers, providers, regulators and clients. This is critical to ensure that the allocation of responsibility, accountability and risk is clear for all participants in the system. Without this, incentives in the system will not be aligned to promote value for money and outcomes for clients, the government is unable to transfer delivery responsibility, and providers are unlikely to accept financial risk for outcomes they are not able to influence.
- High quality programs put clients at the centre: successful programs put clients at the centre by integrating services tailored to individuals' needs, which enables a greater focus on prevention and early intervention. They may also feature flexible funding models – including pooled funding models across services, which have worked well for clients with complex needs, including individualised budgets which give people choice and control.
- Manage the pace of change carefully: developing services by adding new service requirements incrementally can allow more time for providers to respond, rather than attempting wholesale redesign in one step.
- Allow flexibility, but balanced by evidence and minimum standards: while allowing service flexibility, there is still a need to specify evidence-based interventions and minimum service standards. Most successful examples specified quality through minimum accreditation standards, with a complementary performance management regime expressed through contracts.
- Client referral processes need to support a focus on outcomes: the research shows that the way in which cases are referred to providers in human service systems is crucial to ensuring the market is fair and transparent. Options include: mandatory referrals; weighting outcomes and funding according to provider caseloads; and capping the caseload mix.

- Service continuity needs to be balanced against credible contestability: service continuity in commissioned human service systems can be a major challenge, due to the disproportionate importance of maintaining client/provider relationships for some services, whether that be a health visitor, carer, employment support worker or probation manager. While there will be times when it is in the best interests of the client for the relationship to be broken, the research suggests that the most effective contracts facilitate staff transfers to maintain carer/client relationships, whilst replacing management teams and organisational structures which are failing or under-performing.[4]
- Use a balance of financial and non-financial incentives: the research showed the most successful approaches have used a mixture of levers and incentives to drive performance outcomes and value for money, including: contractual volumes and revenue; contract length; reputation (e.g. awards, prizes); transparency and accountability; (e.g. league tables, publication of performance data, client feedback), licensing and regulation.
- The use of financial incentives needs to be carefully calibrated to the type of service, and the performance information available: key lessons from the research regarding the application of financial incentives include:
    - Baseline data and performance measurement are absolute pre-requisites for an effective outcomes-based contracting approach.
    - Payments can be applied to activity, outputs, intermediate outcomes and final outcomes. This is best determined by the maturity of the system and the provider market.
    - Payments can be blended in a contract across activities, outputs and intermediate outcomes. This particularly applies in new markets where providers need time to adjust to a new payment regime.
    - Genuine outcomes can be lengthy and hard to achieve with complex clients. To ensure an ongoing income to providers working with these groups, it may be necessary to (i) apply proxy measures; and (ii) allocate a lower proportion of the contract price to payment for outcomes related to complex behaviours.
    - Payments need to take the complexity of cases into account: both the base payment for activity and the performance payment. This can be done using measures which take account of individual's progress, typically known as 'distance travelled' measures.
    - Where human services markets are in their infancy, it may not be feasible to put funding at risk. In these cases, it may be better to incentivise outputs/outcomes through bonus payments.

2.1.3 Delivery

This activity refers to the engagement, development, procurement, transition, delivery and management of services and the organisations who provide them. There were five key lessons that emerged from the research, set out below.

- A tailored market approach is required: outcomes-based contracting needs to be undertaken with due consideration to the maturity of the market – both provider and commissioner capacity and capability.
- Consistent and clear signalling from government is essential: a clear message from government as it procures and manages service delivery is necessary to create long term confidence among providers, and develop a deep and shared understanding of the systemic changes required.

[4] Sturgess, G. *Contestability in Public Services: An Alternative to Outsourcing*. 2015

- Commissioners need to take a proactive approach to market shaping: commissioners should have a view on the characteristics of the provider market that are desirable to meet the demand, and develop strategies to develop these characteristics. Characteristics for consideration include the geographical spread of provision, the number of providers, the level of competition, and so forth. This includes taking a view of how the market should develop in both the short and longer term. In particular, new markets will require investment and capacity building.
- High quality services take an integrated approach: clients with complex needs have multiple touch points with government services and the best programs ensure that services are coordinated, enabling providers to work together co-operatively to achieve outcomes.
- Effort and attention needs to be paid to developing commissioning capability within government: this goes beyond contract management to managing the system, the market and relationships with providers. In early stages of market development, contract management activity should be a collaborative partnership. In addition the case studies show that implementing these approaches requires significant analytical capability and ring-fenced resources (both people and funding).

2.1.4 Assessment

Assessment involves evaluating outcomes achieved by services, including whether value for money is being achieved. The research showed that assessment and evaluation are critical components of successful outcomes-based contracting. In particular:

- Assessment and monitoring should include independent assurance and evaluation: most of the case studies included a component of independent assurance of data quality and independent evaluation of the outcomes. Where independent evaluations were not available, the success of the program was typically less transparent and the rationale for policy changes was less clear.
- Assessing the system as a whole is important: in addition to measuring the performance of individual providers and ensuring service quality through system regulation, commissioners need to pay significant attention to strategic market health.

2.1.5 Benefits of pilots

Finally, the research included a number of small scale service delivery pilots. Most jurisdictions have piloted new outcomes-based approaches before implementing service or system-wide reform. The benefits of pilots can include:

- Testing approaches: pilots can create opportunities for variation and testing of approaches and measurement; lessons can be applied to national programs.
- Building evidence of what works: pilots have driven significant development work which contributes to the evidence base by creating additional service provision where services hadn't existed in the past; and/or enabling the development of service integration.
- Establishing a baseline of performance: for new cohorts, pilots can demonstrate what is possible (albeit at a small scale).
- Creating new finance options: by operating at a small scale and calibrating risk, some pilots have created new vehicles for additional finance (e.g. social impact investment products).
- Stimulating innovation and new market entrants: innovation can best be stimulated through separate funds or pilots that create the 'freedom to fail', rather than introducing additional risk to the mainstream service.

2.2 Summary of findings from the OOHC research

In addition to research of national and international examples of broader human services commissioning, EY reviewed a number of OOHC services including: Illinois (US), Alberta (Canada), Victoria, and the ACT (Australia), the national UK system, social impact bonds from Essex (UK), Manchester (UK), and Social Benefit Bonds in New South Wales.

Across the OOHC case studies included in this project, a number of consistent themes emerged.

- There is a clear focus on placing children in safe, permanent, stable homes. In particular, the US State of Illinois had a clear focus on achieving permanency by reducing the number of children in care, and was successful in doing so.
- Contestability is increasing and there is increasing evidence that OOHC services are being delivered by, or being transitioned to, the non-government sector. An exception is the UK, where the majority of OOHC services are still provided by the Government.
- OOHC needs to be considered in terms of the wider child protection system. For example, Illinois had a strong focus on adoption and led to agencies providing both foster care and adoption services.
- The pace of reform must be carefully considered and collaboration between the commissioner and providers and carers must be a priority. Most systems have embarked on a 5 year (or longer) reform trajectory.
- Australian case studies demonstrate the importance of giving special consideration to Aboriginal providers given the over-representation of Aboriginal children in care, and the commensurate need for additional capacity.
- Strong communication between the commissioner and provider and carers is essential to ensure the market that develops is stable, appropriately funded, and working as expected. For example, Illinois had a joint provider/government working group.
- It is important to measure and publish results. As well as monitoring permanency, Illinois measured and published a number of child outcomes. These were eventually linked to a funding stream in some jurisdictions.

The approaches taken in each of the case study jurisdictions studied through the course of the report are summarised in table 2.1 below.

Table 2.2 - Out-of-home care approaches in case study jurisdictions

Jurisdiction	Objective/s	Approach	Results to date
Illinois	1. Primary: Reduce the number of children in care 2. Secondary: Improve service quality	1. Incentives for providers to exit children from care 2. Measurement of outcome-based performance indicators	Foster care caseloads fell from 51,000 in 1997 to 15,000 in 2013, and permanency rates increased, bonus payments however ceased in 2010
Alberta	1. Quality improvement 2. Client centred outcomes 3. Joint accountability	Shift funding from multiple service based contracts to single, outcome-based contracts	More children are staying at home rather than entering OOHC, more children are placed with family members, and children are staying in care for shorter durations

Jurisdiction	Objective/s	Approach	Results to date
Essex	Diversion from path of OOHC	Use outcome/performance based contracting, in the form of an SIB, to fund tried and tested and innovative programs (MST, MTFC-A, Resilient Families, Newpin)	79 per cent of participants are still living at home[5]
Manchester	De-escalation of children/young people in residential care		Recently implemented
Benevolent Society SBB (NSW)	Diversion from path of OOHC		On track to meet the year one operational targets for requesting and referring families
Newpin SBB (NSW)	1. Restoration of children and young people in OOHC 2. Prevention for those at risk of entering care		During the first year a 60 per cent restoration rate was achieved
ACT	1. Child centric therapeutic care model 2. Improve outcomes for children and young people 3. Residential care will be relatively small, with a focus on supporting children and young people in family environments 4. Reduce the number of children in OOHC and improve early intervention and prevention techniques	1. Complete overhaul of existing OOHC service model 2. Outcomes-based contracting and a lead contractor 3. Service provision across a continuum of care 4. Incentivise providers through performance measurement in terms of permanency and inflow	The model is still in the development stage and has not been fully implemented in the ACT
Victoria	1. Client centred approach 2. Improve outcomes for children and young people in care 3. Reduce demand for OOHC services and increase permanency 4. Focus on Aboriginal communities	Use outcome-based contracting to incentivise individual needs assessment and improvements in outcomes	Reform has not yet been implemented

[5] Action for children website, accessed on 26/06/2015 <https://www.actionforchildren.org.uk/what-we-do/services-for-professionals/evidence-based-programmes/>

3. The NSW OOHC system

3.1 Overview of the OOHC system

Table 4.1 below provides a summary of the different types of OOHC currently provided in NSW.

Table 4.1 Types of OOHC

Type of care	Description	Children and young people profile
General foster care	Statutory[(a)] or supported care provided by authorised carers in the carer's own home or in a home owned or rented by an agency. This includes relative and kinship care provided by an extended family member or persons of significance to the child or young person	Low to moderate support needs
Intensive foster care	Statutory or supported care providing for a coordinated plan of casework and therapeutic intervention within a community based environment	High support needs and complex groups of children (including siblings)
Residential care	Care provided in a property owned or rented by an agency, staffed by direct care workers and with access to multidisciplinary specialist services	Challenging behaviours and medium to high support needs
Intensive residential care	Time-limited care (6–12 months) provided in a stand-alone facility	High needs and require intensive therapeutic support
Supported independent living	Accommodation and access to support services for up to 2 years	16 to 18 years old with low to moderate support needs and in transition to independent living from OOHC
Supported family group home	Medium to long-term care. The client groups live in regular houses in the community in a family-like environment and are cared for by carers living in the home seven days a week	Groups (e.g. large sibling groups) of 0 to 17 years old with low to moderate support needs but cannot be placed in kinship or foster care

Source: FACS (2014), *Out-of-home Care Contracted Care Program Guidelines*
(a) A care order is in place allocating parental responsibility for a child or young person to the Minister for Community Services. Supported OOHC is care arranged, provided or otherwise supported by FACS following the determination that a child or young person is in need of care and protection. It includes temporary care arrangements.[6]

In 2013 in NSW, of the whole OOHC population, 53 per cent of placements were relative/kinship care, 39 per cent in foster care and 3 per cent in residential care.[7] For NGOs to provide OOHC

[6] FACS (2014), *Out-of-home Care Contracted Care Program Guidelines*
[7] M. Paxman, L. Tully, S. Burke, J. Watson (2014), *Evidence to inform OOHC policy and practice in NSW: an overview of the pathways of care longitudinal study*

services, they need to satisfy the NSW Standards for Statutory OOHC. Standards were introduced in 1998 and have been updated in 2010 and 2013 to reflect changes in policy priorities and laws. Today, there are 4 sections within the OOHC standards relating to the wellbeing of children and young people, casework practice, support and development of carers and placements and management of staff, and organisational systems and processes. These are used by the NSW Office of the Children's Guardian, which accredits and quality assures OOHC providers.[8]

3.2 Recent reforms

The NSW Government is implementing reforms in the delivery of services to children, young people and families in need that have implications for OOHC. Reforms are aligned with the goals set out in the NSW State Plan*: NSW 2021*, including:

- "Increasing the proportion of NSW children who are developmentally on track in Australian Early Development Index domains: (i) physical health and wellbeing, (ii) social competence, (iii) emotional maturity, (iv) language and cognitive skills (school-based), and (v) communication and general knowledge
- Reducing the rate of children and young people reported at risk of significant harm by 1.5 per cent per year
- Reducing the rate of children and young people in statutory out-of-home-care by 1.5 per cent per year"[9]

3.2.1 Transition to the NGO sector

The transition of statutory OOHC services to the NGO sector in NSW is ongoing, with full transition to be completed within a stated target timeframe of 5-10 years. The transition was precipitated by the findings of the Special Commission of Inquiry into Child Protection Services in 2008,[10] and by the Out of Home Care Review in 2009.[11] The transition to the NGO sector underpins a number of other reforms, in particular the ongoing Safe Home for Life reforms (SHFL).

3.2.2 Safe home for life (SHFL)

SHFL is a key, 4 year child protection reform that builds on the 2009 reform program 'Keep Them Safe.' This reform aims to provide a permanent and stable home for life for every child in NSW through a range of initiatives including legislative change, new policy and practice, and a redesign of how technology is used in child protection. Legislative change included the incorporation of the Permanent Placement Principles in the *Children and Young Persons (Care and Protection) Act 1998.*

3.2.3 The Permanent Placement Principles

The Permanent Placement Principles set out a clear hierarchy of preferred placements of a child that is in their best interest:

- The first preference is for the child to be restored to the care of his or her parent or parents
- The second preference is guardianship of a relative, kin or other suitable person
- The next preference is (except in the case of an Aboriginal or Torres Strait Islander child or young person) for the child or young person to be adopted

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[8] NSW Government, Office of the Children's Guardian (2013), *NSW Standards for Statutory Out-of-Home Care*

[9] NSW Government, *NSW 2021: A Plan to make NSW Number One*, 2011

[10] The Hon James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* 2008

[11] Boston Consulting Group, *NSW Government Out of Home Care Review: Comparative and Historical Analysis* 2009

- The last preference is for the child or young person to be placed under the parental responsibility of the Minister
- In the case of Aboriginal and Torres Strait Islander children, adoption is the last preference.[12]

That is, under the law, statutory OOHC is now presented as the least preferable solution. This is consistent with promoting stability and attachment for children, leading to better outcomes, which would involve reducing the numbers of children in OOHC. This is a goal shared in a number of case studies including Illinois, the ACT, Alberta, and others. It reflects the importance of providing children with a stable and permanent home.[13]

3.3 Key issues identified in NSW OOHC

3.3.1 Number of children and length of time in care

The number of children in care has risen every year over the last 10 years in all Australian States and Territories, and the rate has generally trended upwards. The number of children in NSW OOHC has risen every year over the past 10 years, as both the 0-17 year old population, and the rate of children in OOHC per 1000 0-17 population have increased. As at 2013, over 40 per cent of children in NSW OOHC had been in care for more than five years.[14] By comparison, 8 per cent of children in foster care in the United States have been in care for more than five years (2013 data).[15]

3.4 Residential care

While the proportion of children in OOHC who are placed in residential care is lower in NSW than in other Australian states and territories (2.8 per cent in NSW as opposed to an average of 7.1 per cent for all other states and territories), NSW has the third largest absolute residential care population, behind QLD and Victoria.[16] FACS data shows that up to a quarter of residential care cases could more appropriately be in intensive foster care.

The unit price is considerably higher for this type of care in NSW. While residential care accounts for around 3 per cent of the total number of children in OOHC, in 2013-14 it accounted for over a third of the funding to NGOs. Unit prices for standard residential care are higher in NSW ($193,560) than in QLD ($146,560) and Victoria ($179,600). A similar gap exists for intensive residential care.[17]

3.5 Aboriginal children in care

There is a significant over representation of Aboriginal children in the child protection and OOHC service system. As of June 2014, Aboriginal and Torres Strait Islander children made up over 35 per cent of all children in care in NSW.[18] Nationally, the rate of children in care and protection orders per 1000 children in the target population aged 0–17 years was 53.2 for Aboriginal and Torres Strait Islander children and 6.0 for non-Indigenous children.[19]

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[12] NSW Government, *Child Protection Legislation Amendment Bill* 2013

[13] NSW Parliamentary Research Service (2013), *Permanency planning and adoption of children in out-of-home care Briefing Paper No 03/2013*

[14] FACS *Community Services Annual Statistical Report 2012/13* 2013

[15] U.S. Department of Health and Human Services *The AFCARS Report No. 21* 2014

[16] Australian Government, Australian Institute of Family Studies website, viewed on 28 May 2015 <https://aifs.gov.au/cfca/publications/children-care>

[17] NSW Government, FACS (2015), *Strategic Commissioning of OOHC Placements: Unit Cost Structure*

[18] FACS, *Response to the Royal Commission into Institutional Responses to Child Sexual Abuse* 2015

[19] Productivity Commission, *Report on Government Services: Child Protection Services* 2015 page 15.12

3.5.1 Children leaving care

In 2014/15 nearly 500 young people left statutory OOHC when they turned 18. A 2009 Create Foundation survey of 471 young people, 58.6 per cent of whom were still in care (15 to 18 year olds), and 41.6 per cent of whom had left care (maximum age 25 years) found that:

- 35 per cent were homeless in the first year of leaving care
- 46 per cent of young men and 22 per cent of young women had been involved in the juvenile justice system
- 29 per cent of care leavers aged between 18 and 25 were unemployed (compared to the national average of 9.75 per cent).[20]

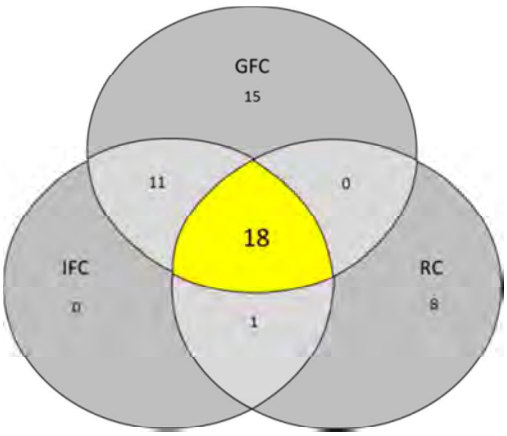
3.5.2 Current OOHC contracts and performance management

The current OOHC system could be described as an activity based funding system. NGOs must meet 95 per cent (or greater) of their funded placement targets, otherwise their funding is reduced. Provider performance against non-financial measures is not currently measured through contracts, and on that basis performance data is not available to support performance management. Quality is assured through the OCG accreditation process.

3.6 Provider Market Characteristics

The characteristics of the provider market were explored using FY13/14 and FY14/15 financial data supplied by FACS. There were limitations to both the scope and depth of the key market characteristics analysis due to data and timing constraints. There are 53 current providers of statutory OOHC services who provide foster care, residential care or both in NSW, with one additional provider exclusively offering single independent living services and family group home services. Figure 3.1 shows the number of providers across each major care type: general foster care (GFC), intensive foster care (IFC) and residential care (RC). It demonstrates that the majority of providers offer all three service types, although there are almost as many providers who provide only general foster care.

Figure 3.1: Number of providers, by care type provided



Source: FACS financial data, March 2015 actuals

Of the 53 organisations providing statutory OOHC services in March 2015, 14 are Aboriginal service providers, defined as providers whose main objective is to provide services to the Aboriginal

[20] McDowall, J. *Create Report Card 2009 Transitioning from Care: Tracking Progress* 2009

community, and who comprise of mainly Aboriginal carers, staff and governance. Out of the 6,993 children in care (across both foster and residential care), 1,146 are cared for by Aboriginal providers. The available data did not provide a breakdown of placements by Aboriginal and non-Aboriginal status of the children in care, by provider. Table 3.1 shows the number of places provided by care type based on actual placements for March 2015, demonstrating that the bulk of the system is made up of general foster care.

Table 3.1: Number of places provided by NGOs, by care type

Placement type	GFC	GFC2	IFC	IFC1	IFC 2	RC	IRC	SIL	Family Group Homes	Total
Number of children	5073	744	709	32	10	191	234	47	38	7078
Share (per cent)	71.7	10.5	10.0	0.5	0.1	2.7	3.3	0.7	0.5	100

Source: FACS Financial Data, March 2015 actuals
Note: IFC 1 and 2 reflect more intensive levels of intensive foster care support. IRC refers to intensive residential care. SIL refers to "Supported Independent Living": transitional support provided to adults who are transitioning out of OOHC.

3.7 Market sounding – key themes

This section provides an overview of the market soundings undertaken through this project. Market sounding meetings were conducted over three weeks with nine current OOHC providers. Providers were selected by FACS to provide a representative sample of foster and residential care, metropolitan, and regional care, small, medium, and large providers, and Aboriginal and non-Aboriginal providers. The peak bodies AbSec and ACWA were also consulted. There were a number of consistent themes to emerge from the market soundings that affect the possible approach to the introduction of outcomes-based contracting to OOHC services, including:

- Participants all expressed strong support for measuring outcomes for children and young people, and many already had case management systems (or were implementing one) which facilitated measurement of outcomes at the individual child level (e.g. actions and impact of case plan activity).
- All participants acknowledged the importance of moving children into safe, permanent homes in the long term, and are already seeking to achieve that through their care approach. Providers noted that the current funding model does not necessarily recognise or incentivise this objective (but this does not mean they are not already pursuing it).
- In respect of payment for outcomes, most providers expressed concern that retrospective (i.e. deferred) payment for outcomes would be challenging. However, a number of providers noted that they had already experienced deferred payments due to delays in receiving payment from FACS for services already delivered. It was also noted that the risks generated would be greater for smaller organisations.
- Some participants noted that elements of 'payment for outcomes' are already in operation in adoption payments and in the trial of restoration support payments. It was felt that the latter had not had a significant impact on incentivising changes in practice. A number of potential reasons were cited, including the fact that the payment only covered the costs of the service, and did not factor in the upfront investment required in developing restoration services.
- Some participants expressed concern regarding the potential perverse incentives of "payment for exits," such as encouraging pathways that were not in the best interests of children. On the other hand, most participants acknowledged that the way the funding model currently works (payment for placement nights) may also create a perverse incentive against pathways out of OOHC.

- Most participants are either already offering services across the continuum of care, or are considering how to expand and fund these service offerings, such as family restoration and support for leaving care.
- All participants acknowledged the urgent need to develop additional capacity to meet the current demand for care for Aboriginal children. However, there was also a view that the system should not be set up to cater for the current over-representation. Instead, the aim should be to reduce the numbers of Aboriginal children in care.
- Aboriginal providers subsequently advised that greater certainty about the numbers of Aboriginal children to be transitioned to their sector would allow them to build that capacity.

4. The suggested vision for the OOHC system

4.1 Introduction

Based on the objectives of the SHFL reforms, and the NSW Government's policies and priorities for OOHC, a long term vision was suggested as part of this project to clearly define what is to be achieved through outcomes-based contracting, which will allow the design and delivery of the contracts to support the achievement of the suggested vision. Therefore, it necessarily captures many things that providers already do, but that may or may not be supported by the current contracting model.

In consultation with key stakeholders, this suggested vision could underpin the significant work to be done to transition to outcomes-based contracting for OOHC.

4.2 A suggested long term vision for NSW OOHC

The suggested vision set out below articulates how the performance, funding and contract management of OOHC services can be positioned to achieve the existing policy priorities of the NSW Government for the child protection system.

The suggested vision for the system is that:

- The design and delivery of OOHC services supports the achievement of the standards set out in the NSW Standards for Statutory Out-of-Home Care, including:
  - The wellbeing and rights of children are the primary focus for their care
  - Children receive safe, appropriate care relevant to their circumstance
  - Children have access to information and experiences which assist them to develop a positive sense of identity
  - Children remain connected to the significant people and places in their lives
  - Children contribute to decisions relating to their lives.
- More children are transitioned from OOHC into safe, permanent homes, the average length of stay in OOHC is reduced, and the rate of children entering care is reduced.
- The number of children in residential and intensive residential care is reduced through interventions which 'de-escalate' the child's need.
- There is a reduction in the over-representation of Aboriginal children in OOHC.
- Flexible funding follows the child according to their evolving needs.
- Performance and outcomes are measured and incentivised through a mix of financial and non-financial approaches.
- Relative performance of providers (including FACS) is measured and reported on (in addition to mandatory minimum absolute performance benchmarks monitored by the OCG).
- 100 per cent of statutory OOHC cases are managed by NGOs.
- FACS is an experienced, collaborative, responsive and commercially aware commissioner of OOHC services.
- Regulation of the sector remains in the hands of the OCG, but is supported by a funding and procurement model that incentivises strong performance.
- Services are provided by viable, high quality providers, selected competitively, on merit.
- Service delivery models support delivery of culturally appropriate care.
- Aboriginal children are provided with cultural supports that enable them to maintain and

develop their sense of cultural identity.

- Independent accreditation and transparent monitoring of standards by the OCG continues to ensure quality benchmarks are met.
- Performance management and evaluation under the contracts supports the accreditation and monitoring undertaken by the OCG and the quality assurance and evaluation to be undertaken through the Quality Assurance Framework (QAF) to be introduced by FACS.

It is important to note that the suggested vision cannot be achieved by the OOHC system alone. For example, achieving an increase in the number of children transitioning to safe, permanent homes will be impacted by a range of factors from within the child protection system (i.e. the implementation of Permanent Planning Principles in casework and court decisions). On the other hand, the goals of the SHFL reforms are unlikely to be achieved if the vision is not embedded in the management of the OOHC system.

4.2.1 Issues informing the approach to contracting

Table 4.1 below summarises the key issues described earlier and the implications for the approach to recontracting.

Table 4.1: Issues informing the commissioning approach

Issues	Implication/s for the approach to commissioning and re-contracting
In line with national trends, the number of children in care has been increasing, and many children have been in care for a long time.	Focus on delivering safe homes for life, including by sustainably increasing exits from OOHC and reducing time in care, including through new performance measures and provider incentives
NSW Government policy is to transition management of statutory OOHC to NGOs.	Plan for and continue to transition FACS cases as funding and capacity becomes available, particularly within Aboriginal care
Contracts do not currently support performance management	Implement performance management through a small number of new, tightly focused performance measures in contracts
	Benchmark performance of both FACS and NGOs
	Move to a competitive allocation of places, with regular market testing and contract flexibility
While NSW has a lower proportion of children in residential care compared to other states and territories, providers report an increasing number of younger children in care, and FACS data shows that up to a quarter of cases could, more appropriately be in intensive foster care	Sustainably reduce the number of children in residential care, including through a review of intensive foster care services
	Incentivise the de-escalation of services for children in residential care through high quality supports and a path to exit

Issues	Implication/s for the approach to commissioning and re-contracting
The large number of Aboriginal children still to be transitioned creates the need for capacity building within the Aboriginal sector	Intensive research and design phase ahead of investment in further capacity building in the Aboriginal sector
Opportunity for much greater integration between OOHC and the rest of the system including preservation and restoration. The current funding model presents incentives for keeping children in care	Strategic commissioning, service and funding model reform to support procurement of services across the continuum of care
There are a range of differences between foster, residential and Aboriginal care services. While there are a number of common issues, there are also some issues unique to each service that require a tailored approach.	The approach recognises the differences between foster and residential care and takes a tailored approach to Aboriginal care

4.3 Achieving the suggested vision

Achieving the suggested vision will require a strategic commissioning approach to be taken to integrate the child protection system across the continuum of care, including: assessment of need, early intervention and preservation services, OOHC, OOHC exit pathways to permanency, and post OOHC services.

There are three key changes which need to be made to the next round of contracts (and beyond) to support achievement of the vision. These are:

- The service specification and supporting funding model within the contracts should be revised to support the achievement of the objectives described in the longer term vision, including the objectives of the SHFL reforms.
- A limited number of targeted performance measures should be introduced into the contracts over time, tied to long term outcomes for children.
- As performance is measured and benchmarked, a partial payment for performance regime should be incorporated into the contracts.

These changes will need to be introduced over time, in close consultation with the sector. Due to the distinctive nature of the services and provider market associated with foster care, residential care and Aboriginal care - including provider capacity to absorb and implement changes to the contracting model - the recommended contracting approaches vary for each service. However, consistent across all contracts are the following suggested changes:

- Between now and early 2017, significant work is required to understand the historical performance of providers, and to design and consult on new performance measures to be included in the next round of contracts. A clear understanding of historic performance could underpin a competitive allocation process in early 2017.
- The next round of contracts should include a limited number of targeted performance measures which support the continued development of a system wide focus on child outcomes. These measures should draw on a range of relevant frameworks, particularly FACS current Quality Assurance Framework project.
- All contracts should include revision of the service system specification, supported by a review and analysis of the unit cost of all services within the "continuum of care". For example, restoration and adoption services, as well as the residential cost base. This work should inform consideration of changes to the OOHC unit prices, as well as changes to the funding model to provide greater funding flexibility based on children's needs.
- The contracts should include flexibility to introduce financial performance incentives in year 2 of the contracts (after a period of performance measurement and benchmarking).

To take account of the distinctive nature of the services and provider markets in foster, residential and Aboriginal care, the following differential approaches should be taken with respect to the contestability of the next re-contracting round:

- The process for foster care involves a 'merit based allocation' that would assess the historical performance of providers. It would set a high bar for the movement of children in care between providers, and invite the participation of new entrants where there are identified service gaps, but would stop short of a fully open, competitive retender. Foster care has recently been through a full scale retender in 2012. The next round of contracts should be used to focus on measuring and paying for performance.
- Residential services should be subject to a fully open retender. Unlike foster care, residential care has not been subject to a full retender in recent years.
- Given the number of Aboriginal children still to be transferred (and consequent need to build more capacity within Aboriginal services), additional capacity building, further market analysis and market development will be required, before a more competitive contracting model is introduced. Nevertheless, the goal should be to introduce the same changes in the contracts with respect to service models, funding and performance measures for Aboriginal foster and residential care providers as with the mainstream to avoid the creation of a two-tiered service.

4.4 Critical success factors for implementation

Finally, the research and precedents from outcomes-based contracting, both in other countries and Australian jurisdictions, point to the following factors as being critical to successful implementation of outcomes-based contracting for OOHC:

- Program management – strong support from and access to Ministers and senior officials for timely decision making and focus on achieving the implementation plan goals.
- Transparency and clear direction – communicating a clear roadmap for reform and the key milestones and changes to be implemented over time is essential to enable providers to both prepare for and respond to Government objectives.
- Co-design – reforms, particularly the design of services, funding models, outcomes measures and incentives, will ideally be designed and developed collaboratively with children, their carers and providers to ensure they are well understood, deliverable and informed by best practice and innovation. Deep and considered engagement with providers through this process is a key aspect of developing a sustainable provider market.
- Pace and flexibility – the introduction of outcomes-based performance and payment regimes needs to be phased to take account of the rate at which providers can bear performance and financial risk. Moving to outcomes-based payments too quickly risks major service and provider failures. Similarly, the contracts need to be sufficiently flexible to allow for the introduction of new reforms without requiring extensive negotiation or unexpected major changes to operating practice.
- Analytics – all the evidence from outcomes-based contracting programs and pilots considered in this project points to the need for a significant investment in an analytical function to determine contract volumes, market capacity, funding models and budgetary impacts, performance indicators, prices and payment regimes.
- Commissioning function – a strong, commercially astute and sufficiently resourced commissioning function is essential to ensure the strategic development of services over the longer term and the design and refinement of new contracts. This function needs to have a mix of strategic, policy, operational, commercial, analytical, program and stakeholder management capabilities, as well as experience in procurement and contract management.
- Change management and transition planning – as much attention needs to be paid to internal operational design, change management and transition planning as to the provider market, particularly where Government functions are an integral part of the service delivery chain.

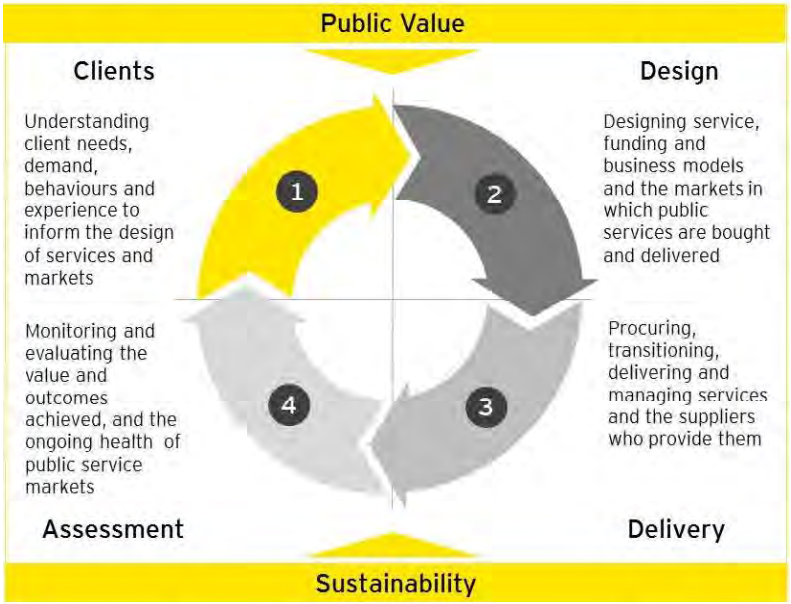
Appendix A: Taking an outcomes focus

Outcomes-based contracting is just one tool in the broad approach to strategic commissioning of health and human services, and must therefore be deployed in the context of a broad, strategic approach to system and service development.

EY's Strategic Commissioning Framework sets out at a high level the key components required in developing public sector markets. The lifecycle, as a guide to commissioning services, is divided into four quadrants. These are shown in the figure below.

- Client needs: the commissioning of services should place the client or 'end-user' of the system at the heart of service design and delivery. This requires the commissioner to understand the needs of its clients, the demand for services, and the way overall demand and individual clients will be likely to respond to service provision.
- Defining and designing services: once client need and demand is well understood, the services, funding and commercial approach should be designed around those needs. This includes designing a plan for interacting with markets, and shaping them where appropriate. Service design should consider the respective desired roles of government and providers in current and future delivery. Evaluation, data collection and reporting functions need to be designed at this stage to support future delivery and assessment.
- Delivering services: this activity refers to the engagement, development, procurement, transition, delivery and management of services and the organisations who provide them.
- Assessment: evaluating outcomes achieved by services, including whether value for money is being achieved, is essential to ensure public services are meeting client's needs. Ongoing assessment and evaluation (independent where possible) should inform both future policies and ongoing management of existing services. Ongoing assessment allows for active market management where required – e.g. ensuring providers are financially viable.

Figure - The commissioning lifecycle



'Outcomes-based contracting' is an approach to procuring and delivering services, typically from non-government providers. It is often also referred to as 'payment by results' (UK), performance based acquisition (US), payment for success (US) or performance based contracting.

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