NSW statutory out-of-home care: Quality Assurance Framework

Section 2: Narrative review

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Prepared by:

Dr Robyn Mildon
Director, Parenting Research Centre

Prof Aron Shlonsky
Professor of Evidence-Informed Practice
Department of Social Work, School of Health Sciences
University of Melbourne

Dr Arno Parolini
Research Specialist, Parenting Research Centre

Annette Michaux
Director, Parenting Research Centre

Disclaimer

The NSW statutory out-of-home care: Quality Assurance Framework report was commissioned by the New South Wales Department of Family and Community Services (FACS).

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CONTENTS

1.   Background

The New South Wales Department of Family and Community Services (FACS) commissioned the Parenting Research Centre (PRC), in partnership with the University of Melbourne, to develop a robust Quality Assurance Framework (QAF) and implementation plan for out-of-home care (OOHC) in NSW. The framework development comes as NSW changes the provision of OOHC from a government-funded – and mainly government-run – service to a government-funded, NGO-run service.

This framework is being developed in the context of a broader monitoring and major reform environment in NSW, which includes the NSW Office of the Children's Guardian's (OCG) development of OOHC accreditation standards (these were in operation since 2003, revised in 2010 and under review at the time of writing); the Australian Government's release of national out-of-home care standards in 2011; the transfer of OOHC to the non-government sector; and, Safe Home for Life reforms, designed to strengthen the child protection system through legislative change, new policy and practice, and a redesign of how technology is used in child protection.

In this context, a QAF for OOHC incorporating new *Standards* is the next step in improving outcomes for children placed in OOHC.

This stage of QAF development involves finding and synthesising information from existing national and international QAFs, or similar approaches for improving OOHC services. This narrative review:

- discusses and defines the concepts of quality assurance (QA), continuous quality improvement (CQI), and outcomes

- synthesises findings from existing frameworks

- makes recommendations for framework development.

2.   Introduction

The main purpose of this review is to describe approaches that agencies, governments and other organisations have developed in their efforts to define, monitor and improve the quality of care provided to children who have been formally placed in OOHC. To that end, the review describes existing frameworks, articulates their common features, and provides suggestions for building a NSW QAF for OOHC. The report builds upon a previous literature review commissioned by the NSW Office of the Children's Guardian (OCG) and conducted by the Social Policy Research Centre, University of New South Wales (Broady et al., 2011).

3.   Terminology and definitions

3.1   Standards

Standards Australia defines 'standards' as:

Published documents setting out specifications and procedures designed to ensure products, services and systems are safe, reliable and consistently perform the way they were intended to. They establish a common language which defines quality and safety criteria (Standards Australia, 2014).

As noted in the OCG literature review (Broady et al., 2011), standards for OOHC have been produced by individual state governments and organisations for implementation within their respective jurisdictions. The authors conclude that, in general, each state's standards reflect the Baseline Out-of-Home Care Standards (Standing Committee of Community Services and Income Security Administrators, 1995), and also demonstrate some degree of alignment with proposed (now endorsed Australian) national standards (KPMG, 2010).

In 1998, NSW was the first Australian jurisdiction to introduce standards in OOHC, originally voluntary, developed by the then Department of Community Services. In 2003 the OCG, in consultation with the OOHC sector, introduced a set of standards as part of a mandatory OOHC accreditation scheme for statutory care (OCG, undated). According to the OCG (2009, p. 50), 'formal accreditation powers were proclaimed in July 2003 alongside Regulations detailing the new accreditation system'. The NSW OOHC standards for statutory OOHC comprise 22 standards which have been regularly reviewed, including at the time of writing. The Standards establish minimum requirements as designated agencies providing OOHC services to gain accreditation and thus provide OOHC in NSW.

3.2   Accreditation

In NSW, all agencies need to be accredited or be participating in the OCG Quality Improvement Program in order to provide OOHC. Accredited agencies must comply with the conditions of accreditation as a designated agency.

The OCG has a Quality Improvement Program which differs from the way the concept of quality improvement is used in this paper. The OCG's Quality Improvement Program is a specific improvement process entered into by agencies that are not yet meeting accreditation requirements.

According to the OCG's Accreditation Guidelines (OCG, 2014a), the accreditation process in NSW involves the following steps:

Step 1: Applying for accreditation. The agency contacts the OCG and discusses its proposed application for accreditation. The agency then submits an application form and other documents required for accreditation.

Step 2: Submitting indirect evidence, assessment and feedback. The agency submits indirect evidence to the OCG, who assesses these and provides feedback. The agency can choose to use an OCG self-assessment tool (OCG, 2014c) to help with accreditation. The OCG's Evidence Index (OCG, 2014b) lists each standard and the assessment criteria against which the agency will be required to provide evidence. Feedback is provided to the agency on any areas needing more work and the OCG analyses the information provided by the agency to determine accreditation. Indirect evidence includes various documents, including policies and procedures; templates related to policies and procedures; service agreements; and organisational publications such as strategic plans, annual reports, and induction and training manuals.

Step 3: Provisional accreditation and direct evidence program. If the agency is provisionally accredited after meeting the requirements of Step 2, it will enter into a direct evidence program (OCG, 2014a). Provisional accreditation allows the agency to offer OOHC, although for full accreditation it must demonstrate that it is meeting the standards in practice (direct evidence program). This stage involves OCG assessing the agency on-site, which includes assessing the evidence submitted. Written feedback is given to the agency after each visit until the program of assessment is complete and the agency has shown that it complies with the standards. Direct evidence is defined by the OCG as 'information that shows how an agency meets the Standards through its practice' (OCG, 2014a, p. 8). Examples include discussions with staff, case and carer records, and staff and human resources records. Also included are agency documents such as audit reports, management information systems, intake and assessment reports, life story work, case plans, contact arrangements, meeting minutes from staff, board and executive meetings. Site observations are also part of the evidence assessment and include site inspections.

Step 4: End of three-year provisional accreditation. If the agency has been delivering OOHC services and has provided satisfactory direct evidence to the OCG, the agency is eligible for full accreditation. This involves applying for accreditation renewal. If the agency has not been delivering OOHC services, its accreditation will lapse and it will need to reapply as a new applicant.

Accreditation in NSW lasts three or five years and various conditions apply to determine whether full or provisional accreditation is granted.

In assessing the evidence presented, the OCG applies the following four rules of evidence to each standard, to determine whether the agency meets the requirements:

1. validity
2. sufficiency
3. currency
4. authenticity.

3.3   Out-of-home care

In NSW there are three types of OOHC: statutory, supported and voluntary. In this paper we focus on statutory OOHC. Statutory OOHC is defined in the *Children and Young Persons' (Care and Protection) Act 1998* as care of a child under an order made by the Children's Court, Supreme Court or under the parental responsibility of the Minister or Director General (Section 135A). The two types of statutory OOHC are foster care, where the child or young person is placed for more than 14 days with an authorised foster carer; and relative/kinship care, where the child or young person is placed for more than 14 days with an authorised family or kin member.

3.4   Quality assurance

The concept of quality assurance (QA) originated in the business sector and has subsequently been applied to social and health care services. It involves measuring the extent to which clients receive a specific service, or sets of services, according to an agreed plan. In child protection,

there has been a movement to apply QA principles across the spectrum of services, including OOHC. The Ontario Association of Children's

Aid Societies defines QA as:

> *…a formal set of activities that reviews and affects the quality of services provided. These activities provide both internal and external parties the confidence that the organisation will consistently meet the requirements for quality* (OACAS, 2004, p. 5).

The definition of quality for providing care and services has been expanded beyond meeting specifications or standards, to include meeting important, socially valid outcomes for the population being served. This has been acknowledged in previous reviews (Broady et al., 2011; The Casey Outcomes and Decision Making Project, 1998; Métis Commission for Children and Families BC, 2011) and in the child welfare literature since the early 1990s (see, for example, Courtney, M., 1993). In line with this, there is an increasing emphasis on outcome-based QA systems that align with the main aims of contemporary child welfare systems: child safety, permanence and wellbeing (see below for detailed definitions of these). This concept of quality is important to child welfare services. Simply adhering to standards of care is only the first step along the pathway to quality and represents, at best, the minimum level of quality in OOHC.

According to the OCG's 2014 Annual Report (OCG, 2014d) the standards were strengthened in 2010 to place greater emphasis on quality improvement. Standard 22 provides an important minimum requirement for agencies to have planning and CQI processes in place, but the OCG does not give detailed guidance on the types of CQI processes that might help agencies improve their outcomes. The OCG reported in its 2011 Annual Report (OCG, 2011) that it was developing mechanisms to better reward and recognise agencies undertaking CQI processes. It was to further report on this in the 2014 Annual Report, but we could find no such information in that document. Reward and recognition are referred to in the introduction to the OCG's Review Discussion Paper (OCG, 2014e). This document refers to an OCG recognition and reward system for CQI that was under development at the time of writing. This system would become available to accredited agencies and was described as a way of "embracing best practice and promoting innovation" (OCG, 2014e).

3.5 Quality assurance frameworks

There is much variability in definitions, terminology and characteristics of frameworks (for example, the ways in which a conceptual model might differ from a theoretical framework, or how a framework differs from a process). The best definition we found came from The Child Welfare Policy and Practice Group (n.d.) as cited in the Métis Commission for Children and Families BC review (Métis Commission, 2011). It defines a framework as:

> *A structure to hold together or support something; an underlying set of ideas; a set of ideas, principles, or rules that provides the basis or outline for something to be more fully developed at a later stage* (Métis Commission, 2011, p. 2).

Using this definition, "a framework defines the 'what' of the practice or approach and allows for the 'how' to be developed at the discretion of the agency based on its diverse and unique needs" (Métis Commission, 2011, p. 9).

Important to the current project is the distinction between standards and a quality assurance framework. Standards provide some of the essential elements upon which quality is built, but they do not provide a framework aimed at continuous optimisation of child functioning across a range of outcomes beyond a minimum threshold. Standards are essential for ensuring that the conditions under which services are provided meet at least a minimal level of care, delivering some of the basic building blocks necessary for achieving better outcomes for individual children and young people. In other words, they are necessary but insufficient components of quality and, in and of themselves, cannot be counted on to measurably improve outcomes for children in OOHC. A framework that incorporates standards as well as outcomes is a roadmap towards achieving those outcomes, but the method of moving towards those outcomes is to be developed by each of the agencies, allowing for a diversity of approaches in the service of the same ideals.

3.6   Continuous quality improvement

The term continuous quality improvement (CQI) refers to a 'philosophy of continual improvement of the processes associated with providing a good or service that meets or exceeds customer expectations' by applying methods to understand and improve the underlying work processes and systems, with a focus on adding value (Shortell et al., 1998, p. 594). CQI goes beyond mere compliance with standards; it involves ongoing learning and improvement of services.

Applying a CQI strategy allows organisations to be proactive rather than reactive by employing a continuous feedback loop for evaluating processes and outcomes. It is the complete process of identifying, describing and analysing both strengths and problems and then implementing, learning from and revising modifications and solutions (NCWRCOI and CFP, 2005, p. 1). CQI processes are consequently expressed through an organisation's mission, vision and values (NCWRCOI and CFP, 2005).

3.7   Outcomes

Broadly, outcomes can be defined as the enduring changes, benefits, learning or other effects that service participants exhibit (Hunter, 2006). Outcomes can take a number of different forms and are different from outputs (units of service delivered). Generally speaking, most standards rely heavily on outputs, which are compliance-driven actions, items, or rules that dictate the minimum requirements of service (such as number of beds, health checks completed, case plans in place). Outcomes measure meaningful change in clients being served by a program (Courtney, 1993) and can be broken down into two broad categories: system level and individual level.

Drawing from the Magura and Moses (1986) Child Well-Being Scales, Courtney (1993) describes three types of outcomes necessary for QA measurement and processes.

- First, system-level factors as 'case status', meaning things that change with respect to the client's service status or legal status (such as moving from group care to kinship care; family restoration). These types of outcomes are typically measured using administrative data.

- Second, individual-level factors come in two forms: client status and client satisfaction.

- Client status refers to individual measures of change with respect to client behaviour, socio-emotional functioning, knowledge, or usable resources. These are typically measured using standardised, validated instruments in order to avoid measurement error.

- Client satisfaction refers to the degree to which services meet the client's subjective needs, expectations or wishes. These are generally measured using validated scales, goal attainment scaling, and open-ended interview questions.

4. Search strategy

Systematic search techniques were used to locate relevant QAFs for OOHC. Although this review falls short of a high-quality scoping review, it is transparent and replicable. The following search terms were entered into some of the major academic databases, including Psycinfo, Social Services Abstracts, Social Science Abstracts, Medline, Social Work Abstracts, Educational Resources Information Center (ERIC) and Social Services Citation Index (SSCI). In addition, grey literature was searched using the Australian National Child Protection Clearinghouse, the U.S. Child Welfare Clearinghouse, the U.S. Child Welfare Information Gateway, and a limited Google Search. The following terms were used for the databases:

- (Quality assurance OR Quality of care OR Quality control* OR Quality of services OR Professional standard* OR Standard* of care OR Care standard*)

AND

- (Out of home care OR Out-of-home care OR Foster care OR Foster home* OR Foster parent* OR Foster child* OR Kinship care* OR Relative care* OR Guardianship OR Adoption OR Adoptive OR Residential care OR Group care OR Congregate care)

AND

- (Child* OR infant* or baby or babies or toddler* or pre-school* or preschool* or boy* or girl* or teen* or adolesc* or youth* or young people or young person or minor* or juvenile*)

NOTE: *refers to truncation term whereby any combinations of letters coming after the term are included in the search (for instance, child* would return child, children, children's).

In total, more than 1000 titles, abstracts, papers and web-based documents were screened for inclusion in the review, resulting in locating four frameworks and a large volume of supporting documents. Grey literature searches yielded a number of important documents but were not counted in the number of articles screened.

5. Quality assurance frameworks

Courtney (1993) provides a succinct summary of the three areas needed in a QAF:

1. Program structural characteristics – these include variables such as adequacy and condition of the physical plant of the placement, numbers of staff or staff-to-child ratios, and qualifications of staff.

2. Program process characteristics – variables associated with functions of placement personnel. Thus, timeliness of assessments and treatment plans, appropriateness of diagnoses (in intensive settings), level of contact between certain staff (such as social workers) and clients, and number of family or school conferences in a given period.

3. Case outcomes – variables that measure meaningful change in the clients being served by a given program.

5.1 Outcomes-focused quality assurance framework: a common set of outcomes

The inclusion of individual child outcomes in QAFs raises the standard well above simple accountability. Traditional systems-level outcomes are not enough to tell us how children and young people are faring. At best, measures such as placement stability, maltreatment recurrence and length of stay in care are proxies for anticipated individual-level functioning. Nonetheless, the relatively easy availability of such measures has probably led to an over-reliance on them in QAFs.

Actual measures of functioning are notably lacking. For this reason, evaluations of OOHC are often limited to indicators that address only two major goals of the child welfare system – permanency and safety – while systematic measures of child wellbeing have generally not been incorporated into those administrative databases used for monitoring and evaluation (Altshuler and Gleeson, 1999). If measures of child wellbeing are included at all, they have historically not been used to evaluate success in care, but rather to predict other outcomes, such as reunification, re-entry and adoption (e.g. Courtney 1994; Landsverk et al. 1996). Definitions of quality and success therefore tend to be formed by what has been measured.

If child wellbeing is not regularly measured, there is a risk that effects and quality of OOHC will be assessed solely against administrative criteria such as caseload size, placement length, stability and cost effectiveness (Altshuler and Gleeson, 1999).

Although QAFs do not specify how to attain outcomes, they can be used to focus attention on critical outcomes over time, enabling agencies to create processes and services designed to meet those outcomes. The vast majority of child welfare literature identifies three main outcome areas essential to achieving quality in OOHC:

Child safety

- 'Children are, first and foremost, protected from abuse and neglect.

- Children are safely maintained in their homes whenever possible and appropriate' (Courtney et al., 2004, p. 1144).

Permanency

- 'Children have permanency and stability in their living situations.

- The continuity of family relationships and connections is preserved for children' (Courtney et al., 2004, p. 1144).

Wellbeing

- 'A child's basic needs are met and the child has the opportunity to grow and develop in an environment that provides consistent nurture, support and stimulation.

- [A child needs to] develop a healthy sense of identity, an understanding of their ethnic heritage[1] and skills for coping with [a variety of situations]' (Pecora et al., 2000, p. 12).

The measurement of outcomes should provide an accurate picture of how well a program is meeting its goals, without incurring excessive costs for data collection, analysis and reporting on behalf of child welfare agencies (Pindus et al., 2008, p. 14).

5.2   Quality assurance frameworks in practice: selected examples

This section briefly summarises three selected QAFs and one framework for outcomes-based decision making. As stated earlier, the main aim is to describe existing approaches to improving the quality of care provided to children. These Frameworks were selected for their comprehensiveness, based on the search of the literature. Suitable Australian examples were not identified through the search. The frameworks included in this review are:

- The National Child Welfare Resource Center for Organizational Improvement (NCWRCOI). USA

- Ontario Association of Children's Aid Societies (OACAS) Framework. Canada

- Ministry of Children and Family Development (MCDF) Integrated Quality Assurance Framework. Canada.

- The Casey Outcomes and Decision-Making Project (CODMP)- Assessing Outcomes in Child Welfare Services: Principles, Concepts, and a Framework of Core Indicators. USA.

The remainder of this section will provide more detail on each of those frameworks where attention was drawn to consistent presentation of the content to facilitate the comparison of approaches. The section closes with a summary of frameworks outlining and comparing the key components of designs. These findings are subsequently consolidated in the next section to form the core of the generic QA framework presented there.

A note on the frameworks

Although the first three frameworks summarised below are categorised as QAFs with a focus on CQI, the framework developed by the Casey Outcomes and Decision-Making Project (CODMP) is neither a QAF, nor does it explicitly include a detailed approach to CQI. Rather, it can be

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[1] A QAF for NSW will have to ensure that Aboriginal children and young people have a true connection with their culture.

interpreted as a comprehensive guide to outcomes-based decision making. Having said this, despite its primary focus on developing an outcome framework, the document does provide a broader perspective, including the contribution of QA and CQI to outcomes-based decision making. More precisely, CODMP defines QA and CQI as elements of a 'successful Outcome-Based Decision-Making Model' (CODMP, 1998, p. 19). Extensive examples provided in the report also illustrate the role of QA and CQI within the outcomes-based decision-making process. However, to date, the available document presents a QAF and CQI approach as a means to an end, without a well-described elaboration of either process. Nevertheless, the CODMP is included in this review in its own right, as a detailed treatment of an outcomes framework process.

5.2.1 Portland, Maine: The National Child Welfare Resource Center for Organizational Improvement

Addressing the trend in the child welfare service sector towards proactive, evidence-based policy development, the National Child Welfare Resource Center for Organizational Improvement (NCWRCOI) developed a QAF for child welfare QA systems in 2002.

By consolidating valuable information such as evidence and best practices from current QA initiatives, legal requirements and regulations, research, and national QA standards, the NCWRCOI aimed to present a coherent and cohesive step-by-step guide for child welfare agencies (O'Brien and Watson, 2002). The aim was to provide a single resource containing "broad elements all agencies should consider in creating new or energizing existing QA systems".[2]

The NCWRCOI framework can be set out as five steps, according to O'Brien and Watson (2002, p. 2):

Step 1: Adopt outcomes and standards.

Step 2: Incorporate QA throughout the agency.

Step 3: Gather data and information.

Step 4: Analyse data and information.

Step 5: Use analyses and information to make improvements.

O'Brien and Watson (2002) emphasise that every QAF development cycle needs, at the outset (step 1), clearly defined goals, which are strong indicators for the outcomes that an agency wants to achieve. Explicit goals therefore provide the direction for the whole QA process and need to be carefully chosen. According to O'Brien and Watson (2002, p. 3), goals defined by child welfare organisations for children and families are generally summarised under the three domains: safety, permanency and wellbeing.

In general, NCWRCOI examples are closely aligned with outcomes defined in existing initiatives such as the Child and Family Service Plan (CSFP) and the Child and Family Services Review (CFSR),

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[2](http://nrcoi.muskie.usm.maine.edu/pubs/pubs2.aspx?PUB_TYPE=&STARTYEAR=1992&ENDYEAR=2100&KEYWORD=&SUBJECT_AREA=11)

including its systemic factors. Besides goals, the authors also describe practice standards as a potential tool to communicate, and facilitate standardisation of, everyday practices.

The importance of frequent and consistent communication of outcomes, standards and expectations is a prerequisite for creating a QA-oriented organisational culture, which is the focus of Step 2 of the NCWRCOI (O'Brien and Watson, 2002, p. 7). This entails a variety of strategies which include internal (e.g. training existing and new staff) and external stakeholders (e.g. training foster parents, contracts for service providers).

In addition to communicating quality expectations to stakeholders, the framework recommends that QA elements be embedded in the agency's strategic planning processes. As mentioned above, the authors argue for the establishment of a QA structure throughout the organisation, as well as at the macro level, including compliance with governmental requirements and needs for scalability.

They emphasise the leadership role of senior management, stating that, unless executive staff are clearly committed to 'setting the tone' for change, paired with specific strategies, any attempt to move an agency beyond compliance monitoring will almost surely fail. Establishing dedicated QA roles also clearly demonstrates the status of QA in the organisation. This is critical to a successful implementation of QA mechanisms (O'Brien and Watson, 2002).

Step 3 of the NCWRCOI framework describes data collection mechanisms and is subdivided into four parts. Continuing their focus on US regulatory requirements, the authors begin by describing mechanisms for collecting quantitative data in compliance with the CFSP and CFSR. They suggest aligning automated data collection with regulatory requirements from the beginning, in order to create synergies between governmental and agency data collection activities. Quantitative data, these authors contend, serves two purposes. The first is to provide information on measureable outcome indicators as part of the QA process. Examples would be the length of time to achieve permanency goals, the number of placement settings, and data on wellbeing and system functioning (O'Brien and Watson, 2002, p. 12). The second purpose stems from the fact that agencies will have to continue to monitor compliance and will therefore still need to collect data that assists with staff and project management.

The second pillar of data collection in this framework is case reviews (both case record and qualitative case reviews). O'Brien and Watson (2002) highlight the benefits of building on existing case review processes and collaborating with external entities such as universities. In order to assess service quality in full depth, a variety of complementary qualitative data collection methods are proposed as a third pillar of this step. These include complaint mechanisms, focus groups, and interviews with children, families and external stakeholders at various points during the service delivery and evaluation cycle. O'Brien and Watson (2002, p. 16) refer here to the potential of the total quality management (TQM) approach, with its strong customer focus. Collaboration with other service providers and organisations may create synergies and leverage resources to address the needs of children and families (O'Brien and Watson, 2002, p. 17). Finally, the use of other sources of information represents the fourth pillar of data collection in the NCWRCOI framework, which incorporates findings from sources such as internal and external evaluations and audits.

In Step 4 of the NCWRCOI framework, the authors describe a model for data analysis processes conducted by child welfare agencies. In line with the previous stages, great benefits can result

from combining internal capacity with external expertise, thus involving a diverse workforce in the process of analysing the data. The aim is to translate the data and information collected in Step 3 into understandable reports targeted at diverse audiences, and to give all employees frequent and timely information about QA services.

The tailoring of specific reports to the needs of staff at all levels is expected to facilitate the use of data analysis processes. From this perspective, the development of reports will most likely take the form of an iterative process involving various stakeholders along the way. O'Brien and Watson (2002, p. 22) list various types of possible reports being produced. The three main ones are outcome reports, practice reports and compliance reports.

Step 5 of the NCWRCOI illustrates the CQI focus of the framework and encompasses the creation of feedback loops, improvements based on the available evidence, and evaluation of the actions taken. Feedback mechanisms are a crucial part of improving services, practices and other system components and are therefore a key factor to the success of a QA system, as outlined in the framework. With the aim of providing the best possible service to clients, the authors call for continuous improvement of service delivery processes, based on the data and information collected and areas for developments identified during the data analysis. They differentiate between four areas of improvement:

- **Improvements in compliance with policy and case practice requirements** – focus is on discrepancies between requirements and case records as identified by case reviewers during record review or qualitative interviews. Possible outcome could be, for example, further staff training.

- **Improvements in documentation** – identifying issues, such as documentation of actions or data entry, result in improved documentation.

- **Improvements in policy** – identifying gaps in the information on quality leads to changes to policy.

- **Resource development** – identified inadequacies in resources have to be addressed.

The final element, which simultaneously represents the start of a new QA cycle, is to evaluate the improvement strategies that have been implemented, and plan further actions if required. As outlined above, this CQI component is critical to the success of any QA system (O'Brien and Watson, 2002, p. 28)

5.2.2 Ontario, Canada: Ontario Association of Children's Aid Societies (OACAS) Framework 2004

The Ontario Association of Children's Aid Societies (OACAS) developed a QAF with the aim to 'provide the field with the "how to" steps for the establishment of a Quality Assurance (QA) program' (OACAS, 2004, p. 4). The framework owes its existence to earlier work done by OACAS in the field of Quality Assurances and Continuous Quality Improvement and the decision of the Provincial Committee on Quality Assurance to respond to an identified need for further implementation assistance for agencies (OACAS, 2004, p. 40).

Like other developments, this framework consists of stages or steps, each of them implemented in the organisational context (OACAS, 2004, p. 8):

Step 1: Build the agency strategy for achieving quality.

Step 2: Create a QA culture.

Step 3: Establish service quality requirements.

Step 4: Collect data.

Step 5: Analyse data for impact.

Step 6: Improve quality and maintain excellence.

Step 1 entails developing clear goals – this can be done through a strategic planning processes. This manifestation of QA in an organisation's strategic plan is intended to send a clear signal that quality is important to the agency. In this sense, the QA strategy should be derived from an organisation's mission and vision, which are often rooted in regulatory requirements and community needs (OACAS, 2004, p. 9). An understanding of its mission and visions will help the agency develop a set of goals, which in turn helps it realise its mission and visions (OACAS, 2004, p. 9). A developed QA action plan completes Step 1 and may be defined as a QA statement (OACAS, 2004, p. 11).

In Step 2, QA has to be embedded into the organisational culture. This starts with clear commitment from the board, through strategies like allocation of resources to QA or the establishment of a QA committee. According to the authors, a crucial success factor of any QA initiative is the direct involvement of senior management staff. Again, allocating resources and exhibiting behaviours that demonstrate the importance of quality are examples of strategies to establish the status of quality in an organisational culture. As in the NCWRCOI, an organisation-specific QA structure is discussed. Its aim is to facilitate the implementation of an agency's QA endeavour and will, again, contribute to a QA-oriented organisational culture.

An important element of the OACAS framework during this process is the communication of quality objectives to all layers of the organisation. The authors list various methods of communication, including training, quality-focused staff performance and inclusion of QA standards in contracts. Effective communication enables an agency and its entities to stay on track, highlight areas for development and productively process feedback (OACAS, 2004, p. 16).

All these actions encourage greater support from staff, foster parents, volunteers and suppliers. Without their commitment, the authors emphasise, a shift towards a quality-focused organisational culture is unlikely to be successful.

Step 3 focuses on defining standards, outcomes, outcome indicators and thresholds for action as a means of articulating service quality requirements. In the present context, standards may be derived from various sources, such as regulatory frameworks or the relevant literature. They 'often address service quality aspects related to inputs, process, access and output' (OACAS, 2004, p. 18).

Outcomes in this framework are defined similarly to the NCWRCOI framework and can be categorised under the three broad domains of child safety, permanency and wellbeing. The

authors emphasise that effective outcome development follows a process of 'define, adopt, track and analyze over time', in which feedback from staff, customers and the community is a crucial element (OACAS, 2004, p. 19). In the OACAS framework (p. 19), outcome indicators describe the 'observable and measureable characteristics or changes' that allow organisations to assess whether they have achieved their desired outcomes. According to the authors, outcome indicators should be selected according to selection criteria described by Hatry (1999). Finally, thresholds for action need to be defined – these represent trigger points for interventions during the service delivery process.

In Step 4, the authors discuss data collection mechanisms and highlight the importance of validity and reliability tests of data via statistical methods. In general, there are two types of data discussed in this framework: quantitative and qualitative. Case review, program evaluation, research and stakeholder feedback are possible data collection methods. OACAS (2004) also draws attention to important considerations for data collection, such as ethics, practicability, measurement and information systems.

Step 5 of the OACAS framework focuses on analysing data to assess impact. Again, the authors emphasise validity and reliability assessment of the data. According to OACAS (2004, p. 26) the shift towards outcome-focused QA will cause a change in the data analysis structures and processes of child welfare agencies. While the authors expect organisational structures for data analysis to be context-related, they mention opportunities to combine internal and external expertise. The results of the data analysis should be presented in QA reports, such as outcome reports, practice reports, and compliance reports (OACAS 2004, p. 27).

Like the NCWRCOI framework, OACAS (2004) states that a clear and timely communication process, including reports tailored to key audiences, is a crucial element of QA systems.

The quality improvement step closes the OACAS quality assurance cycle. Based on the results of the data analysis, agencies should respond to the majority of identified discrepancies between actual and desired outcomes (OACAS, 2004, p. 29). The framework present three optional scenarios, depending on the thresholds of action introduced in Step 3 (OACAS, 2004, p. 29):

- Maintain excellence – balanced approach to continuous improvement and learning that acknowledges and endorses good work. Also, possible elimination of monitoring processes for achieved standards and outcomes to ensure efficiency.

- Identification of opportunities – identification of new policies, services or procedures or potential scaling of best practice.

- Quality improvement – a process following the identification of gaps, comprising five steps:

  a. Address the gap in quality.

  b. Diagnose the causes.

  c. Provide a remedy and prove its effectiveness.

  d. Deal with resistance to change.

  e. Maintain the gains.

According to OACAS (2004), an agency's ability to demonstrate that it has achieved desired outcomes as a result of certain practices leads to best practices as a by-product of the QA process.

5.2.3 British Columbia, Canada: Ministry of Children and Family Development (MCDF) integrated quality assurance framework[3]

The Integrated Quality Assurance Framework (IQAF) is an endeavour of the Ministry of Children and Family Development in British Columbia. It focuses on monitoring service effectiveness, resolving concerns when they arise, and thoughtfully examining practice to inform policy and future services (MCDF, 2008, p. 7). The framework was designed with the aim to serve as "ministry-wide quality assurance framework" (Métis Commission, 2011, p. 14) and has been influenced by the recommendations of the *2006 Hughes Review* and *the Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth action plan* (MCDF, 2008). The MCDF (2011) defines QA as 'interrelated sets of activities that define, measure, evaluate and improve the quality of services, programs, products and processes in all areas of the ministry' (MCDF, 2011, p. 4, as cited by Métis Commission, 2011, p. 14).

According to MCDF (2008, p. 12), the aims of the IQAF are compliance with minimum standards and implementation of processes for improving practice through regular internal and external evaluation. It emphasises instruments such as the United Nations Convention of Rights of the Child and the participation of children, youth and families in evaluation processes (MCDF, 2008, p. 12), so that children, youth and families 'receive a quality of service that meets their needs and thus increases positive outcomes for children and youth' (MCDF, 2008, p. 12).

The MCDF framework is presented in five phases, referred to as an 'approach to continuous quality improvement' (Métis Commission, 2011, p. 15):

Phase 1: Assess

Phase 2: Plan

Phase 3: Implement

Phase 4: Review

Phase 5: Improve

Other frameworks follow stages in a sequence that starts by defining goals and principles and ends with improvement to services based on identified areas for development. The MCDF (2011) takes a slightly different approach by defining key areas of its QAF (MCDF, 2011, as cited by Métis Commission, 2011, p. 15):

- Vision, mission, values and goals – based on the government's vision for BC's children

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[3] The information on the MCDF (2011) Integrated Quality Assurance Framework presented here is drawn mainly from the summary document published by the Métis Commission (2011) and *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth* (MCDF, 2008). Unfortunately, this indirect approach was necessary due to unavailability of the original QAF document. However, the information included provides enough detail for comparing the MCDF (2011) with other QAFs and for synthesis across frameworks.

- Legislation, policy and standards – use of practice and operational standards, international government and business standards, and accreditation standards – Council on Accreditation (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF)

- Accountability mechanisms – procedures to address reporting requirements and performance expectations

- Complaints resolution – the process is accessible, timely and includes an advocacy function

- Research and evaluation – research intends to inform service delivery and public policy, evaluation intends to collect and interpret data about policies, products, people and processes or about programs. Evaluations are conducted in order to demonstrate accountability, generate knowledge and make improvements

- Data collection and analysis – produces an information system to identify and monitor trends, support planning and decision making, and enhance reporting

- Outcome measurement – sets and measures outcomes for youth, children and their families

- Practice monitoring and support – regional QA practitioner teams ensure that the quality of services provided is evaluated and that information gained from the evaluations are used to inform performance improvement plans

- Clinical supervision – increased clinical supervisory training for internal management and for management in delegated and contracted agencies

- Human resources development – to become a leading public service employer – employees are valued for their contributions and competencies and are supported in professional development.

Additionally, the MCDF (2011) includes principles to 'support good quality in service delivery, programs, processes and products' (Métis Commission, 2011, p. 15).

Each of the key areas of the MCDF (2011) is subject to the five phases of the approach to continuous quality improvement. The following illustration of the CQI cycle as part of the MCDF (2011) is described in the literature review published by the Métis Commission (2011, p. 15):

Phase 1 requires an assessment of the status quo, to identify areas of accountability and responsibility as well as risks, opportunities, strengths, expectations and needs. Similar to other frameworks, this phase also entails defining standards, best practices, benchmarks and requirements (MCDF, 2011, as cited by Métis Commission, 2011, p. 15).

In Phase 2 a plan for improvement is developed. This entails explicit goals, prioritisation of improvements or changes and a data collection plan.

Phase 3, implementation, focuses on collecting data collection and measuring outcomes. After this should come review and improvement based on identified learnings and new knowledge resulting from data analysis. This is at the core of Phases 4 and 5 (2011).

In line with the suggestions made by previously described frameworks, the MCDF has established a quality improvement council and endorses the dissemination of information to stakeholders (Métis Commission, 2011, p. 15). Also, the MCDF (2010, p. 16, as cited by Métis Commission, 2011, p. 15) describes its service quality evaluation as 'developmental quality assurance' (DQA). This process shares characteristics with the NCWRCOI and OACAS frameworks: a focus on 'providing information to participants; gathering information from internal and external stakeholders; conducting an analysis of the information relative to standards, outcomes and legislation; collaborating on development of improvement plans; supporting the realization of the goals as set out in plans, and addressing systemic issues emerging from the analyses' (MCDF, 2010, as cited by Métis Commission, 2011, p. 15).

5.2.4 Englewood, Colorado: Assessing outcomes in child welfare services: principles, concepts, and a framework of core indicators

Funded by the Annie E. Casey Foundation/Casey Family Services and the Casey Family Program, the Casey Outcomes and Decision-Making Project aims to provide products that aid a responsive, managed-care approach to child welfare (CODMP, 1998). It emphasises principles and outcome focus as drivers of decision-making processes in child welfare services.

Part 1 of CODMP outlines a set of seven 'philosophical principles' (CODMP, 1998, p. 3):

- child safety and family support

- child and family wellbeing

- community supports for families

- family-centred services

- cultural competence

- system accountability and timeliness

- coordination of system resources.

These principles are similar to mission, vision and goals. They need to be defined at the beginning as they set the direction for the entire process. The authors emphasise that outcomes must be anchored in values' (CODMP, 1998, p. 9).

Based on these principles, Part 2 draws attention to the process of developing an outcomes framework for child welfare agencies and the benefits of outcome-based decision making.

Like the other frameworks, CODMP categorises outcomes into three broad domains: safety, permanency and wellbeing.

CODMP further highlights the importance of clearly defined accountabilities, and understanding of the interrelationships between goals and across agencies, for the allocation of resources (CODMP, 1998, p. 13). Consensus on the definition and measurement of outcomes, and a common terminology, are crucial to achieving goals.

Part 3 elaborates on the definition of outcome indicators in the context of performance measurement. The authors adopt the model by Friedman (1997) and define four dimensions of

performance measurement and examples of corresponding outcome indicators (CODMP, 1998, p. 36):

- quantity of effort (e.g. number of children served)

- output/effect (e.g. number of children who graduate from high school)

- quality of effort (e.g. percentage of children with four or more placement changes)

- quality of results (e.g. percentage of children who graduate from high school).

Outcomes and indicators are concentrated in the latter three categories, but additional, context-related indicators should also be considered (CODMP, p. 37).

In general, CODMP defines a set of elements that must be established for a successful outcome-based decision-making model (CODMP, 1998, pp. 20–23):

- **a well-defined system of intervention** that identifies the services and resources, and the population that will be measured, and provides realistic expectations of what can be achieved

- **a comprehensive set of outcomes and indicators** that are useful in all areas of an agency's operations, involve parents and children in their development and recognise the interdependence of outcomes

- **indicators and outputs** and acknowledgement that a few outcomes and indicators will be more challenging to define and measure than others

- **measurement tools** that reflect the characteristics of the population served, the services used and the context in which outcomes are being measured. Tools measuring service quality should include the perspectives of case workers and families

- **procedures for monitoring outcomes, QA and CQI** that centre on what is the best for the child and their family and that set standards of cultural competence

- **technology for managing information and gathering data** that integrates various levels of data collection and use (e.g. state and agency level) and collects data that allows for differences in culture between evaluation activities

- **involving stakeholders in the transition** to an outcomes-based decision-making model

- establishing **program performance targets** linked directly to better child safety, permanency or wellbeing

- **family satisfaction**, while not an outcome, is used as an indicator of service quality.

The CODMP (1998, pp. 24–30) provides a blueprint for outcomes-based decision making that resembles the stage approach taken in other frameworks.

Steps 1 and 2 involve identifying the system for which outcomes will be defined and intervention will be planned. Knowing the system boundaries facilitates the choice of outcomes and can increase efficiency (CODMP, 1998, p. 24). Depending on the system, an agency will face internal and external factors affecting the balancing of principles and goals with external interests and the

choice of outcomes (CODMP, 1998, p. 24). The choice of intervention should be based on the principles described in Part 1 of the CODMP framework. These steps are comparable to Step 1 of the OACAS framework.

Step 3 focuses on engaging relevant stakeholders and reflects the content of key element 7. The authors emphasise the importance of including families as equal parties from the beginning (CODMP, 1998, p. 25). This step is equivalent to Step 2 of the OACAS framework.

After the system has been identified and stakeholders have been engaged, the outcomes need to be defined. Outcomes must be based on underlying principles and values. The authors suggest developing context-specific logic models to illustrate the clear relationship between desired outcomes and delivered service.

Steps 5 to 7 are comparable to Step 4 of the OACAS framework. The aim is to establish a model for data collection, information management and QA processes that clearly explains how outcomes will affect an agency's decision making process, model boundaries, and systems. It is also important that all measurements and outcomes have been agreed upon by stakeholders and that all domains of outcomes, including outcome indicators for wellbeing and family satisfaction, are being measured (CODMP, 1998, pp. 27–29).

Step 7 also draws attention to analysing data, correctly specifying the analytical model and securing enough funding to conduct a thorough evaluation. In a final note the authors emphasise the importance of regular and relevant feedback for all stakeholders once results are available (CODMP, 1998, p. 30).

5.3   Summary

A framework defines the 'what', but allows for the 'how' to be developed by the agency, based on its diverse and unique needs (Métis Commission, 2011). Although the frameworks of the Ministry for Children and Family Development, the Ontario Association of Children's Aid Society, and the National Child Welfare Resource Center for Organizational Improvement all share the one goal: to accomplish a continuous quality improvement process in an agency, how each agency will achieve this is as diverse as their needs, structures and organisational philosophy.

Table 1 summarises the four frameworks included in this narrative literature review, organised by purpose and outcomes. Please note that column 5 focuses on comparability across frameworks. For example, CODMP does not categorise outcome indicators by type of data, due to its focus on developing outcomes rather than analysing data. The classification shown in Table 1 is for illustrative purposes and was conducted by the authors, based on categorisation of similar outcome indicators in the relevant literature.

Table 2 illustrates logic concepts for the four frameworks discussed in this review. For the MCDF framework presented in column 4, the logic follows the 'approach to continuous quality improvement'. As mentioned above, this differs from the perspective taken by the NCWRCOI and the OACAS frameworks in structure and can be interpreted as 'splitting' the overall QA and CQI process into many CQI cycles, one for each key area. Nevertheless, a comparison across the five phases was chosen as the preferred mode of presentation, with the focus on comparability.

Table 1: Comparison of frameworks by focus and content

	NCWRCOI 2002	OACAS 2004	MCDF[1] 2011	CODMP 1998
Focus	QAF/CQI	QAF/CQI	QAF/CQI	Outcomes-based decision making
Agency / Context	National government-funded agency / Industry driven	State based agency / Industry driven	State Government / Integrated into action plan	Organisation Collaborative / Industry driven
Target group	Child welfare administrators and managers	Agencies in child welfare	Ministry of Children and Family Development	Child Welfare Services – strong focus on managed care
Built in CQI	Yes	Yes	Yes	No[3]
Outcomes	Outcome domains: 1. Safety 2. Permanency 3. Child and family wellbeing	Outcome domains: 1. Safety 2. Permanency 3. Child and family wellbeing Outcome areas: behaviour, attitude, knowledge, values, status, condition	Five policy pillars:[5] prevention, early intervention, intervention and support, the Aboriginal approach, quality assurance	Outcome domains: 1. Safety 2. Permanency 3. Child and family wellbeing
	Defined according to legislative frameworks (e.g. CSFP, ASFA, CFSR)	Examples:[2] CWOIM (CAN), DHHS CWO (USA), LAC (UK)	Guided by the Strong, Safe and Supported policy, UN CRC[6], and Hughes Review	System related <u>Examples listed:</u> Children born healthy, children ready for school, etc.
Outcome indicators (examples)	Quantitative: Recurrence of maltreatment, incidence of child abuse and/or neglect in foster care, foster care re-entries, length of time to achieve reunification	Quantitative: Recurrence of maltreatment, criminal charges, placement rate, family risk	Example: Increase in comprehensive and accurate information used to inform continuous service improvement	Quantitative:[4] Post-finalisation adoption disruption, children placed in OOHC who are placed with providers who are relatives or kin
	Qualitative: Perception of needs met, availability of service staff	Qualitative: Stakeholder feedback regarding perceptions, opinions and feelings	Example: Increase in the use of evidence in policy and practice change	Qualitative:[4] Satisfaction of children with quality and effectiveness of service

[1] Follows the summary by the Métis Commission for Children and Families BC (Métis Commission, 2011). While other frameworks follow a logical sequence as outlined above, the MCDF applies the five phases (Assess, Plan, Implement, Review, Improve) to each of the identified key areas of the integrated QAF. (Métis Commission, 2011, p. 14)

[2] CWOIM – Canadian Child Welfare Outcomes Indicator Matrix, DHHS CWO – U.S. Department of Health and Human Services Child Welfare Outcomes, LAC – United Kingdom Looking After Children.

[3] The CODMP focuses on outcome-framework design. Integration of CQI and QAF is outlined in extended examples.

[4] The classification of outcome indicators into quantitative and qualitative is actually part of measurement rather than indicator definition. Therefore this framework does not discriminate between types of data collected like the other frameworks. The classification shown in this table is therefore as an example, and for comparison, only.

The logic model presented in column 5 of Table 2 summarises the "Blueprint for Outcome-Based Decision Making" presented in the CODMP framework (pp. 24–30). Steps were grouped to increase comparability with other frameworks while still representing the key elements of successful outcome-based decision making (see CODMP, 1998, p. 19). From this perspective, the CODMP is comparable to the OACAS (2004) steps 1 to 4. Additional steps including the CQI procedures are part of an extended example but are not described in detail as part of the framework.

Table 2: Summary of framework logic models

	NCWRCOI 2002	OACAS 2004	MCDF[1] 2011	CODMP 1998
Stage 1	Adopt outcomes and standards	Build the agency strategy for achieving quality	Assess	Identify the system / system of intervention
Stage 2	Incorporate QA throughout the agency	Create a QA culture	Plan	Engage all relevant stakeholders
Stage 3	Gather data and information	Establish service quality requirements	Implement	Identify the outcomes to be achieved
Stage 4	Analyse data and information	Collect data	Review	Develop a model / Take care of details / Establish resources for measurement and evaluation
Stage 5	Use analyses and information to make improvements	Analyse data for impact	Improve	
Stage 6		Improve quality and maintain excellence		

[1] Follows the summary by the Métis Commission for Children and Families BC (Métis Commission, 2011). While other frameworks follow a logical sequence as outlined above, the MCDF applies the five phases (Assess, Plan, Implement, Review, Improve) to each of the identified key areas of the integrated quality assurance framework. (Métis Commission, 2011, p. 14)

Based on the summary presented in this section, combined with information from additional frameworks, relevant literature and research, a generic QAF has been developed. The next section therefore consolidates the core elements of QAFs identified across all four examples included in this narrative summary.

6. A generic quality assurance framework: comparative assessment of quality assurance frameworks

6.1 Quality assurance as a continuous quality improvement (CQI) process

The following section provides an overview of the five main components of a QA cycle, as identified by the literature review. These components have been drawn from the QAFs described above (OACAS, 2004; O'Brien and Watson, 2002; CODMP, 1998; MCDF, 2011). For the sake of comparison, the QAF presented here follows the logic of NCWRCOI (O'Brien and Watson, 2002). The five stages of the generic framework can be interpreted as elements of a continuous quality improvement cycle, which is illustrated in Figure 1.

Figure 1: Quality assurance framework as continuous quality improvement process
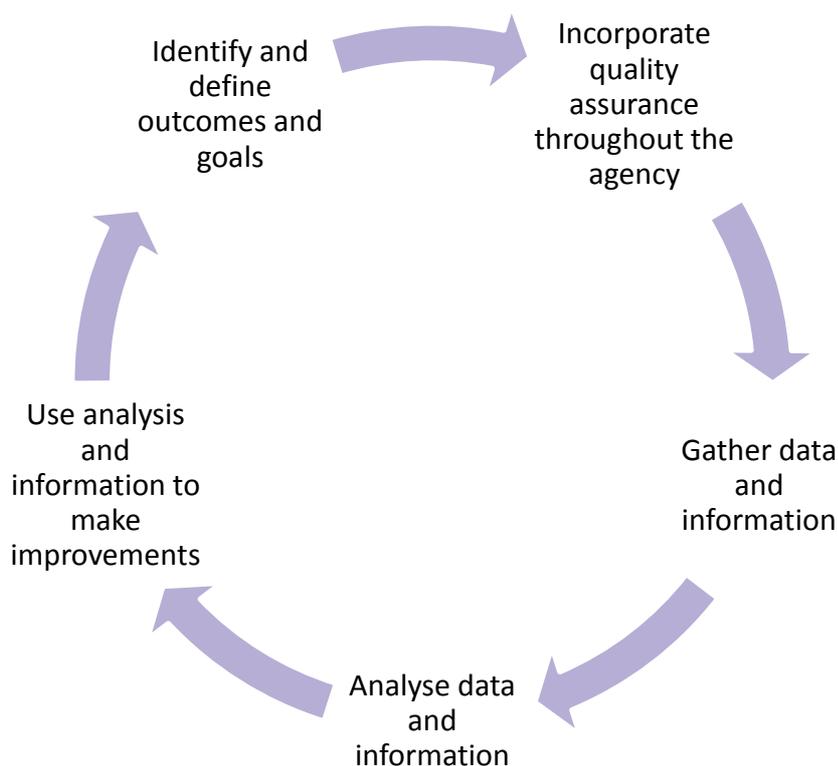
Source: Parenting Research Centre, based on the NCWRCOI framework (O'Brien and Watson, 2002)

Step 1. Identify and define outcomes

The QA cycle begins with identifying a set of outcomes that define the central mission of an organisation or system. As is highlighted in all four QAFs, clearly defining the mission and vision and setting explicit goals are imperative for the success of any QA system, as these steps tell all stakeholders the desired outcomes for clients.

Although the QAFs assessed in the previous section differ mostly in their first two steps, all QAFs agree on the importance of assessing the status quo and defining at the beginning of the initiative the outcomes that the agency wants to achieve. This corroborates Smith's (1992) emphasis on an initial assessment of services and goals before trying to evaluate service provision. Wulczyn (2007, p. 13) goes so far as to describe monitoring performance without setting explicit goals as 'essentially useless'.

But choosing the right outcomes is no small task, as cause-and-effect relationships are rarely straightforward. Rather, they are prone to confounding (Coulton, 1982). The complexity of such systems is often inversely related to measurability of indicators. This complexity can obscure changes caused by service improvements (Myers, 2004).

There must be a shared understanding of the mission, vision, goals and outcomes. Part of the process of defining outcomes includes making sure all parties clearly understand the purpose and audience for outcomes data. A QAF should also include a shared understanding and definition of any practice standards that exist or govern child welfare agencies. The lack of common terminology and standardised definitions is a barrier to QA (CODMP, 1998; Thomas, 2006) and

has also motivated the establishment of frameworks such as NCWRCOI (O'Brien and Watson, 2002).

In general, frameworks suggest aligning QA goals and standards with existing governmental requirements, missions and visions. In the case of NSW, the QAF will integrate available standards such as the OOHC standards developed by the Australian Government and the OOHC accreditation standards developed by the NSW OCG.

But this means agencies must find a balance between internal aims (such as agency mission, vision and goals) and external interests (such as the funding authorities' objectives) (CODMP, 1998, p. 24). McMillen et al. (2008), for example, suggest that a large number of accreditation and regulation standards may hamper an agency's QA efforts due to conflicting resource allocations between evaluation and service provision. CODMP (1998, p. 24) suggests that by 'identifying the system', boundaries can be established that allow stakeholders to focus on relevant sets of goals and stakeholder interests.

The next step is to identify target outcome domains and then map outcome indicators, as measurable characteristics of outcomes, to these domains.[4] All QAFs examined listed the outcome domains of safety, permanency and wellbeing as core indicators against which to assess service delivery by child welfare agencies.

Once outcome domains have been identified and indicators have been drawn out, specific measurement tools should be adopted or developed that address each outcome. This is the focus of Step 3.

Step 2. Incorporate quality assurance throughout the agency

Once a child welfare agency has identified and defined outcomes, it should incorporate them into its strategic planning processes. Commitment from senior management is crucial. Managers must provide leadership, take actions and behave in a way that demonstrates the importance of QA to the organisation. This includes allocating resources, such as dedicated QA staff and expert panels (O'Brien and Watson, 2002; OACAS, 2004; MCDF, 2011). The importance of leadership commitment is demonstrated not only in the QA literature (see Broady et al., 2011) but also in the literature of other disciplines that focus on organisational culture, such as organisational change (e.g. Scott et al., 2003) and implementation science (see Greenhalgh et al., 2004).

Involving staff and stakeholders should also be considered, as these groups hold valuable information and maintain networks connected to the agencies' customers.

A critical element in creating a QA culture is to communicate these expectations throughout the agency and community. This could involve training staff, implementing performance expectations and setting quality standards. Other possible communication strategies include the training of caregivers, and including quality expectations in contracts.

Step 3. Gather data and information

When building a QAF it is important to take advantage of current sources of outcomes data that are being collected from child welfare agencies. This will not only decrease reporting burden and

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[4] This step is out of scope for this particular project, but should be performed in consultation between FACS and child welfare agencies.

double entry of data, but will also ensure the framework aligns with current processes and systems.

As mentioned in Step 1, outcome indicators allow progress towards a desired outcome or goal to be measured. In general, the complexity of outcomes calls for a mixed-methods approach, in the sense that QA should be based on both quantitative and qualitative measurements of children and young people in OOHC. Regardless of the type of data, measurements should be assessed in terms of validity and reliability (OACAS, 2004). Importantly, measurement tools should function reliably and validly with repeated use for individual clients (that is, they should be valid and reliable for measuring progress over time, and the timing of administration should reflect the capacity of the tool to measure change over time).

Systems-level quantitative data can be collected from internal and external sources. This is usually collected via administrative data collection systems. This data often relates to program structural characteristics or program process characteristics (Courtney, 1993).

In order to assess outcome indicators at the individual level, such as child and family wellbeing or service quality, it is likely that information will need to be collected via methods such as qualitative case reviews, interviews or focus groups with children and families, or stakeholder surveys (O'Brien and Watson, 2002). As mentioned above, standardised, validated instruments should be used where possible, to avoid measurement errors.

As previously mentioned, practicability and feasibility of data collection mechanisms should also play an important role in this process (Broady et al., 2011). The aim is to 'accurately show how well initiatives are meeting their goals without excessively burdening either the organisation or staff with costly data collection, analysis and reporting requirements' (Broady et al., 2011, p. 19).

Step 4. Analyse data and information

The complexity of outcome structures, and the potential repercussions of confounding on identification of parameters in analytical models, show the importance of evaluating the collected data thoroughly. Robust data analysis needs specialised skills, so an agency must employ staff or consultants who are adequately trained in quantitative and qualitative analytical methods, and who also have a thorough understanding of child welfare practice.

An important issue, related to confounding, is context-related analysis. The need to account for potentially influential variables, such as cultural background, is crucial to the validity of findings. A thorough understanding of the system of interest is therefore imperative. Consequently, the data analytical process should be inclusive, in the sense that a variety of stakeholders should participate in the evaluation, including external partners such as universities, consultants or community members (O'Brien and Watson, 2002, pp. 20–21). Inclusiveness is needed because the assessing whether or not a program contributed to the achievement of a desired outcome suggests causality. Statistical inference is therefore insufficient to assess the effects of particular initiatives in the absence of valid causality assumptions (Freedman, 2006; Pearl, 2009). For example, Wulczyn (2007) emphasises the relevance of local knowledge to the meaningful interpretation of baseline data, and highlights the need to control for differences in observed patterns due to population characteristics. Courtney (1993) discusses contextual factors in matters such as choosing the best type of care for children. Wulczyn (2008) takes this idea even further by demonstrating the need to consider dynamic aspects and feedback loops over

children's lifetimes. In short, any good analysis involves integrating the service and population contexts into the design and statistical procedures used.

Translating analytical results and information into reports is the second cornerstone of Step 4. The aim is to give stakeholders regular and up-to-date reports on the QA process. These reports should be tailored to particular audiences, in order to make analytical results more relevant to individual work processes. Additionally, it is important to communicate findings through a dynamic, or iterative, process that provides feedback mechanisms. This creates a direct link between QA and the improvement process, thus closing the CQI cycle of this generic framework.

Step 5. Use analysis and information to make improvements

The focus on client outcomes demands that data should not only be used to track progress of children and young people in OOHC but should also be used to guide changes in child welfare practice. All frameworks we reviewed either directly include elements of continuous quality improvement (O'Brien and Watson, 2002; OACAS, 2004; MCDF, 2011) or highlight the potential for an integrated CQI process (CODMP, 1998).[5]

Feedback loops allow stakeholders to exchange information dynamically, and help improve the system at various levels. O'Brien and Watson (2002, p. 25) assert the importance of sending regular analytical reports to staff at all levels of the organisation. Staff can use this information to plan and implement changes in their practice. Feedback loops should also encourage practitioners to discuss practice issues during case reviews. Also, any progress in implementing recommendations from a QA process can be reported to senior staff.

The OACAS framework differentiates between 'maintain excellence' and 'quality improvement'. The latter is presented as a five-step process (pp. 29–32). As previously mentioned, the MCDF framework also defines the quality improvement process in five phases (Métis Commission, 2011). Any improvements made by agencies should also be evaluated to ensure that they are effective. This is an important step in such an iterative quality improvement process. A comprehensive QAF will also explore data to identify opportunities to develop new services, policies or procedures.

Coulton (1982) refers to the premise of efficiency for QA systems and points out that agencies need to be aware of the benefit–cost ratios of QA processes. From this perspective, data collection and analytical efforts must be proportional to risks. Agencies should consider ceasing to monitor those processes or services that continuously achieve desired outcomes.

6.2   Linking quality to the use of effective practice

The key component of developing an outcomes-focused QAF is the link between the QAF and implementing evidence-informed and increasingly more effective practice. A QAF that promotes effective services and programs will ensure that the right types of services are being given to the right children at the right time, in order to optimise their safety, permanency and wellbeing. Recently, a Framework Workgroup of the Children's Bureau developed a 'Framework to design,

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[5] As mentioned in the summary, the CODMP framework (1998) does not extend beyond creating an outcomes framework. However, QA and CQI are listed as key elements of a successful outcomes-based decision model (p. 21) and in examples (p. 28).

test, spread, and sustain effective practice in child welfare' (Framework Group, 2014). That framework builds evidence for child welfare practice and allows agencies to make decisions on implementing interventions as part of their everyday practice. While that framework is not a continuous QAF, it provides guidance on how to incorporate evidence-based practice into interventions. It involves the following phases (Framework Group, 2014, pp. 8–20):

- Identify and explore – identify the problem, target population and possible solutions. This phase relies on prior research to develop a theory of change.

- Develop and test – develop and specify core components of an intervention, test options for installation and implementation, monitor fidelity and assess whether the core components are delivered as intended. Assess short-term outcomes.

- Compare and learn – assess whether an intervention resulted better outcomes for the target population, and which sections of the population experienced the most/ least effective results, and under what conditions. Use evaluations of the intervention, data analysis and studies performed on the intervention.

- Replicate and adapt – integrate evidence-supported interventions with practitioner expertise, while considering the environment surrounding the intervention.

- Apply and improve – continually improve delivery of interventions. Use evaluation findings to improve results. Stakeholders can learn about the adaptations of an intervention, understand its outcomes to strengthen practice, build consistency or further understand an intervention.

7.   Conclusion

The main aim of this review is to describe approaches that agencies, governments and other funders have developed in their efforts to define, monitor and improve the quality of care provided to children who have been formally placed in OOHC. It summarises existing frameworks, identifies common features, and provides suggestions for building a NSW QAF for out-of-home care.

At the centre of quality improvement is the shift from mere compliance with minimum standards to an outcomes-focused service provision. Extending the measurement of service quality to include children's and families' wellbeing is a necessary step towards providing the best care possible for children (see DHHS, 2012). The Métis Commission (2011, p. 23), for example, denotes this development as 'person-centred' and states that 'the ultimate aim of continuous quality improvement is to enhance the quality of life of the people served by the agency or system'.

Despite the current trend towards quality improvement, the lack of a standardised terminology continues to contribute to confusion in the literature and may be a barrier to implementing CQI in the field, especially when many stakeholders are involved.

Nevertheless, the review showed that quality assurance and improvement messages need to be empowering and strength-based. They must engage all stakeholders and demonstrate strong management commitment and leadership.

Management commitment is very important. This includes leadership behaviour, as well as allocating resources to QA. QA needs to be implemented throughout the agency and the organisational environment.

The interrelation between outcomes and the complexity of measurement and analysis requires a holistic view of the system. A characteristic of a complex adaptive system is that complexity arises from the interaction and relations of its elements. This fact must be acknowledged throughout the whole quality improvement process, in order to identify relationships between provided services and outcomes (e.g. Sterman, 2000). A systemic perspective on quality improvement minimises policy resistance and increases the likelihood of bringing about a QA-focused organisational culture.

A system-wide view of quality improvement must involve all stakeholders. Consequently, service improvement requires working collaboratively with the people being served, from the very beginning of the process. A dynamic exchange, using feedback loops, is essential for the continuous improvement of processes and services. Decision-making processes should be based on consensus, and must be underpinned by shared mission, vision and goals. To be successful, an agency needs to balance the diverse interests of internal and external stakeholders: families, children, funding entities and employees.

It is also essential to acknowledge that quality improvement is a dynamic continuous process. Perceptions of appropriate QA techniques, treatments and service provision are not static – they change over time (Coulson, 1982). Consequently, QA must not be limited to static comparatives. Rather, it should be an ongoing process, accompanied by continuous learning and change. Results from data analysis, evidence from research and other relevant information need to be translated into usable formats that help stakeholders continuously assess and adapt the system, identify areas for development, and deliver the best services and outcomes for clients.

8.   References

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