CCCFR Quality and Safety Review - Aggregate Report

Department of Education, Skills and Employment

July 2021

pwc



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1

Executive Summary

Executive Summary

Introduction

PricewaterhouseCoopers Consulting Australia (PwC) and PricewaterhouseCoopers Indigenous Consulting (PIC) were engaged by the Department of Education, Skills and Employment (DESE) to undertake a review of the quality and safety of Community Child Care Fund Restricted (CCCFR) services that are not regulated under relevant State/Territory regulations or the National Quality Framework (NQF), plus a review of a sample of five services regulated by State Regulatory Authorities (SRA) and five NQF regulated services. The review involved two key components:

1. **Desktop diagnostic:** Undertaking an initial assessment as to whether the CCCFR services are likely to be meeting quality and safety requirements in the CCCFR Funding Agreements and the Minister's Rules. This was based on desktop information and data made available to PwC/PIC by DESE.
2. **In-depth diagnostic:** Undertaking an in-depth site visit with a sample of CCCFR services to gather more detailed information on how these services are implementing quality and safety requirements and identify additional support measures that could help CCCFR services to strengthen their quality and safety.

Approach

The engagement involved undertaking a four-phase approach, involving:

Phase 1: Project planning

- Phase 1 involved planning the stages of the project and confirming the priorities of the review.

Phase 2: Design and data collection

- Phase 2 involved data collection (from 2019 Quality Improvement Plans (QIPs), 2019-20 Compliance and Operations Reports (CORs), the Serious Incidents Register and 2019-20 Budget and Business Planning Tools).
- These materials were used to develop a desktop diagnostic report for each CCCFR service that is not regulated under State/Territory regulations or the NQF and a sample of five services regulated by SRAs and five NQF regulated services.
- Diagnostic reports were based on a criteria where available information was assessed against a series of quality and safety-related compliance questions that were treated as 'critical.' Based on the responses services were given a overall rating of amber or green.
- A preliminary report was developed including interim findings and recommendations of factors for consideration in selecting services for an in-depth review of quality and safety. Factors included: diagnostic report results, jurisdiction, provider type, presence of serious incidents and other issues identified by DESE Agreement Managers.

Phase 3: Mobilisation

- Phase 3 involved undertaking 14 site visits to services (of which three were done virtually due to COVID-19 restrictions).
- Inputs that were developed as part of the planning and preparation of the site visits included; a consultation guide, service report template, a pre-site visit briefing for the review team and providers of selected services.

Phase 4: Reporting

- Phase 4 involved developing individual service reports for each site visit. These were provided to DESE and to the service for comment before being finalised.
- This phase also involved developing this final aggregate report that summarises key findings and recommendations.

Executive Summary (con't)

This report outlines detailed analysis of the two phases of this project (the desktop diagnostic and in-depth site visits) which have informed eight overall findings. The following is a summary of findings of the review, more detail on these findings can be found in Chapter 7 and supporting analysis and material is contained in Chapters 4-6.

Overall key findings

1. **CCCFR services have complex environmental/contextual conditions** - services reported experiencing multifaceted challenges based on their physical environment, remoteness and the cohort of families that they support which often combine to result in challenging contexts for services to manage quality and safety. These contexts both constrain services' abilities to access the supports they need to maintain safety and quality as well as increasing the difficulty or riskiness of service delivery.
2. **Inconsistent management capability** - a spectrum of experience of management personnel was observed with variable experience across the child care sector, working in remote contexts and/or working with Indigenous communities. Services that appeared to have the strongest safety and quality practices often had personnel who combined their knowledge of up-to-date guidance and best practice in early childhood education and care settings with an ability to work with local staff and the community to incorporate cultural knowledge and values into the way the service is delivered.
3. **Safety appears to be a required foundation to build quality** - from the sample of services included in this review, it appeared that services who were still working towards implementing a strong foundation of safety practices and strategies were not able to devote the time and attention required to fully implement 'quality early childhood education and care' (eg intentional educational programming).
4. **Inconsistent implementation of policies and procedures** - policies and procedures appeared, in a majority of services, to have minimal influence on the day-to-day practices of staff, with almost no staff referring to policies and procedures when speaking with review teams. Policies and procedures were often lengthy, wordy and similar between services, indicating that services may have used a common template rather than developing policies and procedures that were tailored to their service contexts.
5. **Continuously evolving safety and quality conditions** - when comparing findings from in-depth site visits to the desktop diagnostics, the current operation of services appeared to bear minimal resemblance to the reports relied upon in completing the desktop diagnostic. Services often reported that information from CORs and QIPs was outdated. As such, any review of quality and safety can only be considered at a point in time and actual quality and safety often changes over time as service conditions, staffing and practices change.
6. **Limitations of undertaking desktop analysis of current reporting** - the desktop diagnostic analysis found that there were limitations in the current reporting provided by services (through CORs and QIPs) which results in significant gaps in understanding the safety and quality of services when reviewing this information alone.

Executive Summary (con't)

7. **Context may be a stronger driver of safety and quality at CCCFR services than regulation** - a spectrum of safety and quality of services was observed across the 14 in-depth reviews undertaken. It was not clear if there were substantial differences in the quality and safety of services based on their regulation under NQF, SRA or neither. While the sample was small, emerging evidence may suggest that service's contexts, including the degree of staff turnover and management capability, are more accurate determinants of safety and quality.
8. **More detailed documentation supplied by CCCFR services regulated by SRA or the NQF does not necessarily translate into improved safety and quality** - while the desktop diagnostic revealed that SRA and NQF services generally supplied more information in QIPs, this did not always appear to translate into improved safety and quality practices on the ground.

Based on the overall key findings of this review we have provided eight recommendations that DESE could consider implementing to improve the quality and safety of services that are not regulated by the NQF or SRA. We have proposed seven short to medium term recommendations which could be implemented within the next twelve months and a further two long term recommendations which may take longer to implement and DESE could consider implementing over two to three years. Further detail on each recommendation is provided in Chapter 8.

Short-medium term recommendations

1. **Awareness of Minister's Rules -** Given that CCCFR services are not currently required to be working towards the NQF, DESE could consider providing additional resources and improving access to existing resources to enable services, particularly those operating within a remote context, to build their understanding of how the quality and safety requirements in the Minister's Rules and the Funding Agreement should be implemented, and whether services should be striving to work towards the NQF.
2. **Compliance and Operations Report template -** DESE could consider redesigning the COR reporting template and questions to better align the information collected through CORs with indicators that services are providing safe and quality services.
3. **Quality Improvement Plan template -** DESE could consider designing a QIP template that is shorter and more targeted to the requirements that CCCFR services that are not regulated by the NQF or State/Territory regulations are required to be implementing. A redesigned template could be aligned to guidance that DESE may develop in line with recommendation 1.
4. **Physical environment constraints -** DESE could consider providing resources that articulate common strategies that services could implement to address physical constraints. DESE could also consider having processes in place to follow-up on any physical limitations identified in service QIPs and/or CORs to ensure services understand the options available to resolve issues.

Executive Summary (con't)

5. **Training resources -** DESE could consider developing and providing resources to help services manage the onboarding of new staff, to ensure basic concepts are covered such as; adequate supervision, safety checks and manual handling. These resources should consider best practice and be relevant for service contexts including operating in remote environments and culturally appropriate practice.
6. **Role of Agreement Managers in supporting services to maintain and strengthen quality and safety -** DESE could consider expanding the role of Agreement Managers to include responsibility for supporting services to maintain and strengthen quality and safety. This expanded role could involve more engagement with services to provide tailored training support, following up on reported safety issues and providing updates to the CCCF management team regarding quality and safety. DESE could also consider the role that Agreement Managers could play in supporting the handover of services to new service management staff to ensure that important information regarding the Minister's Rules and available support resources is provided.
7. **Regular site visits to check on safety and quality at CCCFR services -** DESE could consider undertaking quality and safety reviews for other CCCFR services that are not regulated under relevant State/Territory regulations or the NQF. This could be implemented using the methodology adopted in this review and identifying a sample of services to be visited each year.

Long term recommendations

1. **Workforce issues -** DESE could consider a renewed focus on collaborating with a range of employment and education stakeholders, such as Registered Training Organisations (RTOs) and TAFEs to improve the supply of qualified educators in remote communities. This could also involve partnering with RTO(s) to deliver culturally appropriate training and qualifications which are applicable to services' contexts and to support staff to complete training and placements in community.
2. **Transition to be regulated by State/Territory Regulation or NQF over time -** DESE could consider working with SRAs and ACECQA to gradually transition all CCCFR services to be regulated under State/Territory regulations or the NQF. This would likely involve providing support for services to transition and further consultation with services and assessment may be needed.

2

Context and purpose of the review

2.1 Background and context

Background

There are currently 156 Community Child Care Fund Restricted (CCCFR) services. These services can either be regulated under relevant State/Territory regulations (SRA) or the National Quality Framework (NQF)[1], or not be regulated under either the NQF or SRA (and not required to work towards the NQF). The breakdown is provided in the table below.

Type of CCCFR service	#
State/Territory regulated	73
Regulated under NQF	24
Not regulated under relevant State/Territory regulations or the NQF	59
Total	**156**

There are currently 59 CCCFR services that are not regulated under the relevant State and Territory regulations or the NQF. These services are required to meet safety and quality benchmarks set out in the Child Care Subsidy (CCS) Minister's Rules and CCCFR funding agreements.

Quality and Safety Review

The purpose of this report is to summarise the findings from the desktop diagnostic results and in-depth service site visits. The report also includes short, medium and long-term recommendations, including opportunities to:

- provide more detailed guidance to CCCFR services on safety and quality requirements that apply and strengthen reporting requirements
- provide more training and opportunities to build the capacity of services to deliver safe and high quality services
- change the arrangements for the regulation of these services going forward.

[1] Note that throughout this report we will use 'NQF' to refer to both the National Law under which services are regulated and the National Quality Standards which define the quality aspects of care.

2.2 Summary of services included in this review

s 22

Desktop diagnostic

Out of the 156 CCCFR services, a desktop diagnostic report was developed for:

- 55* services that are not regulated under relevant State/Territory regulations or the NQF
- six services that are regulated by SRAs and
- five services regulated under the NQF.

In-depth diagnostic

In consultation with DESE, 14 CCCFR services were selected for an in-depth site visit (illustrated in the figure on the right). This included one service that is regulated by a SRA and one service that is regulated under the NFQ.

The services were selected based on a blended approach taking into account factors such as jurisdiction, provider type, serious incidents, assessment ratings, information on critical incidents and other safety or quality related issues that have been identified from the desktop review.

**Note: Desktop diagnostic reports were not completed for four CCCFR services that are not regulated under relevant State/Territory regulations or the NQF as these services were not operating at the time of assessment.*

***Note: Due to COVID-19 restrictions, the site visit team was unable to access three services and these site visits were undertaken via video-conference.*

3

Approach

3.1 Overview of the approach

The table below provides a high-level summary of the project methodology, including key activities and deliverables at each stage.

	Stage 1- Project planning	Stage 2 - Design and data collection		Stage 3 - Mobilisation	Stage 4 - Reporting
	Project planning & initiation	***Design of desktop diagnostic***	***Data collection***	***Consultations and site visits***	***Draft and final report***
Activities	• A Day 1 workshop was hosted to discuss ways of working and identify DESE's priorities for the review. • A project plan was developed. • A data request was issued for documentation and background materials, including service-level data on QIPs, BBPT, compliance and operations reports, serious incidents reports etc.	• Co-design with DESE was completed to design a diagnostic template, that included a baseline desktop diagnostic for the 55* services not regulated under relevant State/Territory regulations or the NQF, 6 SRA and 5 NQF services. • A draft consultation guide for in-depth site visits was developed. • The diagnostic report template and consultation guide was finalised based on feedback from DESE.	• PwC/PIC undertook desktop diagnostics based on available desktop information. • PwC/PIC provided preliminary findings on individual service diagnostic results including recommendations for services that could benefit from the in-depth review. • Diagnostic results informed DESE's selection of services that participated in the in-depth diagnostic. • PwC/PIC drafted communication materials for DESE to distribute to services participating in in-depth review. • DESE consulted with CCCFR team to determine which services would receive an in-depth site visit. • PwC/PIC developed an individual service report template for in-depth site visits which was finalised based on feedback from DESE.	• PwC/PIC delivered team training for the combined review teams including DESE representatives and an SME consultant to ensure consistency of consultations. • PwC/PIC organised pre-site visit discussions with selected services. • PwC/PIC scheduled in-depth site-visits with 14 services • Review teams delivered a one day consultation with 14 services (or a 2-4 hour virtual consult if site visits were not possible due to COVID-19). • Consultation included; - a review of current quality and safety practices at the service and provider level. - interviews with key staff about what additional measures would help to enhance and maintain quality and safety at the service and any impediments to service quality and safety.	• PwC/PIC developed individual service reports for the 14 selected services • PwC/PIC developed a draft aggregate report (this document), including key findings and short-term and medium-term recommendations for DESE to consider. • Delivery of final aggregate report

**Note: Desktop diagnostic reports were not completed for four CCCFR services that are not regulated under relevant State/Territory regulations or the NQF as these services were not operating at the time of assessment.*

3.2 Approach to the desktop diagnostic reports

In order to inform the desktop diagnostics and overall approach to the review, PwC/PIC and DESE undertook a number of co-design sessions to develop a framework in order to consistently assess and review the quality and safety of CCCFR services. These co-design sessions also involved an external subject matter expert on quality and safety in child care settings, appointed by DESE to assist with the review.

The key issue that emerged in these co-design sessions was the lack of detailed information provided to CCCFR services that are not regulated under the NQF or State/Territory regulations, on the minimum quality and safety requirements that these services need to meet. The only quality and safety requirements that apply to these services are set out in the Minister's Rules and CCCFR Funding Agreements, but the level of detail in these documents on how the requirements should be applied in practice is limited. For example, the Minister's Rules require that the provider must deliver 'high quality child care' and ensure children are 'adequately supervised at all times' but do not specify required staffing ratios or qualification requirements. The Minister's Rules and CCCFR Funding Agreements do not require that services work towards the NQF.

As such, PwC/PIC and DESE co-designed a review framework that was informed by the high level requirements in the Minister's Rules and CCCFR Funding Agreements and used information collected through the CORs and QIPs that are indicators or 'proxies' to determine where possible whether services were likely to be meeting the requirements. The site visits would then build on this information obtained through desktop review by collecting more detailed information on how services are implementing the high level requirements in the Minister's Rules and CCCFR Funding Agreements in practice, and to identify any barriers as well as measures to strengthen quality and safety.

Through the co-design sessions with DESE, it was determined that the purpose of the desktop diagnostic reports were to:

- Identify the types of data that Department of Education, Skills and Employment (DESE) currently collects that are used or can be used to assess and monitor the quality and safety requirements of CCCFR services, and other available information that could relate to the services' overall 'quality and safety profile'.
- Make an initial assessment (based on available data) as to whether CCCFR services are likely to be compliant with quality and safety requirements in the CCCFR Funding Agreements and the Minister's Rules. Where data does not exist, highlight these information gaps for further consideration during an in-depth site visit.
- Based on the initial assessment, identify up to 14 services that would benefit from an in-depth site visit.

The approach that PwC/PIC took to the desktop diagnostic review is set out at a high level on the next slide.

3.2 Approach to the desktop diagnostic reports (con't)

1. **Determine the criteria used to review the quality and safety of child care services**
   As agreed with DESE, the criteria were drawn from the safety and quality requirements set out in the Minister's Rules and CCCFR Funding Agreements.

2. **Agree on available data sources**
   DESE provided available data sources that could inform the desktop review. The diagnostic reports are based on information from 2019-20 Compliance and Operations reports (CORs), 2019 Quality Improvement Plans (QIPs), 2019-20 Budget and Business Planning Tools and the DESE's Serious Incident Register. Note that all of these data sources are based on self reported data from services.

3. **Determine which questions are "critical" to assessing whether services are likely to be meeting quality and safety requirements**
   We agreed with DESE a subset of the questions that would be defined as critical. Using available data, we assessed if the service was likely to be meeting the requirements. Note that for a number of critical questions there was no data available. These critical questions are set out on the right hand side of this page.

4. **Provide a rating for each service**
   Based on available information, each service is assessed to have a amber or green rating:
   Amber - Based on the available information and assessment of the service against its compliance requirements, further review is recommended
   Green - Based on the available information and assessment of the service against its compliance requirements, service appears to be compliant
   Note services who were reported to be on DESE's Serious Incident Register are automatically determined to receive an 'amber' rating.

Quality-related compliance questions that were treated as being "critical":

- *Is the service committed to high quality child care?*
- *Is the service equipped to provide high quality child care in terms of:*
  - *having adequate supervision?*
  - *having precautions to protect children from harm or injury?*
  - *having at least one staff who holds an approved first aid qualification being present at all times that care is being provided?*
- *Does the service collaborate with relevant agencies to improve early childhood development and meet the needs of vulnerable or disadvantaged families or communities?*

Safety-related compliance questions that were treated as being "critical":

- *Does the service comply with all applicable WHS legislative and regulatory requirements?*
- *Does the service comply with WHS laws in terms of:*
  - *reporting a notifiable work health and safety incident to the regulator in accordance with timing and notice specifications?*
  - *providing written notice to the Secretary within 24 hours of receipt of any notice or correspondence in relation to WHS laws?*
  - *providing a copy of its work health and safety management plans and processes, when requested?*
  - *complying with all applicable WHS laws and directions, including when using Commonwealth's premises or facilities?*
  - *complying with all applicable WHS laws and directions, including when using Commonwealth's premises or facilities?*
- *Does the service have appropriate arrangements to manage serious incidents?*
- *Where there has been a serious incident occurring or when circumstances could have resulted in a serious incident, did the service notify the Secretary in writing within 24 hours?*
- *Do the service staff have appropriate Working with Children Checks?*

3.3 Approach to the in-depth site visits

After the desktop diagnostics were completed, 14 services were selected for a site visit. This was based on factors such as:

- Service jurisdiction
- Provider type
- DESE serious incidents register
- Assessment ratings of desktop diagnostics
- Information on critical incidents and other safety or quality related issues that have been identified from the desktop review
- Consultation from DESE's Funding Agreement Managers.

The purpose of the in-depth site visits were to:

- Gather detailed information to understand how CCCFR services that are not regulated under relevant State/Territory regulations or the NQF are implementing the quality and safety requirements in the Minister's Rules and CCCFR Funding Agreements, particularly where the desktop diagnostic identified a gap in information about the service's quality and safety practices and policies.
- Identify any key differences between quality and safety elements of a service regulated under the relevant State and Territory regulations or the NQF, compared to services that are not regulated under the relevant State and Territory regulations or the NQF.
- Identify areas where the service is unlikely to be meeting quality and safety requirements and understand any barriers to quality and safety at the service.
- Identify measures that could help to enhance and maintain quality and safety at the service.

The approach that PwC/PIC took to the in-depth site visits was co-designed with DESE, and is set out at a high level on the next slide.

3.3 Approach to the in-depth site visits (con't)

Inputs involved in the planning and preparation of in-depth site visits:

1. Consultation guide

A consultation guide was developed to:

- Provide site visit teams with a framework for collecting information
- Provide a detailed set of questions to help guide the discussion with service providers and service staff
- Ensure consistency in the approach taken by each of the visit teams to conducting and capturing information from the site visits.

2. In-depth service report template

An in-depth service report template was developed to:

- Summarise key findings from each site visit
- Provide the service with a summary of the key strengths and areas of improvement that were identified from the site visits, and any critical risks that may require DESE to follow up
-

3. Pre-site visit briefing for site visit representatives

A pre-site visit briefing / training session was conducted for site visit team (which included representatives from PwC/PIC/DESE and subject expert matter consultant) to:

- Confirm guiding principles of the site visits
- Confirm the roles and responsibilities of site visit representatives
- Understand the key documents relevant for the site visit

4. Pre-site visit briefing for provider representatives

PwC/PIC had teleconference calls with the relevant representative from the provider to:

- Introduce the relevant PwC/PIC/DESE site team members
- Provide an overview of the purpose and objectives of the site visit
- Acknowledge any sensitivities that the site visit team should be aware of before the site visit
- Communicate any documentation that may be required from the provider/service in advance or during the site visit
- Agree the logistics of when/where the site visit will take place
- Answer any questions regarding the site visit.

Site visit with services

The site visit consultation involved five key areas:

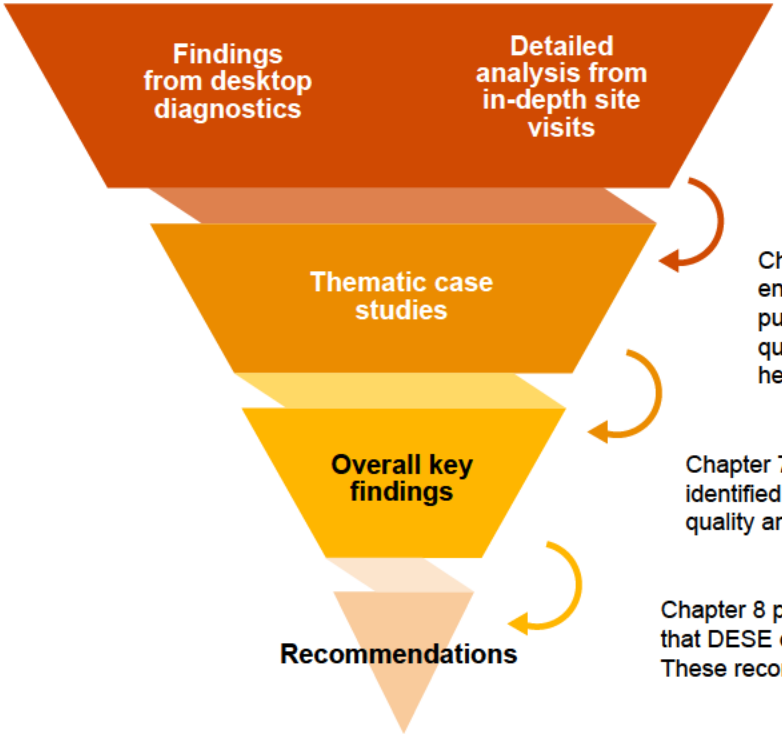
- Building rapport and providing context
- A tour of the service
- Discussion with service provider representative
- Discussion with service staff
- Wrapping up and next steps

The site visit team asked questions about the following key safety and quality areas:

- Service context and governance
- Awareness of Minister's Rules and CCCFR Funding Agreement
- Approach to providing high quality early childhood education and care
- Child safety and protection
- Workplace health and safety
- Transport and excursions
- Serious incidents
- Staff arrangements and supervision.

3.4 Overview of the approach to generating overall key findings

The figure below provides an overview of the remaining chapters and how the insights from desktop diagnostics and in-depth site visits have been analysed to form thematic case studies, helped identify key findings and finally provided a basis into making recommendations that DESE should consider going forward.



Chapter 4 outlines the key findings from the desktop diagnostics. These findings were originally presented in a preliminary report which outlined findings from the desktop diagnostics and provided guiding factors to support DESE to select services for in-depth site visits.

Chapter 5 outlines detailed analysis of the in-depth site visits. It is structured against each quality and safety focus area that underpinned the consultation guide and individual service reports.

Chapter 6 outlines a number of thematic case studies which highlight how environmental/contextual factors interact with service's quality and safety practices. The purpose of the case studies is to detail how these factors may have an impact on the quality and safety of services, and how some services are adopting tailored solutions to help manage the identified challenges.

Chapter 7 summarises the key findings from the in-depth site visits, based on the identified analysis and thematic case studies. These findings intersect across multiple quality and safety focus areas or have broader sector implications.

Chapter 8 provides a series of short to medium and long term recommendations that DESE could consider as the regulators of CCCFR services going forward. These recommendations are based on the key findings of the report.

4

Key findings from desktop diagnostics

4.1 Key findings from desktop diagnostics

Only some questions had enough data available to ascertain the quality and safety of services against the Minister's Rules and Funding Agreements.

Of the 37 questions from the desktop diagnostic which explore the compliance requirements under the Minister's Rules and Funding Agreements with service, only five questions had enough available information^ to provide insights into the quality and safety of services. More detail regarding these five areas is summarised in the following two pages. Please note that the analysis in these slides relates to the 55 CCCFR services that are not regulated by States/Territories or under the NQF.

Adequate supervision requirements

- 42/55 services received an amber rating for this question based on their self-reported impact of staffing issues being 'medium' (15 services), 'high' (19 services) or 'very high' (8 services).
- Some services provided additional information in QIPs which validated that they had practices in place to provide adequate supervision, for example: one QIP included that the staff practice maintaining correct educator to child ratios at all times s 22 , rated as 'very high' impact)
- In other instances QIPs identified that there were immediate concerns related to adequate supervision, for example: one QIP reported that the service had identified a need to improve educators' supervision of children "to be aware of all children and what they are doing" and that training is required for staff to know the required supervision levels (s 22 , rated as 'high impact')
- There is no guidance within the CORs on how services should rate their staffing issues. It appears that this rating is not currently a good indication of whether adequate supervision is being provided. As the information contained within QIPs in this area is highly variable, it is not possible to use QIPs as an alternative proxy. It is noted that when services supplied it, some valuable information about adequate supervision was identified.

Having at least one staff member present at all times who has a First Aid Certificate

- 41/55 services received an amber rating for this question based on having at least one staff member who did not have a First Aid Certificate. Of these services, 28 had less than or equal to 50% of staff who had a First Aid Certificate.*
- 5 services reported having no staff member with a First Aid Certificate.
- The requirement in this case is for services to ensure that there is at least one person with a First Aid Certificate present at all times while care is provided. From this response it is difficult to define what number or proportion of staff is sufficient to ensure this is achieved. While it is clear that services who had no First Aid Certificates cannot meet this requirement, other services with only one staff member may also be unable to meet this if that staff member is not present.
- In addition, as this information is reported at a point in time it is difficult to determine that service has a process/policy for ensuring that a present staff member at all times has an appropriate First Aid qualification.

*note one service did not provide information on First Aid Certificates.

^from Compliance and Operations reports, Quality Improvement Plans,Budget and Business Planning Tools and the DESE Serious Incident Register.

4.1 Key findings from desktop diagnostics (con't)

Only some questions had enough data available to ascertain the quality and safety of services against the Minister's Rules and Funding Agreements.

Transport and Excursion policies

- There is no Minister's Rule or Funding Agreement requirement for services to have a Transport and Excursion policy and as such services were not rated 'amber' or 'green' based on their response to this question.
- 21/55 services reported that they do not provide private transport including taking children on excursions and as such were not required to answer the transport and excursions policy question in the CORs.
- A small number of these services provided additional information within the question 2K* of the CORs which indicated that they provide a pick-up/drop-off service which appears to contradict the response to question 2C*.
- A larger number of services provided additional information in their QIP which made reference to taking children on excursions. For example: one QIP included that children have options to undertake spontaneous excursions including bike riding around the community throughout the day and during these times children are given the option to stay in the centre for sleeping/rest instead of attending the excursion s 22
- We note that the wording and conditionality of the questions in the CORs may be suggesting to service providers that a Transport and Excursions policy is only required if the service provides private transport (eg. a bus). In many remote services excursions may be undertaken by walking and service providers may not currently be aware that an excursion policy should be in place for these types of excursions.

Work Health and Safety

- 53/55 services reported that they comply with all applicable WHS legislative and regulatory requirements.
- Of these 53 services, 11 provided no explanatory text related to how they comply with these requirements.
- The large majority of services provided no information regarding the four key areas of WHS required in the Minister's Rules.
- Despite this question being included in the CORs a lack of explanatory information or additional questions has made it impossible to be confident of services's self-reported compliance with these conditions.

Staff qualifications

- There is no requirement in the Minister's Rules or Funding Agreement requirement for services to have a certain level of qualified staff.
- 32/55 services reported that less than or equal to 50% of their staff had early childhood or education related qualifications.
- Services also reported the proportion of their staff who are studying qualifications in early childhood or education.However it is noted that it is not possible to identify which staff are both qualified and/or studying to become qualified from the CORs report.
- In some services it appears that staff who are already qualified may also be engaged in studying further qualifications. It is not possible to identify if unqualified staff are becoming engaged in study which may be a challenge for tracking improvement in this area.

Question 2C: Does your service access or provide private transport to children or families, including taking children on excursions? And Question 2K: Does the service provide flexible support to meet the needs of families in the community and address barriers to child care participation?

4.1 Key findings from desktop diagnostics (con't)

A review of available data reveals that services are interpreting key requirements from the Minister's Rules and Funding Agreements very differently.

Two examples of how services have interpreted the Minister's Rules and Funding Agreements include:

1. Commitment to high quality child care

'High quality child care' encompasses broad topics in Minister's Rules or Funding Agreements. As such, it appears that services have defined this to mean a variety of things. Some common themes reported by the services include:

- High quality is defined to be the application of the NQF: In many of these cases services have then rated themselves as "working towards", particularly in instances when it appears that the service has a good understanding of what the NQF requirements are. We have rated these services as 'amber' however in some cases it appears that these services may have a better understanding of quality child care than other providers who have rated themselves as 'yes' using an alternative definition or without a demonstrated understanding of the NQF requirements.
- High quality is related to educational programming, tailored education and/or cultural appropriateness of the education.
- High quality is related to children's holistic health (nutrition, medical, hygiene, sleep etc).
- High quality is related to children's safety including protection from harm and hazards.

2. Children's Health and Safety

- Information to answer the desktop diagnostic question of *"Is the service equipped to provide high quality child care in terms of: having precautions to protect children from harm or injury?"* Is not provided in the CORs, as such this information was sourced predominantly from the QIP, Quality Area 2 - Children's Health and Safety.
- Responses by services in Quality Area 2 of the QIP reflected that a large number of services had a commendable focus on children's health including the provision of healthy food, dental/hand/face hygiene, sleep routines etc.
- Significantly less services addressed safety issues including hazard identification and removal, Child Safe Standards, First Aid arrangements, sign in/out procedures, emergency management etc.

Other findings include

- A small number of QIPs identified immediate safety and quality concerns (at the time of reporting). These related to the presence of physical hazards or staff being unable to provide adequate supervision.
- The QIP template is lengthy, and for services that used this template, many were incomplete and/or had high level information which was not sufficient to determine if the services are providing quality and/or safe services in line with the Minister's Rules and Funding Agreements. Some services skipped the sections related to areas for improvement.
- The desktop diagnostic identified some CORs and QIPs that are incomplete and/or have conflicting information. There may be an opportunity for DESE to review the completeness of these documents to identify services which require further review or support on an ongoing basis.

4.1 Key findings from desktop diagnostics (con't)

It was more common for the available information used to inform the assessment of SRA/NQF services to be drawn from QIPs than CORs.

Below are some key findings from the desktop assessment of the 11 SRA/NQF services.

Level and quality of information obtained through desktop review

- The level and quality of information provided by SRA/NQF services to DESE was found to be significantly different to those not regulated by a SRA or the NQF. Examples include:
  - No SRA/NQF services were included on the DESE serious incident register, although it is noted that some of these services may have reported incidents via their regulatory authority which would not be captured in the DESE register.
  - SRA/NQF services provided significantly more information in QIPs which was useful in informing the desktop diagnostic. SRA/NQF services generally completed their QIPs using the ACECQA template and all sections including opportunities for improvement were usually completed with significant explanatory information including detail about how they meet quality and safety requirements.
  - This compared to the CORs, where for services that are regulated under the National Law/National Quality Framework, the COR template directs services to skip questions 2B to 2H resulting in less information being available for these services from the CORs.
  - Two NQF services provided no information for nine critical questions (out of a possible 14 questions). These two services only provided information for one safety related area.

Similarities and differences between the cohorts of services

- While many of the services experience similar challenges in providing high quality child care (e.g. recruitment and retention of suitable qualified staff), a key difference observed is that SRA/NQF services were more likely to have documented strategies to manage these challenges and maintain quality and safety at their services within their QIPs.
- An example of this was five (45%) of the SRA/NQF services reported having staffing issues of medium, high or very high impact and were rated amber for the adequate supervision quality area as a result. This compared to 42 (76%) services that are not regulated by an SRA or the NQF that reported similar staffing issues. Examples of the additional information provided in QIPs by SRA/NQF regulated services includes;
  - s 22 reported that it maintains educator to child ratios within Quality Area 2 of its QIP, and
  - s 22 reported that all indoor and outdoor areas are always supervised and that the level of supervision is adjusted depending on the group of children within Quality Area 2 of its QIP.

5

Detailed analysis from in-depth site visits

5.2 Detailed analysis of in-depth site visits

There was a low level of awareness of Minister's Rules as most services reported focussing on working towards the NQF.

Awareness of Minister's Rules and CCCFR Funding Agreement

- While most services understood that they are exempt from certain standards, such as the NQF, most could not play back the specific requirements in the Minister's Rules and CCCFR Funding Agreement. Common responses as to why this was the case included:
    - Services noted that they were focussing on working towards the NQF
    - A recent emphasis on the NQF at CCCFR conferences had led to some confusion about what requirements services are required to meet.
- In one case, a service's incorrect understanding of the requirements for staff to commence study in ECEC within six months of employment had possibly led to long-term staff leaving the service as this was seen as a barrier to employment.
- Some services reported that they found the requirements in the Minister's Rules too "high level" to guide practice and given that services are not required to implement the NQF these services found it hard to understand what minimum standards they should be implementing.
- Despite the low level of awareness of service requirements under the Minister's Rules, it was clear that many services were committed to working towards the NQF. These services were at different points in their implementation of the NQF. Some examples of indicators that could be seen as enablers or barriers to meeting the NQF include:
    - Reported enablers
        - Linking policies and procedures to NQF Quality Areas
        - Undertaking programming activities (e.g. reporting observations in child portfolios, staff having frequent planning times to undertake programming).
    - Reported barriers
        - Not having a purpose built building / physical environment that would meet the NQF
        - Not being able to meet staff qualifications, particularly for remote services who experience challenges attracting and retaining qualified staff.

5.2 Detailed analysis of in-depth site visits

While most services have a good understanding of what is involved in providing high quality care, all recognise the opportunity for staff to undertake more training to be better able to deliver high quality.

Approach to providing high quality early childhood education and care (1/2)

- Across all services, most identified at least one component of 'high quality care' as outlined in the Minister's Rules:
  - **Providing tailored educational program that meets the needs and interests of children** - Many services reported that this is often achieved through programming, which services currently undertake to varying degrees. For example, some services may be undertaking this informally by noting child interests or having a high level routine, while others record observations in child portfolios and link these to educational outcomes to develop extension activities. Further detail on programming is described in Section 6.5 - Case study 4.
  - **Providing a service and educational program that acknowledges and strengthens the cultural identity -** Many services provided examples of how they consider the cultural identity of children and how they operate within the service's cultural context, most commonly through its engagement with families and the local community. Examples include employing local staff, having relationships with community Elders, having cultural activities embedded in the curriculum and involving families in the child's education journey.
  - **Providing adequate supervision -** Most services reported that having adequate supervision was an important component of delivering high quality care. Most defined this as meeting educator and child ratios, where possible, as reported under the NQF. Many services had strategies in place to ensure children were being supervised at all times, in some case services identified this as an area for improvement.
  - **Protecting children from harm or injury -** Most services reported that meeting children's basic needs, such as keeping them safe, was part of their understanding of what it means to deliver a high quality service. Services reported that this involved providing a safe and secure physical environment. Additionally, some services also noted that meeting the needs of children also involved providing them with healthy foods and ensuring that they are well fed.
  - **Having at least one staff member who holds a current approved first aid qualification -** This component of 'high quality care' was reported less frequently among services. However many did note that they provide First Aid training for their staff.
- Many services also demonstrated their close links and partnerships with the broader community, such as providing referrals to social services, having occupational and speech therapists attend the service etc. Only two services identified opportunities where access to additional supports and / or engagement with community could be strengthened.

5.2 Detailed analysis of in-depth site visits

While most services have a good understanding of what is involved in providing high quality care, all recognise the opportunity for staff to undertake more training to be better able to deliver high quality.

Approach to providing high quality early childhood education and care (2/2)

- Some services reported that having qualified staff is an important aspect of delivering a high quality service. For example, some services require that all staff must hold, or be studying, a Certificate III qualification (noting that one service misinterpreted this as a requirement that it must meet under regulations). However, other services also reported that having qualified staff can be considered more broadly, where the experience of an educator is also important. For example, educators who have been in the sector for a long time, understand the local community and 'enjoy coming to work' were noted as important factors.
- Nearly all services reported updating their QIPs at least yearly. Some services reported that QIPs are seen as a dynamic document which are often revisited or edited with staff (e.g. at team meetings).
- When asked about how they implement quality and safety measures, staff rarely referred to relevant policies and procedures. This was more often observed when speaking to management or provider representatives. However, some services did describe practices that help to increase the awareness of policies among staff, including:
    - Having staff read, understand and 'sign off' on policies that have been recently updated
    - Using staff meetings as an opportunity to 'refresh' staff on key policies
    - Involving staff in the review and implementation of new policies to ensure they are fit-for-purpose
    - Having visual reminders (posters) and using simple mottos to remind staff of important key practices (e.g. supervision mottos)
    - Many services reported that they are in the process of undertaking a review of policies and procedures to ensure they are up to date
- Almost all services identified that they would benefit from more training. Some common examples identified by services include:
    - Strengthening cultural competency of staff (e.g. cultural safety, learning local language)
    - Strategies for managing challenging behaviours in children or children with additional needs
    - Work Health and Safety injury prevention and management
- Some services reported barriers to accessing training, most commonly due to staff shortages (e.g. not having enough staff to cover for those attending training) and cost of training for remote services who need to travel to attend training.

5.2 Detailed analysis of in-depth site visits

Opportunities relating to service's sign in / sign out process, as well as safety improvements to its physical environment were commonly reported during site visits.

Approach to child safety

- Most services reported that they have processes and procedures in place to manage risks associated with child safety, such as daily safety checks, having regular maintenance of equipment, keeping gates locked / spaces enclosed where appropropriate and processes to deal with hygiene related issues (e.g. toileting, nappy change and soiled items). This was often supported by sighting instructional posters that services had around the service, however, for some services, there was an opportunity to have more posters displayed to improve the understanding of child safety of staff or other visitors (e.g. parents who frequently attend the service).
- Opportunities relating to strengthening service's sign in / sign out process were identified in approximately half of the site visits. The most common opportunities involved:
    - Services having to remind parents to sign in / sign out children. Services reported barriers including parents not needing to sign in / sign out during COVID-19, parents having low literacy skills, experiencing technical difficulties with the sign in / sign out software or the process not being culturally appropriate for families.
    - Recording who picks up a child and / or having a list of people who are authorised to collect each child from the service/bus drop off.
- The large majority of services reported some level of constraint relating to their physical environment, most commonly:
    - Not having a purpose-built facility
    - Not having enough outdoor / indoor space
    - Other physical safety risks (e.g. fencing issues, not having enough shade, asbestos, vandalism, other equipment or furniture requiring maintenance or upgrades)

  While most services were able to describe how they have managed or adapted their space (e.g."making it work the best we can"), some reported that this was a key barrier in being able to grow the service and delivering a safe and high quality service for children.

5.2 Detailed analysis of in-depth site visits

Some services reported that they experience challenges in meeting mandatory requirements as there are often cultural sensitivities to consider for local educators in the community.

Service responsibilities in keeping children safe from abuse and neglect

- Many services reported a good understanding of responsibilities in keeping a child safe from abuse and neglect, including:
  - All staff having appropriate Working with Children checks
  - Staff completing completing child protection and safety training
  - Working with other relevant agencies and support services to support families with issues of child abuse and neglect
  - Understanding the type of cues to look for in children and having a process to record observations
- Opportunities relating to strengthening services' processes around mandatory reporting requirements were identified in half of the site visits. The most common opportunities involved:
  - Gaining better alignment between service policies and practices relating to mandatory reporting requirements (e.g. through refreshing on policies or providing more training for staff / families)
  - Having staff understand what would constitute an observation that required mandatory reporting
- The reported challenges that services experience with addressing child protection and keeping children safe from abuse and neglect is often specific to its operating context:
  - Some services deal with this issue more than others. This has meant some services have developed good working relationships with the relevant Department of Child Protection / Territory Families, community Elders and other social services to help them manage any concerns. However, one service noted that Territory Families do not routinely visit the community to work with or observe children and families which places a greater burden on the service to report concerns.
  - Some services reported that staff can be reluctant to undertake mandatory reporting as they may experience backlash from the local community if action is taken to follow up the report. To address this, some services noted that staff can inform higher management about their concerns, or have other methods in terms of engagement (e.g. talking to community clinic or providing early intervention support to families to avoid the need to make a formal report).

5.2 Detailed analysis of in-depth site visits

Services broadly reported having good policies and procedures in place to deal with Work Health and Safety, however some improvements such as having regular training and reminders were identified.

Workplace health and safety (WHS)

- Services reported having various initiatives and / or policies and procedures in place to ensure there is a safe working environment. Some common processes include:
  - Approximately half of the services reported that they have a WHS officer (or similar) or are in the process of having a member of staff trained and qualified as a WHS officer
  - Having WHS as a standing agenda items in staff and / or board meetings to raise and address any related issues
  - Creating a working environment that is free from bullying and workplace harassment (e.g. open communication, staff feeling comfortable to report any issues to management)
  - Staff knowing how to undertake child lifting and manual handling, and having appropriate equipment to support this (e.g. installed steps up to nappy changing station to prevent back strain).
- Common elements that services identified to improve WHS processes include:
  - Having regular WHS training for staff (e.g. beyond initial staff induction)
  - Having a better understanding of WHS notification requirements to DESE
  - Having more posters and reminders around the service to support staff to implement safe practices.

5.2 Detailed analysis of in-depth site visits

Most services have established routines in place to manage the safety of children when using a bus but there were opportunities to strengthen these processes to ensure children are never left alone on the bus.

Transport

- 10 services reported that they offer some form of transport (e.g. bus pick-up, bus drop off and / or transport to and from excursions).
- Managers and staff of most services who provide a pick-up and drop-off service for children on a regular basis were able to explain details of established routines to manage the safety of children. These included elements such as:
    - Two staff undertaking transport at all times to ensure that one staff member is always seated in the back to supervise children
    - Having age-appropriate car seats for children and ensuring that each child's seatbelt is buckled by an educator
    - Having regular maintenance of all vehicles used to transport children
    - Undertaking headcounts of children when leaving the building, getting onto and off the bus
    - Ensuring the bus is parked at a safe location for children when being picked up
    - Routines for children including one educator driving the bus and the other walking to the bus with children in two lines, holding hands and waiting for the bus to be stationary before opening a gate to exit.
- Opportunities to improve the safety of transport provided included:
    - Taking a list of children who are on the bus and using this list to sign children in and out of the bus.
    - Checking the bus prior to closing it up after use to ensure no children are left inside. It is noted that around half of services reported doing this as part of their regular process, however approximately 50% of service staff only said they did after being prompted. In these cases, it was less clear whether this was something that was regularly completed and/or that service staff understood the need to thoroughly check in case children were still on the bus without the educators knowledge (for example asleep, hiding etc).
- Elements that services identified for improvement include:
    - Two services identified that they did not have a suitable location for storing the bus. In one case the service stores the bus inside the outside play area as the other bus parking is not secure and in the other case the bus is parked in an uncovered area resulting in it being dangerously hot during summer.

5.2 Detailed analysis of in-depth site visits

More than half of services reported that they do not currently undertake excursions, most commonly due to staffing shortages.

Excursions

- Eight services reported that they do not currently undertake excursions. Of these, five services have put excursions on a temporary pause. Reasons for not undertaking excursions included:
  - Not having enough staff to take children on excursions (most services reported having higher staff to child ratios when on excursions to ensure greater supervision)
  - Management not having sufficient confidence in staff supervision skills to maintain safety while on excursions
  - Not having safe locations within the community to go on excursions
  - Excursions not being required as children have opportunities to explore the natural outdoor environment at the service.
- Of the services who reported taking children on excursions, some reported taking children on 'spontaneous' excursions. These excursions were always to places within the community (e.g. the local park). Strategies that services used to manage these spontaneous excursions varied and included:
  - Undertaking a rapid, verbal risk assessment prior to departing the service including designating roles and responsibilities and collecting supplies for the 'excursions bag' which are always ready to go
  - Taking children on the service bus and not leaving the bus (i.e. allowing children to just look out the windows of the bus)
  - Having a set of standing risk assessments for places in the community that staff can take children to and limiting excursions to only these locations
  - Having routines in place including children wearing high visibility vests and using a lead rope to walk with children.
- Services that undertook planned excursions reported completing full risk assessment processes including having these risk assessments approved by management prior to departing on an excursion and a full suite of safety practices in place including the provision of supplies, safety checks and a list of children attending the excursion. These services usually also gained specific parental consent for each excursion which was usually in addition to standard consent provided on an enrolment form.
- Opportunities to improve the excursions process for some services included:
  - Designating staff roles and responsibilities including potentially designating a smaller group of children for staff to be responsible for supervising while on excursions.
  - In services where spontaneous excursions occur, creating a list of standing approved risk assessments and associated procedures to ensure safety and limiting excursions to these locations.

5.2 Detailed analysis of in-depth site visits

Overall, there were common opportunities for services to refresh their understanding of what would constitute a serious incident and awareness of the reporting requirements.

Serious incidents
• Services most commonly reported that they understood a serious incident to have occurred if a child had died, was seriously injured or required medical treatment while at the service. Services less commonly reported that a child going missing, being locked in any area while unsupervised or escaping from the service would constitute a serious incident, however when prompted all services agreed that these circumstances would be a serious incident. • Additionally, very few services reported having an understanding that a circumstance which could have resulted in a serious incident (i.e. a near miss) was required to be reported. When prompted, many services found the definition in the Minister's Rules to be unclear and were unsure what the threshold would be for reporting of a near miss. • Eight services reported being unclear about when they were required to report incidents. For example, some services reported that they would report to the State/Territory regulator, while others reported that they knew they had to report to DESE, but were unsure of the process to do this or who to contact. Some services were also unaware of who their DESE Agreement Manager was. • Services that had not experienced a serious incident often struggled to consider how they would respond in the circumstance of an incident and/or reported statements such as "that just couldn't happen here" when asked about circumstances such as losing a child or even accidentally gaining an additional child while on excursion. While these statements demonstrated that services are confident in their safety protocols it did raise concerns about service's ability to respond to a serious incident if one was to occur, particularly in services where other opportunities for improvement in supervision, sign in/sign out processes or transport and excursion processes were identified. • Staff often indicated that they would undertake a headcount of children to ensure all children are present but rarely reported cross checking a list of children's names to ensure that the correct children were in attendance. This was particularly concerning given that two of the 14 services reported that they had experienced a situation where additional children had been picked up on an excursion by mistake and given that the majority of services experience significant variability in the children who attend on a day to day basis. • However, some services who have recently experienced a serious incident showed the measures they have since put in place to prevent a similar incident from occurring again. For example, one service reported that it has updated the relevant policy and re-trained staff on the changes.

5.2 Detailed analysis of in-depth site visits

It was common for services to report challenges in attracting and retaining qualified staff, which has implications for service operations and the overall quality of care.

Staff arrangements

• Most services knew who the nominated supervisor was and were able to articulate the responsibilities of this person in maintaining day-to-day operations, keeping staff and children safe and managing any serious incidents if required. In one case the service provider (who was not located at the service site) identified themself as the nominated supervisor but was still able to identify who at the service was in day-to-day charge of the service.
• Services reported various arrangements for conducting a handover (including some written handovers, most a verbal handover) to a second in charge who would be the nominated supervisor if the regular supervisor was away. Some services reported that they would have a different staff member from out of the community come to the service to act in the position. In some services it was identified that there was no second in charge who could act as the nominated supervisor and in these cases the regular supervisor was under significant pressure not to take leave (including sick leave) as this would result in the service needing to close.
• Services frequently reported that staff attendance at work was unreliable and this impacted upon service's ability to maintain staff to child ratios.
• Many services described their challenges related to attracting and retaining qualified staff. Services reported that this is currently a sector-wide issue. For services in remote communities, some also reported that this is also due to a lack of available housing and accommodation for educators who relocate into the community. The majority of services indicated that having sufficient staffing was the biggest impediment to them providing adequate supervision.
• Almost all services in remote communities reported challenges in supporting local staff to complete qualifications in early childhood education and care. Most often this was due to challenges in staff being required to travel out of the community to complete intensive study blocks or placements. Some services also reported that staff find it hard to study at home and need time during the work day to complete study which cannot always be provided.
• Services reported that not having enough staff has resulted in:
  ○ Not going on excursions (as services want to have higher educator to child ratios to manage risk)
  ○ Staff not having time to improve 'quality' related aspects of their service as they are predominately focussing on ensuring child safety (e.g. implementing programming, updating and reviewing policies regularly)
  ○ Services had mixed responses when it came to having staffing constraints affecting service accessibility, where:
  ■ One service reported they would close the centre if they had staff shortages
  ■ Some services reported that they have an open door policy, but require support from mothers/guardians to supervise their children.

5.2 Detailed analysis of in-depth site visits

Services were able to demonstrate a wide range of supervision strategies, however having sufficient staffing was seen as a key barrier to providing adequate supervision.

Staff supervision

- The majority of services reported having strong behaviours in place which ensured supervision of children, these included:
  - Using simple phrases and mottos to remind staff of what good supervision is (e.g. “watch, engage and keep them safe,” “no turning backs” and “no phones at work”)
  - Encouraging staff to communicate constantly throughout the day to ensure that other staff can step in to supervise at all times if required
  - Having routine ‘positions’ that staff take around the indoor or outdoor space to ensure they can see all children and one another
  - Being aware of the room dynamics and managing their space (e.g. if there are sleeping children, staff would only use indoor rooms, if there are a high number of children on a given day, the staff would only open certain spaces to make it manageable)
  - Encouraging active supervision in the form of playing with children and encouraging children to take part in activities.
- The majority of services indicated that having sufficient staffing was the biggest impediment to them providing adequate supervision. Four services reported that they would ask families (including one service which had volunteers) to stay with their children at the service when there were not enough staff members available at the service to supervise children.
- Most services reported adhering to some form of staff to child ratios. In some services the service operates on a standard 1:4 ratio regardless of the children’s age, in other services the service was guided by the State/Territory regulations for ratios or the NQF. Many services operate with family style groupings resulting in services who are guided by the NQF implementing a 1:4 ratio.
- Some services reported experiencing challenges in maintaining safe levels of supervision when managing challenging behaviours in children.
- Opportunities to improve supervision included:
  - Some services were unaware of industry best practice to physically check sleeping children every 5-10 minutes, introducing these checks was recommended.
  - In some services there is opportunity to provide greater guidance for educators in what good supervision is and role modelling these behaviours.

6

Thematic case studies

6.1 Overview of thematic case studies

This section outlines a number of case studies which highlight how environmental/contextual factors interact with service's quality and safety practices. The purpose of the case studies is to detail how these factors may have an impact on the quality and safety of services, and how some services are adopting tailored solutions to help manage the identified challenges.

The case studies have drawn on information from both the desktop and in-depth diagnostics however it is noted that the majority of detailed information regarding service's circumstances relies on the additional detail which was only able to be captured during in-depth site visits with services.

Note that each case study is based on general 'themes' and may be applicable to one or more services.

The next few slides provides case studies on the following factors:

1. How services are managing physical constraints
2. How services are implementing a culturally safe environment
3. How services are supporting children with additional needs
4. How services are undertaking programming.

6.2 Case study 1 - Managing physical constraints

Context

- Nearly all services reported to have some form of limitation in terms of their physical environment, such as:
  - Not having a purpose-built facility
  - Not having enough outdoor / indoor space
  - Other physical safety risks (e.g. fencing issues, not having enough shade, asbestos, vandalism, other equipment or furniture requiring maintenance or upgrades).
- Many services had reported details of these physical defects in their CORs and QIPs but had not resolved these prior to the site visit.

Strategies service has implemented / or were identified as part of site visits

- Services reported that they implement a range of supervision strategies to address physical constraints, including:
  - Ensuring staff are appropriately placed around the centre to supervise all areas that are accessed by children. This can be also be supported by instructional posters reminding staff of which positions they should cover to ensure there are no blind spots / coverage of higher risk areas
  - Staff communicating frequently and ensuring they are always able to see other staff for support
  - Understanding group and room dynamics (e.g. having certain spaces enclosed to manage sleeping children)

Identified challenges

- Most services reported that physical constraints pose additional supervision challenges to ensure children are playing in a safe and secure environment
- In some cases, services reported that they require frequent repairs and maintenance or temporary cessation of the use of certain areas to mitigate the environmental safety risks
- It can often take services a long time to rectify physical constraints due to delays in arranging tradespeople to complete the works, or having to find more funding to address the issue.
- Where defects have been reported there does not appear to be a consistent process for DESE to follow up on these, confirm that they have been addressed or understand any mitigation strategies that are in place.

Potential implications

- Services adapt their spaces to ensure there is adequate supervision and that they are not compromising the basic safety or quality of care of children. In some cases this results in services being unable to utilise parts of the service space until repairs/upgrades can be arranged.
- Some services rely on staff to implement supervision strategies specific to their context that can overcome physical constraints.
- In some instances services are unable to fully mitigate or overcome the risks posed by their physical constraints.

6.3 Case study 2 - valuing and implementing cultural practices

Context

- Most services in this review who had a primary focus on providing care for Indigenous children and families reported having a wide variety of strategies and processes in place to ensure that the services are appropriate for the community and culturally safe for staff and children. These were often reported in services' QIPs but frequently did not include details of how services were implementing strategies.
- Each Indigenous community has a unique culture and therefore what constitutes appropriate and safe service delivery is unique to each service, although there are principles which could apply universally.

Strategies service has implemented / or were identified as part of site visits

- Services that appeared to be most effective in providing culturally appropriate services demonstrated a strengths-based approach to building on the skills and cultural knowledge of staff. In these services staff were mentored to be confident leaders within the service, took on leadership roles in delivering cultural education activities for children and reported having ambitions to manage the service for their community in the future. Some things that were common in these services included:
  - The use of mottos and sayings that were easily understood by all staff including those with English as an additional language.
  - Using visual reminders and posters to highlight key messages around supervision.
  - Coaching and mentoring of unqualified staff by qualified staff in a way that built upon strengths and gave staff opportunities to succeed and grow.

Identified challenges

- In some communities, services identified key areas where Western and local Indigenous practices differed in terms of managing the safety of children. Where cultural differences emerged, the effectiveness of the culturally appropriate strategies used to navigate these differences appeared crucial in determining whether children's safety was being effectively managed.
- In some communities, managers and staff faced challenges in distinguishing that the provision of child care in the formal setting of the service requires a higher level of duty of care, compared to care provided by the community outside of the service, in an informal setting.

Potential implications

- Services that implemented strengths-based approaches accompanied by common tools such as mottos and visual reminders most often had staff who were able to confidently communicate or demonstrate quality and safety principles to the review team and usually reported taking pride in the service.
- In some services it appeared that managers, who were often from outside of the community, were not effectively and consistently engaging with local staff to work together to incorporate safety and supervision requirements and cultural knowledge and values into the way the service was delivered. In these services, managers often reported implementing rules to govern staff behaviour including 'no resting at work,' 'no going to the clinic during work' or 'tell someone when you go to the bathroom.' This did not appear to be an effective or appropriate strategy for ensuring high quality and safe supervision of children.

6.4 Case study 3 - supporting children with additional needs

Context

- Some services care for a high number of children with additional needs, including children with challenging behaviours, children with signs of developmental delay, children who are non-verbal, children with disabilities and children who require specialist services.
- In some cases services and families do not have regular access to specialist services in their remote location resulting in children being unable to access regular treatment.

Strategies service has implemented / or were identified as part of site visits

- Holding regular staff meetings to discuss and identify different strategies to manage behavioral or other issues of children of concern.
- Having open communication between staff and understanding which staff members are more experienced and can help provide additional support
- Engaging with local community and offering specialist services as part of child care (e.g. having occupational and speech therapists who visit services weekly to support children with high needs).
- Opportunity to provide staff with more training specifically related to strategies for managing children's behaviour or trauma informed care.
- Opportunity to better adapt the space - such as having enough dedicated space for educators to care for children with additional needs.

Identified challenges

- Services reported that caring for children with additional needs requires more intensive supports from staff, either through supervision and / or connecting families to the appropriate services (e.g. referrals to specialist services, helping parents understand their NDIS plans).
- Services sometimes reported that this additional support meant they take on less children to avoid placing undue pressure on staff. In other cases services reported that these behaviours impact on the level of supervision provided for other children.
- One service reported that having additional supervision in place means it is ineligible for additional staff wages support through the Inclusion Support Program (ISP) despite the service catering to a large number of children with additional needs.

Potential implications

- Services that implemented a range of internal processes combined with the support of other services were able to provide tailored support and meet the needs of all children, including children with additional needs
- Having an experienced and trained workforce is crucial to being able to create a safe and secure environment for children with additional needs.

6.5 Case study 4 - undertaking programming activities

Context

- Services are currently undertaking programming activities to varying degrees. For example:
  - Some services reported that they are undertaking this informally by noting child interests, having a high level routine, or being guided by children's interests on the day
  - Other services reported that they record observations in child portfolios and link these to educational outcomes and use them to develop extension activities.
- Where services undertook formal, documented programming this was usually reported in service QIPs however services with less formal programming practices often did not describe this in QIPs.

Strategies service has implemented / or were identified as part of site visits

- Opportunity for senior educators / team leaders to delegate tasks such as cooking and cleaning to other staff to free up more time for intentional programming at the service.
- Opportunity to incorporate staff feedback into programming, such as having a regular reflection session each week
- Opportunity to implement a culturally responsive program, such as having local staff provide input and bringing their cultural perspective, collaborating with other services who can share their programming expertise (e.g. how to incorporate activities and learnings with the changing of the seasons and other culturally significant events)
- Opportunity to explore IT solutions, which can save educators time and help streamline the approach to documenting observations.

Identified challenges

- Some services reported that time was one of the biggest barriers to undertaking more formalised programming practices. This was particularly evident from services who are experiencing staffing shortages, who need to place a greater focus on 'safety', relative to aspects of 'quality,' such as the learning and development of children.
- Some services reported that continually responding to and supporting children with additional needs often results in them being unable to provide programming for other children.

Potential implications

- Intentional programming that is culturally responsive and involves input from service staff can help with children's learning and development.
- In some services an over focus on formalised programming resulted in services not implementing the basics such as encouraging educators to offer activities to children that are aligned to their interests and developmental needs. There is benefit to implementing the basics even if services do not record this through a formal process.

7

Overall key findings

7.1 Overall key findings

There are multiple factors that have an impact on services' ability to deliver quality and safety - it's often the combination or interaction of these factors that can determine the level of risk of a service.

CCCFR services have complex environmental/contextual conditions

- CCCFR services reported experiencing multi-faceted challenges based on their operating environment, which often combine and result in challenging contexts for services to manage quality and safety. These contexts both constrain services' abilities to access the supports they need to maintain safety and quality as well as increasing the difficulty or riskiness of service delivery. A selection of these include:
  - Unfavourable climate conditions were often reported to result in additional repairs and maintenance of services being required due to weather damage and can limit the spaces that services can safely use due to extreme heat and cold. In remote communities many services reported experiencing significant delays to tradespeople being about to complete repairs.
  - Remote communities face challenges in recruiting and retaining suitable non-local staff to work in community. This results in high staff turnover and occasionally, poorly suited candidates being placed in leadership roles of services. This is coupled with challenges in supporting local staff to undertake training and qualifications and grow their skills. In some communities, challenges related to staff absenteeism may make it unviable for services to operate with a 100% local workforce.
  - The communities who use these services are often vulnerable and disadvantaged, resulting in higher incidences of additional needs in children and families requiring more wrap around support services to support their wellbeing. In some communities wrap around supports are not readily available, which increases the burden on service staff to respond to these needs.

Inconsistent management capability and consistency

- Many of the services included in this review reported experiencing high staff turnover including in their management staff and/or had management personnel who were new in the role (less than 12 months). Services with relatively newer management personnel were more likely to report confusion in understanding the requirements of the Minister's Rules. Those who were well informed appeared to have close working relationships with their Agreement Manager, who may have supported them to gain this understanding.
- There was a spectrum of experience in Management personnel which often included deep experience in the child care sector but less often included experience working in remote contexts and/or working with Indigenous communities. Services that appeared to have the strongest safety and quality practices had often achieved a balance of this skill set and experience in its teams. This enabled staff to combine their knowledge of up-to-date guidance and best practice in child care with contextually relevant information, to implement policies and practices which appeared to be effective and aligned to community expectations.
- Services who had consistent management with deep remote context experience appeared in some cases to be lacking up-to-date knowledge of child care best practice and/or the ability to implement this in a remote setting.
- In some services, differences in experience coupled with high staff turnover appeared to have led to inconsistent and confusing messaging about the practices staff were required to implement. For example, posters and signage implemented by one Coordinator may have remained in place despite a new Coordinator commencing and implementing new practices.

7.1 Overall key findings (con't)

There are overarching factors that have an impact on service's ability to deliver quality and safety - it's often the combination or interaction of these factors that can determine the level of risk of a service.

Safety appears to be a required foundation to build quality

- From the sample of services included in this review, it appeared that services who were still working towards implementing a strong foundation of safety practices and strategies were not able to devote the time and attention required to fully implement 'quality early childhood education and care' (eg educational programming and other activities such as communications with families and referrals to additional support services). This appeared to have been impacted by:
  - On-site Managers / Coordinators being required to be present to manage safety risks at all times, which often results in them being unavailable to develop or deliver educational activities for children. Where other staff were able to undertake quality supervision of children, these staff often stepped off the floor to undertake cleaning and cooking activities, rather than programming.
  - Service staff that are working towards understanding their roles in terms of supervision and safety of children may not have been ready to start implementing educational programming for children.
  - Some services experienced challenges in implementing a routine or boundaries at the service, resulting in service staff being consumed in following children's sometimes chaotic play rather than proactively directing children toward educational activities.
  - Some service staff and Coordinators reported that it can be stressful to manage and care for children with challenging behaviours. This often meant staff did not have the capacity or time to undertake programming-related activities.

Inconsistent implementation of policies and procedures

- As part of this review, services were asked to send through safety and quality related policies and procedures ahead of the site visit. From a review of these policies*, it was noted that:
  - Policies and procedures were often very lengthy, wordy and similar between services, indicating that services may have used a common template.
  - Only one opportunity for improvement was identified - this related to clarifying whether the reported educator to staff ratio was implemented in practice
- Policies and procedures appeared in a large majority of services to have a minimal influence on the day-to-day practices of staff, with almost no staff referring to policies and procedures when speaking with the site visit team. This was more often observed when speaking to management or 'provider' representatives.
- In some services, policies and procedures appeared to contradict how things were actually performed at the service. In particular, the sign in / sign out, excursion, mandatory reporting and workplace health and safety policies frequently included clauses which staff reported were not regularly taking place at the service. While this does not necessarily mean that service practices are unsafe, it does demonstrate that services are not utilising policies and procedures to guide their work and that reviewing desktop documentation is not sufficient to determine if services are providing quality or safety.

*Note: Review of policies and procedures were undertaken at a high level. PwC/PIC team often relied on the subject matter expert to identify any obvious issues with the documents.

7.1 Overall key findings (con't)

There are limitations to reviewing quality and safety through both in-depth site visits and desktop reviews, a combined approach in conjunction with possible improvements to desktop reporting may provide DESE with greater certainty of the quality and safety of services.

Continuously evolving safety and quality conditions

- When comparing findings from the in-depth site visit to the initial desktop findings from the desktop diagnostics, it was clear the current operation of services had minimal resemblance to details reported in the CORs (2019-20) and the QIPs (2019). Services often reported that information from these reports was outdated, demonstrating how quickly circumstances can change in services, particularly those operating in a remote setting.
- Services that also experience high staff turnover or recruit non-local staff may experience greater variability in quality and safety as new staff implement different practices to manage safety and quality and handover is not always completed as it takes significant time to recruit and onboard new staff resulting in a gap between when the staff member leaves and a new staff member starts at the service.
- Given this, it is noted that site visits only provide a point-in-time view of how services are delivering quality and safety elements. Even if no critical safety risks were identified at a particular service, this may change as service conditions, staff and practices change overtime.
- As a result, this may present a risk to DESE in terms of having up to date and accurate information on the quality and safety of CCCFR services in the context of COR reporting being done once a year and site visits not being regularly and consistently undertaken.

Limitations of undertaking desktop analysis of current reporting

- The desktop diagnostic analysis found that there were some limitations in the current reporting provided by services (CORs and QIPs) which results in significant gaps in understanding the safety and quality of services when reviewing this information alone. These limitations included:
  - The QIP template is lengthy, and for services that used this template, many were incomplete and/or had high level information which was not sufficient to determine if the services are providing quality and/or safe services in line with the Minister's Rules and Funding Agreements. Some services skipped the sections related to areas for improvement.
  - The desktop diagnostic identified some CORs and QIPs that are incomplete and/or have conflicting information.
  - There are areas of the Minister's Rules which are not captured in the COR report template.
  - QIPs are not regularly requested resulting in this information often being more than 12 months old.
- In undertaking in-depth site visits with services the review team also found that information from these reports was often outdated and sometimes was not reflective of the practice that services were implementing on the ground.

7.1 Overall key findings (con't)

While desktop diagnostics revealed evidence of differences in the quality and safety of services that are regulated under SRA or the NQF compared to those that are not, this was not supported by observations made at the small sample of site visits to SRA and NQF services.

Context may be a stronger driver of safety and quality at CCCFR services than regulation

- From the small sample of CCCFR services that are not regulated under relevant State/Territory regulations or the NQF, the review has found that all services are adapting to their unique context, which has meant services are approaching quality and safety differently.
- From the two CCCFR regulated services that were visited, it is unclear whether there are key differences to how services under alternative regulations are approaching quality and safety. While both regulated services demonstrated a number of strengths, such as strong supervision practices in the SRA regulated service and good programming practices for the NQF regulated service, both services also identified opportunities to improve their quality and safety that are consistent with CCCFR services that are not regulated under relevant State/Territory regulations or the NQF. These opportunities related to creating a culturally appropriate/safe environment for staff, having better awareness of policies and procedures and/or experiencing constraints in their physical environment.
- These two visits may imply that there are sector-wide issues that all CCCFR services are experiencing and therefore related recommendations could also benefit CCCFR regulated services.

More detailed documentation supplied by CCCFR services regulated by SRA or the NQF does not necessarily translate into improved safety and quality

- The desktop diagnostics of SRA and NQF services revealed that these services often provided significantly more information in QIPs which was useful in informing the desktop diagnostic. SRA/NQF services generally completed their QIPs using the ACECQA template and all sections including opportunities for improvement were usually completed with significant explanatory information including detail about how they meet quality and safety requirements.
- In completing in-depth site visits of two SRA/NQF services it was observed that the additional information provided in QIPs may or may not be reflective of current practices in place at the services.
- The sample size was too small to ascertain all drivers of these differences. At a high level it appears that NQF and SRA services who experience similar contextual challenges in providing high quality child care as services that are not regulated by SRA and NQF (e.g. recruitment and retention of suitable qualified staff particularly in remote places), may also experience variability in quality and safety when staff turnover occurs.
- One SRA service which was reviewed appeared to have a stable workforce and management and this may have been a driver of their safety and quality practices being closely aligned to their QIP and COR. This was not observed to be the case in one NQF service where significant staff turnover had occurred.



Recommendations

7.1 Short-medium term recommendations

Based on key findings from both the desktop and in-depth diagnostics, below are a series of short to medium term recommendations that DESE could consider implementing within the next twelve months, as the regulators of CCCFR services going forward.

1

Awareness of Minister's Rules

- DESE could consider providing additional resources and improving access to existing resources to enable services to build their understanding of the minimum requirements in the Minister's Rules and the Funding Agreement, how these should be implemented and whether services should be striving to work towards the NQF.
- Consider providing additional tailored information at future CCCFR conferences to ensure services are clear on which requirements apply to them (noting that staff turnover sometimes results in staff having incorrect information about their own service's requirements).
- Consider providing more detail on how DESE expects services to implement the requirements in the Minister's Rules in remote contexts, to help services interpret and understand the rules in practice. This could include providing guidance on example policies and procedures that are appropriate for CCCFR services that are not regulated under relevant State/Territory regulations or the NQF and incorporate appropriate flexibility for services in remote contexts and operating within Indigenous communities. In compiling this information DESE could draw on best practice from across CCCFR and other remote services. This would help ensure policy and procedure documents more accurately reflect 'what is happening on the ground,' as opposed to having stock-templated policies that would be more appropriate for services that are required to meet the NQF.
- Additionally, DESE could support services to develop procedures based on the policies which staff can use to guide their day-to-day practice. This would ensure that staff are informed of policies, provide greater transparency to communities and provide consistency during handover of key roles and responsibilities.

2

Compliance and operations report template

- Consider redesigning the COR reporting template and questions to better align the information collected through CORs with indicators that services are providing safe and quality services. In redesigning the COR, DESE should consider:
  - adding specific wording to enable services to provide a more granular level of detail so that DESE can understand and assess whether the service is 'equipped to provide high quality child care'
  - requesting and assessing QIPs as part of the submission of CORs (or at an alternative regular time) to ensure services update QIPs annually, consistent with the Minister's Rules
  - requiring services to provide more data such as on management and notification processes for serious incidents (including circumstances which could have resulted in a serious incident)
  - changing the question related to Transport and Excursions. It currently assumes that if services do not provide access to transport, they should not have a Transport and Excursions Policy. This excludes services that may be undertaking excursions on foot or by other means.
  - changing the question related to staff qualifications to include whether unqualified staff are engaged in study.

7.1 Short-medium term recommendations

Based on key findings from both the desktop and in-depth diagnostics, below are a series of short to medium term recommendations that DESE could consider implementing within the next twelve months, as the regulators of CCCFR services going forward.

3

Quality improvement plan template

- Consider designing a QIP template that is shorter and more targeted to the requirements that CCCFR services who are not regulated by the NQF or State/Territory regulations are required to be implementing (compared to the comprehensive and lengthy ACECQA template that services are currently provided with but often do not complete).
- A redesigned template could be aligned to guidance that DESE may develop in line with recommendation 1 and support services to document their practice against the requirements that DESE defines.



4

Physical environment constraints

- Consider providing resources (e.g. case studies or Q&A) on common strategies that services could implement to address or overcome physical constraints in the short-medium term
- Consider having processes in place to follow-up on any physical limitations identified in service QIPs and/or CORs to ensure services understand the options available for them to resolve them (particularly where the buildings are provided by DESE).



5

Training resources

- Consider developing and providing resources that are fundamental to a service's operation (in terms of quality and safety) to help services manage the onboarding of new staff, such as:
  - How to undertake adequate supervision
  - How to perform safety checks
  - Safe manual handling in child care
- Consider providing ongoing training for services on best practice in early childhood education and care settings, including resources that are specific to services's context, such as:
  - Operating in a remote context
  - Understanding cultural appropriateness and safety at child care services
  - Strengths-based mentoring and role modelling of unqualified educators.



7.1 Short-medium term recommendations

Based on key findings from both the desktop and in-depth diagnostics, below are a series of short to medium term recommendations that DESE could consider implementing within the next twelve months, as the regulators of CCCFR services going forward.

6

Role of Agreement Managers in supporting services to maintain and strengthen quality and safety

- DESE could consider expanding the role of Agreement Managers of services that are not regulated by State/Territory regulations or the NQF to include responsibility for supporting services to maintain and strengthen quality and safety. Agreement managers who were going to take on this role would likely require some training to assist them to identify safety challenges and suggest opportunities for improvement. This expanded role would likely involve more engagement with services in terms of providing tailored training support, following up on reported safety issues and providing more regular updates to the CCCF management team regarding quality and safety of CCCFR services.
- DESE could also consider the role that Agreement Managers could play in supporting the handover of services to new service management staff to ensure that new management have important information regarding the Minister's Rules and available support resources. As observed during this review, the high staff turnover at services appears to be a key barrier in services continually maintaining and improving quality and safety.



7

Regular site visits to check on safety and quality at CCCFR services

- DESE could consider undertaking similar quality and safety reviews for other CCCFR services that are not regulated under relevant State/Territory regulations or the NQF. This could be undertaken using a similar approach where a sample of services are visited every year. This is in line with how other regulators ensure there are appropriate quality and safety measures in place at the services under their remit.



7.2 Long term recommendations

Based on key findings from both the desktop and in-depth diagnostics, below are a series of long term recommendations that may take longer to fully implement and DESE could consider implementing over the next two to three years.

1

Workforce issues

- DESE could consider a renewed focus on collaborating with a wider range of employment and education stakeholders, such as Registered Training Organisations (RTOs) and TAFEs to improve the supply of qualified educators in remote communities. This could also involve partnering with RTO(s) to deliver culturally appropriate training and qualifications which are applicable to services' contexts and to support staff to complete training and placements in community.



2

Transition to be regulated by State/Territory Regulation or NQF over time

- DESE could consider working with SRAs and ACECQA to gradually transition all CCCFR services to be regulated under State/Territory regulations or the NQF. This would likely involve providing support for services to transition and further consultation with services and assessment may be needed to understand:
  - Whether services require additional funding to meet and operate at the appropriate standards (e.g. physical limitations, staff housing requirements and operational costs)
  - Whether some services require long-standing exemptions that are specific to their unique operating environment. For example, this may be related to the service's ability to retain and attract suitably qualified staff in the long term.



A

Appendix

ss 22, 47C, 47E(d), 47G

ss 22, 47C, 47E(d), 47G

ss 22, 47C, 47E(d), 47G

ss 22, 47C, 47E(d), 47G

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