KPMG

Financial Review of Non-Family-Based Residential Care

Prepared for: Commissions of Inquiry Order (No 1) 2025: Inquiry into Queensland's child safety system

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Acknowledgement of Country

KPMG acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past, present, and future as the Traditional Custodians of the land, water and skies of where we work.

At KPMG, our future is one where all Australians are united by a shared, honest, and complete understanding of our past, present, and future. We are committed to making this future a reality. Our story celebrates and acknowledges that the cultures, histories, rights, and voices of Aboriginal and Torres Strait Islander People are heard, understood, respected, and celebrated.

Australia's First Peoples continue to hold distinctive cultural, spiritual, physical and economical relationships with their land, water and skies. We take our obligations to the land and environments in which we operate seriously.

Guided by our purpose to 'Inspire Confidence. Empower Change', we are committed to placing truth-telling, self-determination and cultural safety at the centre of our approach. Driven by our commitment to achieving this, KPMG has implemented mandatory cultural awareness training for all staff as well as our Indigenous Peoples Policy. This sincere and sustained commitment has led to our 2021-2025 Reconciliation Action Plan being acknowledged by Reconciliation Australia as 'Elevate' – our third RAP to receive this highest level of recognition. We continually push ourselves to be more courageous in our actions particularly in advocating for the Uluru Statement from the Heart.

We look forward to making our contribution towards a new future for Aboriginal and Torres Strait Islander peoples so that they can chart a strong future for themselves, their families and communities. We believe we can achieve much more together than we can apart.

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This deliverable has been prepared as outlined with the Department of Justice in the Scope Section of the engagement contract dated 30 January 2026. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

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Glossary (1/2)

Abbreviation	Definition
$	In Australian Dollars (AUD)
$'000s or k	Thousands of Australian Dollars
ACNC	Australian Charities and Not-for-profits Commission
AI	Artificial Intelligence
ATSICCO	Aboriginal and Torres Strait Islander Community-Controlled Organisation
ATSICPP	Aboriginal and Torres Strait Islander Child Placement Principle
Average IPS Funding Per Placement Per Day	Total IPS contract divided by number of children and contract duration; and averaging the result across each Provider's five IPS Pricing Schedules
Average OSD Funding Per Placement Per Day	Total FY25 OSD funding divided by number of equivalent full year placements and further divided by 365 (the number of days in the year). All information is taken from Provider Witness Statements
Base Rate	Ordinary hourly pay rate – it excludes penalties, overtime, allowances, bonuses and casual loadings
Business Rules Benchmark	Attachment 1 to the Individualised Placement and Support Business Rules (Version 5.1, September 2022)
CEO	Chief Executive Officer
Commission	Commission of Inquiry into the Child Safety System
Contract margin	The value of a Provider's IPS Schedule less the estimated value of the IPS Schedule based on the Business Rules Benchmark
Department	Department of Families, Seniors, Disability Services and Child Safety of Queensland
Dual funded	Providers that receive funding under both OSD (Outsourced Service Delivery) and IPS (Individual Placement and Support) arrangements
FBC	Family Based Care - A form of OOHC where children are placed with families, such as foster and kinship care.

Abbreviation	Definition
FIFO	Fly-In Fly-Out
Fit for purpose	Throughout Part C, 'fit for purpose' is assessed against the purpose described in each source report, and separately against potential reliance for funding, workforce or long-term planning decisions
FP	For-profit
FY	Financial Year
HSQF	Human Services Quality Framework is Queensland's quality and safeguarding framework for organisations that deliver government-funded human services across child protection, residential care, youth services, family support, disability mental health and community services. Features the Human Services Quality Standards (HSQS), certification processes and a framework for quality improvement
Income Rate	Base rate for a residential youth worker in IPS Pricing Schedules
Intake	The point at which concerns about a child are received by the child protection system
IPS	Individual Placement and Support
IPS Business Rules	Individualised Placement and Support Business Rules (Version 5.1, September 2022)
IPS Contract	IPS agreement between the Department and the provider that sets out the requirements for the delivery of services
IPS Pricing Schedule	A standardised pricing template completed by a Provider that sets out the full cost of delivering an IPS package for a specific young person
Licensed	Licence to provide care services in accordance with section 125 of the Child Protection Act 1999
m	Millions of Australian Dollars
Model of care	A model of care describes the organising principles, values and practices that guide how services are delivered to keep children safe and promote their wellbeing. There is not one standard model of care utilised in Queensland residential care settings

Glossary (2/2)

Abbreviation	Definition
Monte Carlo Simulation	A method used in SAM where child pathways are simulated using randomness based on past patterns, so each model run represents one possible future rather than a guaranteed outcome
NDIS	National Disability Insurance Scheme
NFBC	Non-family-based care
NFP	Not-for-profit
NP	Not provided
NSW	New South Wales
OOHC	Out of Home Care - The statutory care of children who are unable to live safely with their parents, including family-based care (foster care and kinship care) and non-family-based care (residential care and other approved placements)
Ordinary hours	Hours worked between 6:00 a.m and 8:00 p.m., Monday to Friday (i.e. hours that do not include any loadings or penalty rates)
OSD	Outsourced Service Delivery
PBFM	Parameter-Based Funding Model - The cost model used by Government to translate future demand into funding estimates under defined targets and assumptions
PD	Probability Distribution - A statistical representation, which is currently derived from historical data, of the likelihood that a child will transition between stages or pathways within the child protection system
Placement supply mix	The distribution of children across different OOHC placement types (FBC and NFBC), and the distribution of available placement capacity within each of those care types
Provider	An organisation that delivers out-of-home residential care
QFCC	Queensland Family and Child Commission

Abbreviation	Definition
RC	Residential Care - A form of OOHC where children are placed in staffed residential settings, typically involving higher resource intensity. In this Review, 'NFBC' refers to staffed residential care settings (RC). Where source documents use 'residential care' or 'RC', this report uses 'NFBC'
Related Party	A person or entity that can control, jointly control, or significantly influence the reporting entity, or is subject to such influence by the entity
RFI	Request for Information
SAM	Simulated Analytical Model - The demand model used by Government to forecast future volumes and flows of children at each stage of the QLD child protection system
SAM-to-PBFM	For this Part C Review, the combined SAM and PBFM models, treated as a single model system because SAM demand outputs are used directly by PBFM to calculate funding
SCHADS CA	Social, Community, Home Care and Disability Services Industry Award for Social and Crisis Accommodation employees
SCHADS SaCS	Social, Community, Home Care and Disability Services Industry Award for Social and Community Services employees
Staff Margin	The difference between the Income Rate and the base rate paid to residential youth workers on an hourly basis
Witness Statement	Written response to the Notice to Produce issued by the Commission of Inquiry into the Child Safety System dated 19 December 2025
Youth Worker Margin	The staff margin multiplied by the number of staffing hours in an IPS Pricing Schedule

01

Executive Summary

Analytical approach and structure

ES.1. KPMG was engaged on 30 January 2026 by the Commission of Inquiry into Child Safety System (the Commission) through the Department of Justice to provide analysis on the current market for residential out of home care in Queensland, the financial position of a sample of providers and the models that have been constructed or published to assess future demand and cost for these services.

ES.2. Our analysis has been conducted in three streams of work with clear linkages between the components. Our analysis was conducted based on a range of datasets that were collected by the Commission under their powers of inquiry and included:

a. [redacted] dataset which includes service types and contract characteristics - document ID: [redacted];

b. Additional departmental data and documentation, including briefing notes, internal strategy papers and supporting materials, used to provide policy, commissioning and market context for the analysis;

c. Provider-submitted financial information including financial statements, pricing schedules, payroll and witness materials which underpins an analysis of costs, margins and funding patterns;

d. IPS Business Rules describing departmental benchmarks defining acceptable labour, overhead and cost assumptions used to assess pricing reasonableness;

e. Departmental procurement documentation containing guidance on contracting and oversight used to evaluate procurement assurance and governance effectiveness;

f. [redacted] – document ID: [redacted] and

g. Buyer Beware report – document ID: [redacted].

ES.3. The approach and scope of each stream is outlined to the right.

Stream 1: Understanding the residential out-of-home care market in Queensland

ES.4. Stream 1 examined the structure and operation of Queensland's residential care market using desktop research as well as contract data provided by the Department of Families, Seniors, Disability Services and Child Safety (the Department). The analysis assessed market size and composition, including the number and types of providers, regional distribution, funding flows and participation over time. Provider characteristics and funding outcomes were compared by contract type, licensing status and organisational form. This included analysis of Outsourced Service Delivery (OSD) arrangements and Individualised Placement and Support (IPS) contracts. Differences between licensed and unlicensed providers and not-for-profit and for-profit providers were examined to identify variation in scale, funding concentration, cost growth and market stability.

Stream 2: Assessing the financial health of the residential care market

ES.5. Stream 2 reviewed the financial position of 20 residential care providers selected by the Commission as a representative cross-section of the market. Using the Provider Witness Statements together with their financial statements, selected IPS Pricing Schedules, OSD budgets, a payroll extract and roster data we sought to identify the reasonableness of the profit margins.

ES.6. The analysis focused on identifying labour and operational costs against recommended benchmarks and highlighting related party transactions. The outcomes were used to compare the performance to different operating, funding and employee models and detail underlying trends and themes.

Stream 3: Forecasting future demand for residential care

ES.7. Stream 3 assessed the projected non-family-based care (NFBC) and Out of Home Care (OOHC) demand and cost models identified by the Commission through to FY2030. The analysis reviewed the robustness of those existing projections based on their documented methodology, assumptions and stated use, and identified targeted enhancements to support clearer interpretation, stronger sensitivity testing, and a better understanding of the cost impact of potential interventions by decision-makers.

Summary of findings (continued overleaf)

ES.8. Our findings, outlined in detail in the full report, can be summarised into six main themes:

Theme 1 – Inelastic demand and changing market composition are impacting the efficiency and quality of the residential care service system

ES.9. The state of current market supply presents risks to sustainable, cost effective and high quality service provision due to limited growth in longer term, licensed arrangements and an unstable level of provision in some regions. Queensland's residential care market experienced sustained cost growth driven by inelastic demand and rising input costs, including housing, utilities and insurance costs. Expenditure increased overall and on a per-provider basis. The out-of-home care service mix included a greater use of residential care placements where family-based alternatives were unavailable, as well as high-cost short-term placements.

ES.10. In terms of market composition, a small number of providers continued to receive a large share of funding. The number of unlicensed providers increased while the numbers of licensed providers remained stable, with for-profit participation expanding as a share of the market. IPS contracts accounted for a growing share of placement nights and funding and became increasingly more expensive per day compared to OSD arrangements.

ES.11. Supply conditions varied significantly by region, with uneven provider availability, funding levels and cost growth. Aboriginal and Torres Strait Islander Community Controlled Organisations represented a small share of providers, noting delivery demand for Aboriginal and Torres Strait Islander children and young people increased markedly.

Theme 2 – Strengthening market stewardship capabilities

ES.12. Building a stronger commissioning model for residential care requires action at all stages of the commissioning cycle. This includes measures that deepen long term planning capability, introduce proactive market shaping in areas of low supply, regularise 'entry to market' thresholds and quality expectations and systematise data collection to monitor and manage performance.

ES.13. Observed market outcomes indicate weaknesses in current stewardship and commissioning arrangements. Limited long-term planning and poor visibility of future supply constrain proactive demand management. Reliance on short-term and surge contracting has improved responsiveness but weakened incentives for investment in licensed capacity, contributing to cost escalation and market volatility.

ES.14. Current contract, quality and performance information does not enable a robust assessment of provider performance. Inconsistent data, limited outcome measures and inadequate oversight restrict the ability to compare providers, monitor quality and identify emerging risks, reducing the scope for early intervention.

ES.15. Interjurisdictional approaches, ranging from implementation of stronger performance frameworks to greater direct government involvement, illustrate options to improve quality and sustainability.

Theme 3 – Profitability, growth and scale of IPS Providers

ES.16. The financial analysis shows that the net profit reported by the Providers in our sample is not a reliable indicator of financial performance, as owners and related parties often extract economic value through a variety of mechanisms - including above-market remuneration, management fees, acquisition of non-core assets, dividends and related-party charges - rather than through reported profit.

ES.17. The key driver of profitability is the labour inputs used when completing an IPS Pricing Schedule where average Department benchmarks are frequently exceeded. This is in part because operating cost and salaries and wages benchmarks have seemingly remained unchanged since August 2020 and December 2020 respectively, but also because once staff costs have been agreed during the procurement process, they are not revised down and appear to be used for future tender submissions.

ES.18. Consequently, for-profit IPS-only providers demonstrate rapid revenue growth over short periods, often without significant working capital or a need to invest in the business. Growth appears driven by placement access and pricing schedules rather than demonstrated efficiency, service maturity or measurable quality of care outcomes for children.

Theme 4 – Lack of incentives to transition IPS to OSD and incomplete IPS oversight under current procurement approach

ES.19. IPS Provider Witness Statements acknowledge OSD as a policy objective, but providers do not demonstrate an active intention to transition under current settings. Willingness to move to OSD is described as contingent on changes to funding, cost recovery or regulatory arrangements.

ES.20. The outputs reviewed indicate that current IPS funding and procurement settings make IPS more commercially attractive than OSD for providers, offering little incentive for providers to transition. At the same time, limited scrutiny of IPS Pricing Schedules reduces confidence that prices reflect efficient or value-for-money service delivery.

ES.21. The Queensland Government is seeking to convert a number of Provider contracts from IPS to OSD which could offer security for Providers and support cost reduction for the State. However, Providers have noted in their Witness Statements that this may undermine their ongoing financial viability which would in turn reduce supply in the market and undermine the State's ongoing ability to deliver residential care services.

Summary of findings (continued)

Theme 5 – Strengthening the forecasting model

ES.22. Existing demand and cost models, including modelling in the Buyer Beware Report, provide clear signals about the likely scale and direction of future NFBC demand and associated cost risk if current pressures persist. They have been useful for agenda-setting and illustrating potential system pressure, but were developed for specific, point-in-time purposes and rely heavily on trend extrapolation, fixed assumptions and single-point estimates. As a result, they are not well suited to ongoing system management, funding planning or decision-making that requires sensitivity to changing conditions and uncertainty.

ES.24. Among the models reviewed, the Simulated Analytical Model (SAM) to Parameter-Based Funding Model (PBFM) system represents the most credible platform for more decision-useful analysis because it is already embedded in government forecasting and budget processes, provides a system view and supports more localised analysis of demand and cost. However, in its current form, its outputs remain conditional on externally specified inputs, historical pathway assumptions and target-driven settings.

ES.25. There is therefore a risk that current outputs, particularly from the PBFM, are interpreted as forecasts of funding required rather than conditional funding benchmarks. The report accordingly concludes that the official model system should be strengthened to support a broader, more transparent and more decision-useful view of future demand, funding requirements, and the cost implications of potential interventions in Queensland's OOHC system.

Theme 6 – Better modelling for demand capacity and market stewardship

ES.26. A better-practice modelling approach would incorporate driver-based demand inputs, transparent governance over key system pathway assumptions, explicit representation of placement type supply (including family-based care and NFBC), capacity and substitution constraints, and reporting that reflects the uncertainty inherent in the system rather than relying only on single-point outputs. Current models do not adequately explain why demand changes or how outcomes would respond to shifts in policy, system behaviour or external conditions.

ES.27. In the current SAM, future intakes are externally specified rather than generated from observable drivers, and probability distributions, which determine the likelihood of a child moving through each stage of the child protection system, are largely derived from historical patterns without a formal process to ensure they remain representative as system conditions evolve. This limits confidence that the model structure can appropriately reflect future changes in demand dynamics or pathway behaviour.

ES.28. Current modelling also does not explicitly represent placement supply, capacity or market constraints, which limits confidence where placement availability materially affects outcomes and cost. In the PBFM, cost escalation assumptions are largely indexation-based and outputs are commonly reported as single figures, which can obscure uncertainty and interpretation risk. Accordingly, the report recommends targeted enhancements to the SAM-to-PBFM model system so that it better integrates demand drivers, system pathways, behavioural parameters and capacity constraints, supported by sensitivity ranges that inform budget planning, workforce planning, intervention testing and market-shaping decisions across Queensland's OOHC and related sectors contributing to placement demand.

02

Introduction

Background and introduction

Background

BI.1. Queensland's residential care system has expanded rapidly over the past decade, shifting from a last-resort, short-term placement option to a core component of the out-of-home care system. The number of children in residential care has more than tripled since 2015, driven largely by the marked reduction of foster and kinship care supply and increasing placement of younger children and those with highly complex needs into group-based settings not designed for long-term care. As a result, residential care has become a default response to system pressure rather than a therapeutic intervention of choice.

BI.2. Evidence has consistently demonstrated that this growth has occurred alongside poor and, in some cases, worsening outcomes for children and young people. The 2024 Children in Care Census and subsequent reporting highlighted high rates of trauma, self-harm, suicide attempts, unmet mental health needs, placement instability, children going missing from care, and exposure to further abuse while in residential placements. These issues were widely understood as systemic and longstanding, rather than isolated provider failings.

BI.3. At the same time, the residential care market has become increasingly costly and fragmented, growing into a billion-dollar sector without corresponding improvements in safety or wellbeing. Persistent concerns regarding provider oversight, profit extraction, workforce shortages, and the State's effectiveness as a corporate parent have remained unresolved despite multiple reviews and reform efforts. It was this convergence of rapid growth, demonstrably poor outcomes, market and workforce dysfunction, and repeated failure to implement earlier reforms that led the Queensland Government to establish a Commission of Inquiry into the Child Safety System in 2025, with residential care at its core.

BI.4. In May 2025, the Queensland Government established the Commission of Inquiry into Child Safety Sector (the Commission) with the aim of identifying and addressing systemic issues within the child safety system. Led by Commissioner Paul Elias Anastassiou KC, the Commission's goal is to improve outcomes for children, carers and families across Queensland, and to create a safer community for all Queenslanders.

BI.5. The Terms of Reference for the Commission of Inquiry instruct it to examine the following four areas:

- **Reforming the Residential Care System:** Investigating models of care and the factors contributing to the growth and reliance on a billion-dollar residential care sector.
- **Fixing a Broken System:** Reviewing the effectiveness of Queensland's child safety system to keep children safe, including governance, financial and procurement processes.
- **Safer Children:** Exploring failures both systemic and policy that have impeded the Department to provide support to families and protection to children at risk of harm.
- **Safer Communities:** Evaluating the effectiveness of the Department as a corporate parent and whether it is able to meet community expectations around parenting.

BI.6. Of relevance to the Commission's Terms of Reference is recent economic modelling by the Queensland Family and Child Commission (QFCC), which found that Queensland's Out of Home Care system is under severe financial strain, with residential care costs increasing from $200 million in 2015 to $1.12 billion in 2024. The QFCC estimates that annual costs are projected to exceed $7 billion by 2030. It noted that the State Government operates as a "price taker", with little market oversight and generic contracting that prioritises volume over value. It highlights that a lack of financial stewardship has entrenched inefficiencies and escalated costs, leaving the system vulnerable to unsustainable growth [3].

BI.7. The Commission, through the Department of Justice, has engaged KPMG to complete a report providing findings and opinions on the demand for and costs currently incurred and expected to be incurred by the Department of Families, Seniors, Disability Services and Child Safety (the Department) in relation to the delivery of non-family-based residential care services to children in state care.

Scope of Work & Purpose

BI.8 The review comprises three distinct but related components, set out as chapters of this report. The scope of each component is described below, with additional details including the purpose and limitations described in detail in relevant sections of the report.

Scope

Understanding the market for non-family-based residential care in Queensland

BI.9 Part A analyses the current structure of the residential care sector, including quantitative information on delivery volume and funding by provider type, region and cohort of delivery. Longitudinal analysis supports identification of patterns of entry, exit and changes in market composition. This report also sets out qualitative information on provider quality and performance, jurisdictional regulatory arrangements and alternative tertiary care providers.

BI.10. In addition, Part A develops a theoretical basis underpinning demand and supply of residential care services. This includes a summary of the inelastic nature of residential care demand and drivers for the increase in demand, as well as labour and non-labour supply constraints and availability of services for particular cohorts.

BI.11 Finally, Part A sets out market interventions across the commissioning cycle to support quality improvements, based on interjurisdictional examples.

Assessing the financial health of the residential care market

BI.12. Part B considers the profit margins generated by 20 Providers selected by the Commission as a representative cross-section of suppliers and comment on the reasonableness of those margins having regard to:

a) The input costs incurred by Providers (including labour and overheads);

b) The different models of care offered by residential care Providers;

c) The procurement practices of the Department;

d) The availability of alternative suppliers in the market (covered in Part A); and

e) Any other factors deemed relevant.

BI.13. Suppliers were selected by reference to the following criteria: for-profit v not-profit; licensed v not licensed; large providers v small providers; providers in different regions; and providers with different focus areas or models of care.

Forecasting future demand for residential care

B1.14. The Commission identified projected demand and cost models for non-family-based care (NFBC) through to 2030 for KPMG to review. Part C assesses the robustness of these existing projections based on their documented methodology, assumptions and stated use. It examines underlying model methodology, identifies opportunities for further sensitivity testing of key demand and cost drivers to strengthen forecasts, and provides reasoned commentary on the reliability of projections, including key uncertainties and risks.

BI.15. In addition, Part C summarises the context, purpose and intended use of each model as presented in the source reports, including how the models are positioned within broader reform objectives and decision-making processes. This is intended to support appropriate interpretation of the modelling results prior to detailed methodological assessment.

03

Understanding the market for non-family-based residential care in Queensland

Part A. Scope of Work & Purpose

Scope

Part A analyses the current structure of the residential care sector, including quantitative information on delivery volume and funding by provider type, region and cohort of delivery. This longitudinal analysis supports identification of changes in market composition. This report also sets out qualitative information on provider quality and performance, jurisdictional regulatory arrangements and alternative tertiary care providers.

In addition, Part A develops a theoretical basis underpinning demand and supply of residential care services. This includes a summary of the inelastic nature of residential care demand and drivers for the increase in demand, as well as labour and non-labour supply constraints and availability of services for key cohorts.

Finally, Part A sets out market interventions across the commissioning cycle to support quality improvements, based on interjurisdictional examples.

Purpose

Given the significant increases in residential care expenditure in recent years, Queensland is considering policy options to limit cost increases while maintaining standards of quality and safety for children and young people. Part A key findings support the identification of potential market interventions to shift patterns of demand from high-cost options, re-shape the mix of providers, and alleviate critical supply constraints.

Limitations

This review was undertaken without consulting providers. As a result, while patterns are identified in terms of net increases and decreases, there is limited data on the rationale for these changes. Additionally, the quantitative data provided does not support analysis of attribution or causality.

There was limited opportunity to validate categorisations and definitions with data owners. Noting the complexity of categorising service groupings and that particular services may cross multiple service types, analysis has aligned with Departmental-provided definitions of ‘residential care’ as compared to ‘family-based care’ and ‘other’ service types.

Part A. Summary Findings

1. Over the last four financial years Queensland saw sustained cost increases for residential care, due to inelastic demand pressures and labour and non-labour supply constraints.

- From FY2021-22 to FY2024-25, expenditure grew overall and at a per-provider level for residential care. This reflected increased demand at three levels: firstly, for out-of-home-care, which is often associated with worsening social drivers; for residential care, which may be exacerbated by limited availability of family-based care alternatives; and for high-cost short-term residential care placements, which may be associated with limited forward planning to establish lower-cost placement options.
- Supply was also constrained due to increases in underlying labour, housing, electricity and utilities and insurance costs, resulting in cost increases being passed on to the Queensland government.

2. The provider market shifted in composition across the four years in scope of analysis.

- The market was dominated by a relatively small group of providers, with the top fifteen providers receiving half of the total residential care funding.
- Across FY2021-22 to FY2024-25, while the number of licensed providers remained stable, the number of unlicensed providers increased significantly, meaning that by FY2024-25 licensed providers comprised less than a quarter of total providers in the market.
- Between FY2021-22 and FY2024-25, IPS contracts formed a growing proportion of total placement nights and total funding compared to OSD contracts. IPS contracts also became increasingly expensive compared to OSD contracts on a per-day basis between FY2021-22 and FY2024-25.
- For-profit participation in the market increased over the four years; by FY2024-25, over two-thirds of providers were for-profit. Not-for-profit providers continued to receive more funding at a per-provider level.

3. Supply conditions varied significantly across regions and cohorts.

- Provider numbers, funding levels and daily rates differed significantly by region, with uneven cost growth.
- Aboriginal and Torres Strait Islander Community Controlled Organisations formed a small proportion of the market (with under ten active providers per year from FY2021-22 to FY2024-25), though demand consistently grew over the same period.

4. There is limited visibility of available quality and performance data.

- Available contract and performance management information does not support a comprehensive assessment of provider quality across the residential care market.

5. Queensland could consider incorporating further policy and contractual mechanisms to shape the residential care market proactively, respond earlier where performance concerns arise, and ensure ongoing visibility, continuity and required standards of care.

- Ongoing reforms in Queensland, including a focus on robust demand forecasting and shifting procurement mechanisms, will provide a stronger basis to manage cost escalation while maintaining quality and safety standards.
- Queensland could also consider incorporating commissioning reforms seen in New South Wales and Victoria, spanning a spectrum of complexity from implementing more comprehensive performance frameworks for providers through to considering a greater direct role for government in service delivery.

Part A. Key Findings

#	Finding	Ref
1	The number of providers delivering residential care in Queensland remained relatively stable from FY2021-22 to FY2024-25. The market was dominated by a relatively small group of providers, with the top fifteen providers receiving half of total residential care funding.	p. 18 and p. 19
2	Across FY2021-22 to FY2024-25, while the number of licensed providers remained stable, the number of unlicensed providers increased significantly, meaning that by FY2024-25 licensed providers comprised less than one quarter of total providers in the market.	p. 20
3	Between FY2021-22 and FY2024-25, IPS contracts formed a growing proportion of total placement nights and total funding compared to OSD contracts. IPS contracts also became increasingly expensive compared to OSD contracts on a per-day basis between FY2021-22 and FY2024-25.	p.21
4	For-profit participation in the market increased over the four years; by FY2024-25, over two-thirds of providers were for-profit. Not-for-profit providers continued to receive more funding at a per-provider level.	p. 22 and p. 23
5	Provider numbers, funding levels and daily rates differed significantly by region, with uneven cost growth. The South East region saw the greatest fluctuation in the number of providers, while North Queensland saw the biggest increases in daily cost of residential care provision over FY2021-22 to FY2024-25.	p. 24
6	Aboriginal and Torres Strait Islander Community Controlled Organisations form a small proportion of the market (with under ten active providers from FY2021-22 to FY2024-25), despite an over-representation of Aboriginal and Torres Strait Islander children and young people in residential care.	p. 25
7	Available contract and performance management information does not support a comprehensive assessment of provider quality across the residential care market. Although there is scarce information on performance at a system level, our analysis in Part B of this report explored the nominated models of care and training requirements for a select cohort of providers.	p. 27
8	The regulatory system for residential care in Queensland is distributed across several agencies, compared to Victoria and New South Wales where functions and powers are vested in one entity per jurisdiction (the Social Services Regulator in Victoria and the Office of the Children's Guardian in New South Wales).	p. 28
9	Over the last few years, demand increased at three levels: firstly, for out-of-home-care, which may be linked to worsening social drivers; for residential care, which may be exacerbated by limited availability of family-based care alternatives; and for high-cost short-term residential care placements, which may be associated with limited forward planning to establish lower-cost placement options.	p. 33 to p. 37
10	Supply was also constrained due to increases in underlying labour, housing, electricity and utilities and insurance costs, resulting in cost increases being passed on to the Queensland government. Supply constraints were exacerbated in particular settings, including provision for First Nations children and young people and in regional and remote communities.	p. 39 to p. 41
11	Ongoing reforms in Queensland, including a focus on robust demand forecasting and shifting procurement mechanisms, will provide a stronger basis to manage cost escalation while maintaining quality and safety standards. Queensland could also consider incorporating reforms seen in New South Wales and Victoria, spanning a spectrum of complexity from implementing more comprehensive performance frameworks for providers through to considering a greater direct role for government in service delivery.	p. 43
12	A best practice commissioning model for residential care services would allow the Queensland Government to proactively plan for future demand for residential care placements through rigorous demand modelling, a deep understanding of the market and potentially new and alternative suppliers, a robust procurement process supported by monitoring, compliance and evaluation processes that measure performance, ensure high quality service provision and allow for continuous improvement over time.	p. 44

3.1

Market Structure

Current State Overview

Residential care provider landscape and overall expenditure

A.1. Queensland's residential care market largely outsources its service delivery to non-government organisations. This structure means the Department of Families, Seniors, Disability Services and Child Safety (the Department) is the key buyer and system steward, while providers compete or are selected to deliver placements under contractual arrangements. The Department acts as a market steward to ensure continuity of supply and quality through commissioning settings, licensing and oversight mechanisms, rather than exercising direct operational control.

A.2. As shown in Figure A.1 below, in FY2024-25 there were 163 organisations receiving funding for delivery of residential care services in Queensland. This decreased from 169 organisations in FY2023-24, noting that overall funding provided to residential care providers increased in the same period. This indicated an increase in average funding per provider, as can be seen in Table A. A.1.

Figure A.1: Number of residential care providers and total residential care funding [1]

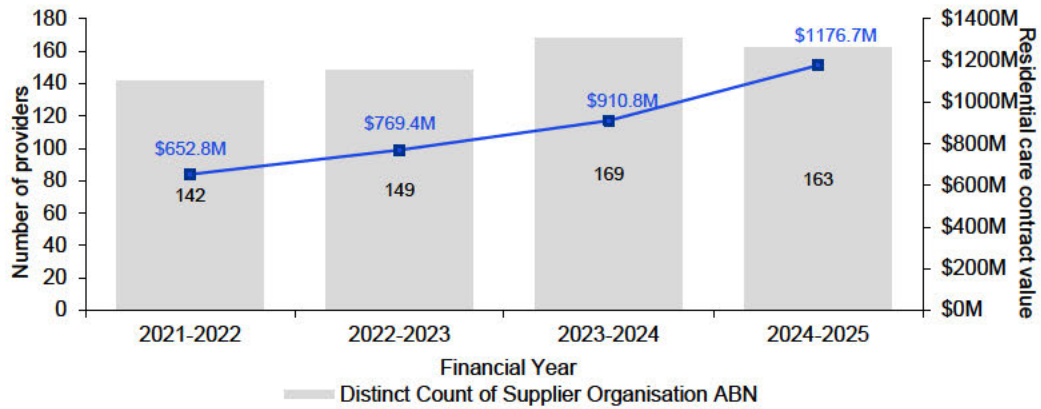


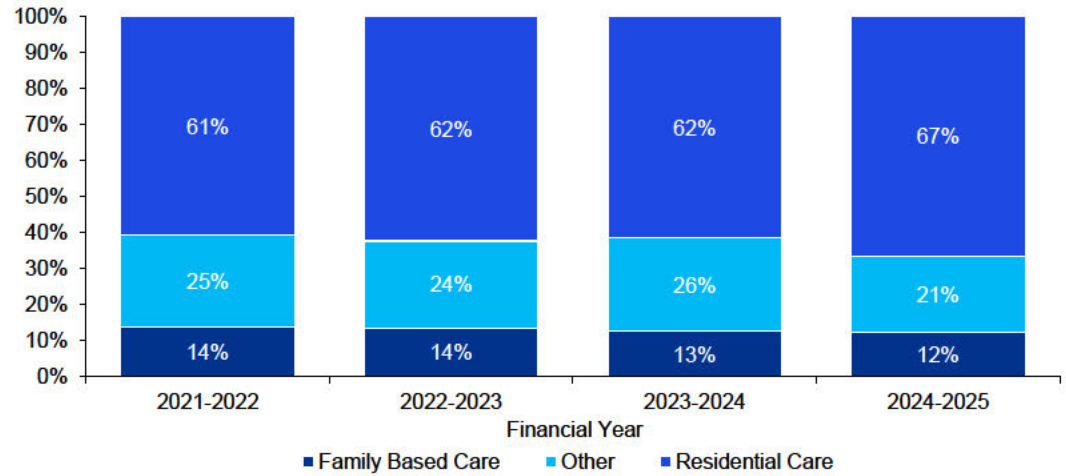
Table A.1: Average funding received per provider [1]

Financial Year	2021-2022	2022-2023	2023-2024	2024-2025
Average funding received per provider	$4.6M	$5.2M	$5.4M	$7.2M
Percent increase on previous year	N/A	12%	4%	34%

Residential care expenditure increase

A.3. Costs in Queensland residential care have increased rapidly and now represent a major fiscal pressure on the State. The FY2024-25 budget for residential care services overran by approximately $500 million [2], and the Queensland Family and Child Commission (QFCC) projected that out-of-home care (OOHC) costs could exceed $7 billion annually by 2030 without reform [3]. As shown in Figure A.2, residential care accounted for a growing majority of expenditure across Department-captured care types* between FY2021-22 and FY2024-25.

Figure A.2: Residential care funding as a proportion of expenditure across captured care types [1]*

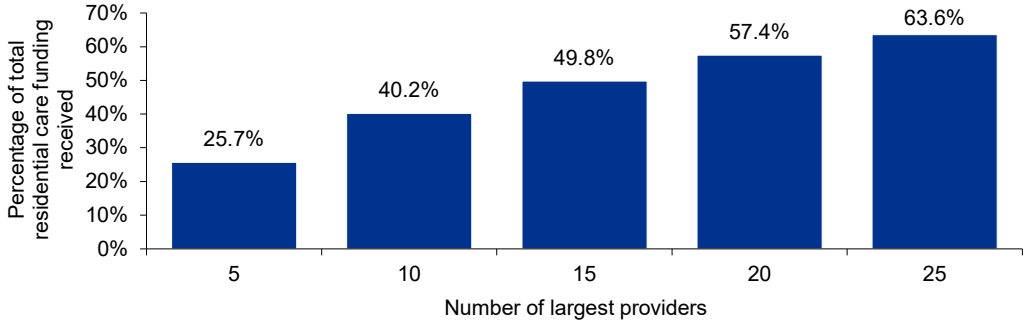


*Note that this was based on care types captured in Departmental-provided datasets, and on the Department's definition of residential care, family-based care and other services. The Department mapped residential care, family-based care and other services categories to investment areas including child protection – placement services, child protection – support services, direct payments, domestic and family violence services, families, family-based care, individual support, Making Decisions in Our Way (delegated authority support services), service system support and development, services for young people, and transition to adulthood services. This mapping may not be exhaustive and should not be interpreted as covering all OOHC categories.

Provider breakdown: provider size

A.4. As can be seen in Figure A.3 below, in FY2024-25 five providers received 25.7% of total funding, while twenty providers received over half of total funding available. This meant that 143 providers received the remaining 42.6% of funding.

Figure A.3: Percentage of total residential care funding received by the largest providers FY2024-25 [1]



A.5. An overview of the top ten providers by funding amount in FY2024-25 is set out in Figure A.4, as well as total placement nights in Figure A.5. The two providers receiving the greatest amount of funding received more than $150m of funding between them. A summary of key characteristics of the top ten providers is set out in Table A.2.

Figure A.4: Top ten residential care providers by expenditure FY2024-25 [1]

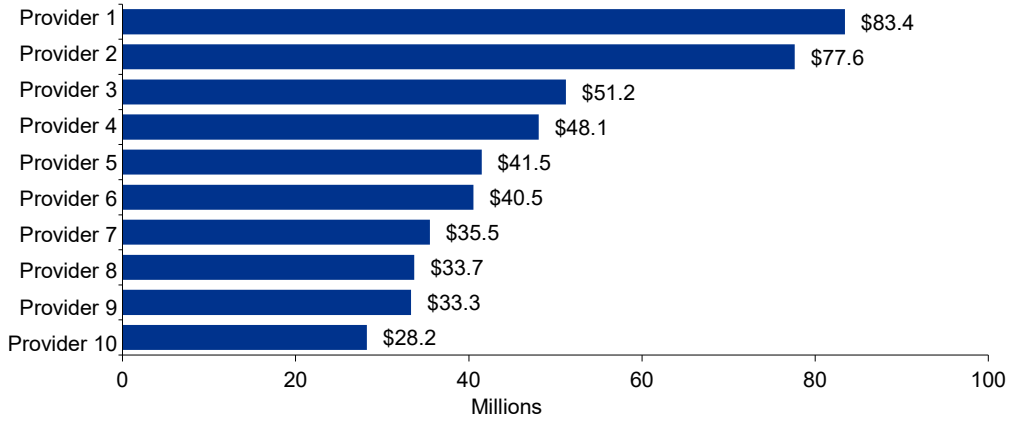


Figure A.5: Top ten residential care providers by total placement nights FY2024-25 [1]

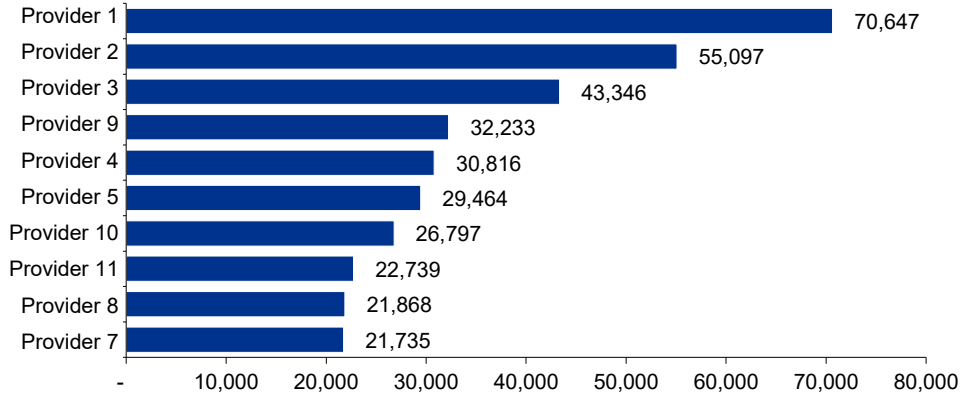


Table A.2: Summary of top ten residential care providers by expenditure FY2024-25 [1]

Supplier Organisation Name	FY2024-25 residential care contract value	Proportion of total FY2024-25 residential care contract value	ACNC Status	Licensed Status	Funding Stream
Provider 1	$83.4M	7.1%	No	Licensed	Dual Funded
Provider 2	$77.6M	6.6%	Yes	Licensed	Dual Funded
Provider 3	$51.2M	4.4%	Yes	Licensed	Dual Funded
Provider 4	$48.1M	4.1%	No	Licensed	Dual Funded
Provider 5	$41.5M	3.5%	Yes	Licensed	Dual Funded
Provider 6	$40.5M	3.5%	No	Licensed	Dual Funded
Provider 7	$35.5M	3.0%	Yes	Licensed	Dual Funded
Provider 8	$33.7M	2.9%	No	In scope	IPS only
Provider 9	$33.3M	2.8%	Yes	Licensed	Dual Funded
Provider 10	$28.2M	2.4%	Yes	Licensed	Dual Funded

Provider breakdown: licensing status

A.6. Providers can be licensed or unlicensed. Licensed services are certified under the Human Services Quality Framework (HSQF) [4]. Unlicensed providers (often used for immediate or specialised placements) are regulated and monitored by the Department but not subject to certification assessment processes; some unlicensed providers may be in-scope for licensing and actively working towards certification [4].

A.7. Figures A.6 and A.7 show shows the relative numbers of licensed and unlicensed providers from FY2021-22 to FY2024-25. The number of licensed providers remained relatively stable across all four years, meaning that as the market grew, licensed providers came to occupy a decreasing share of total providers (from 27% in FY2021-22 to 23% in FY2024-25). The number of unlicensed providers increased significantly from FY2021-22 to FY2024-25 (104 to 125).

Figure A.6: Number of providers by licensing status [1]

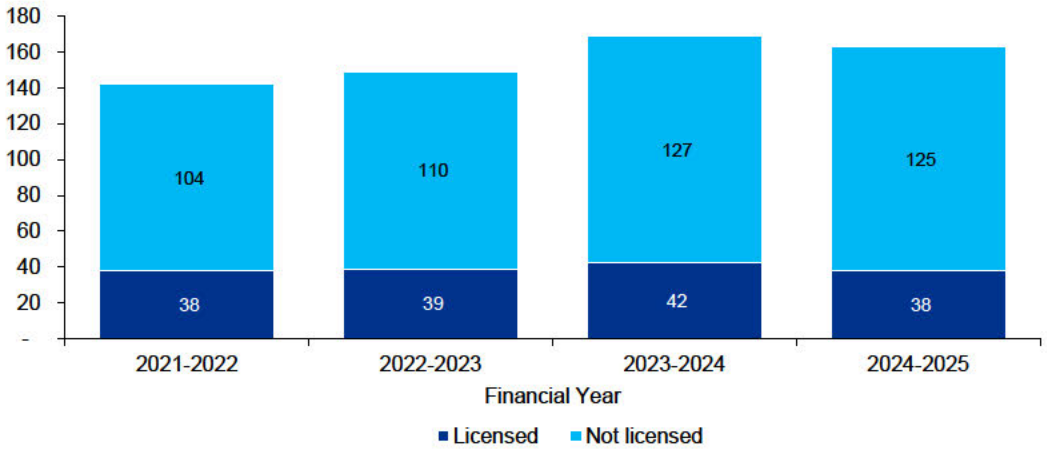
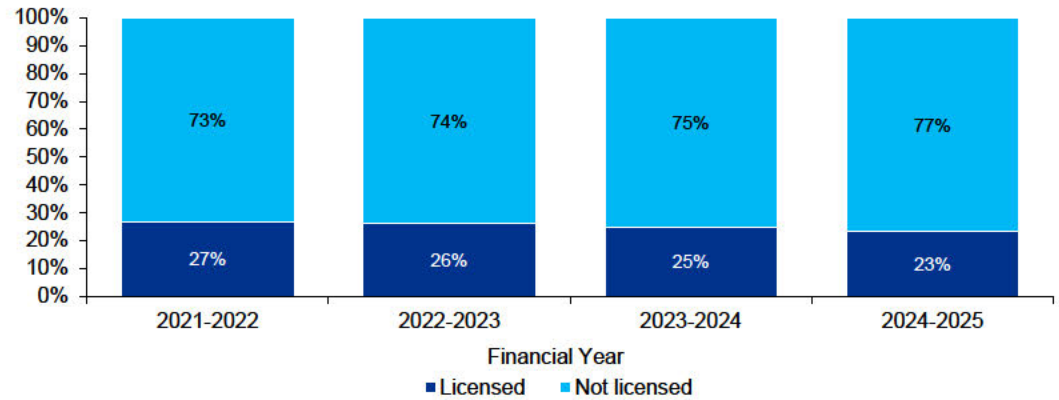
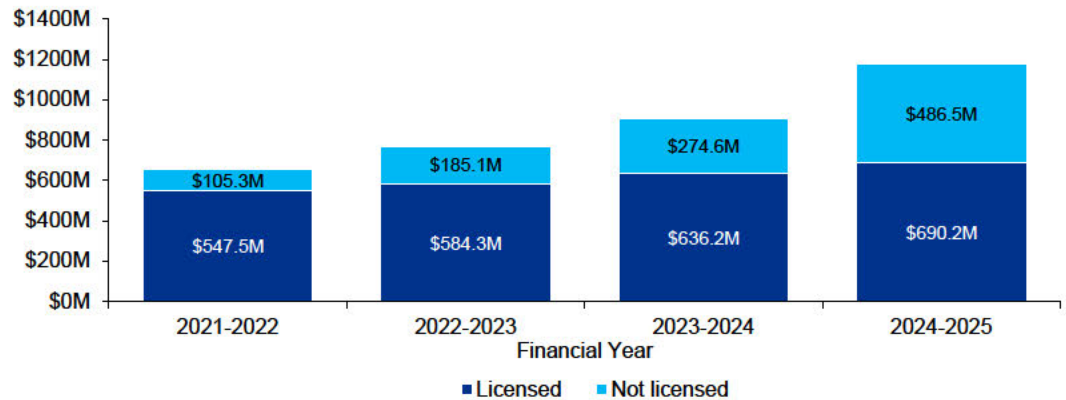


Figure A.7: Relative proportion of providers by licensing status [1]



A.8. While there were significantly more unlicensed than licensed providers from FY2021-22 to FY2024-25, most residential care funding flowed to licensed providers. In FY2024-25, more than half of total residential care funding went to licensed providers ($690.2m, out of a total pool of $1176.7m of funding to residential care).

Figure A.8: Total funding to providers by licensing status [1]



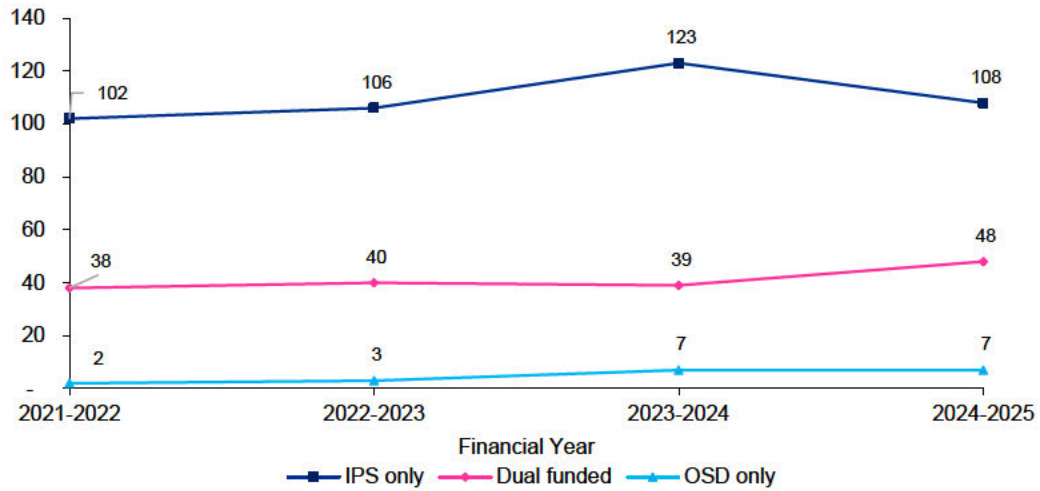
Provider breakdown: contract type

A.9. The residential care service provider market consists of a core layer of contracted providers and a secondary surge layer activated to fill capacity gaps: these are categorised as Outsourced Service Delivery (OSD) and Individualised Placement and Support (IPS) respectively.

Providers by the types of contract they deliver

A.10. OSD contracts are typically multi-year agreements under which licensed providers deliver defined residential care placements, providing the system's base of planned capacity. By comparison, IPS involves child-specific spot purchasing used where OSD beds are unavailable or where a child or young person's needs exceed existing capacity. IPS providers are not required to be licensed [3], can operate with less oversight than licensed OSD providers [5] and are also often more expensive. Providers can deliver both OSD and IPS contracts (categorised as 'dual-funded' providers). The number of providers that exclusively delivered IPS or OSD contracts as well as dual-funded providers is summarised in Figure A.9 below.

Figure A.9: Number of providers by types of contracts they deliver [1]



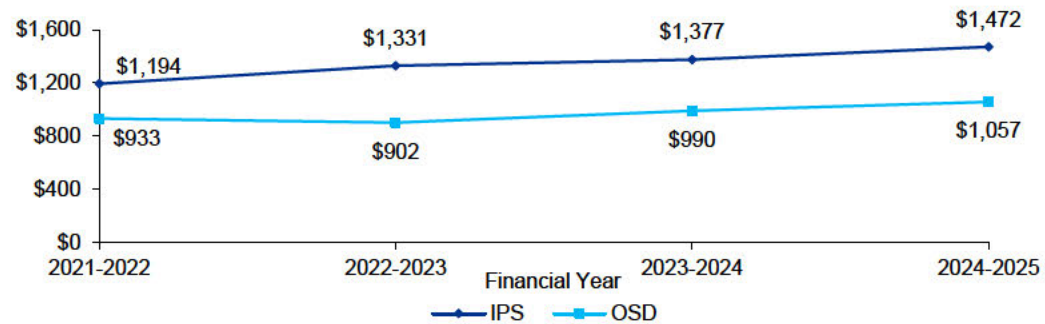
Key differences in contract types (volume procured and funding)

A.11. Table A.3 shows that between FY2021-22 to FY2024-25, IPS contracts formed a growing proportion of total placement nights and total funding compared to OSD contracts. IPS placement nights increased from 48% of total placement nights in FY2021-22 to 57% in FY2024-25; IPS funding increased from 61% of total funding in FY2021-22 to 66% in FY2024-25. Figure A.10 also reveals an increased cost gap between the two contract types. In FY2021-22 the median IPS contract was 28% more expensive per day than the median OSD contract; in FY2024-25 this difference rose to 39%.

Table A.3: Placement nights and total funding by IPS and OSD contract [1]

Contract type	Measure	Financial Year			
		2021-2022	2022-2023	2023-2024	2024-2025
IPS	Number of placement nights	306,585	331,637	378,526	473,331
	Total funding	$401.3M	$492.7M	$599.1M	$774.4M
OSD	Number of placement nights	326,419	337,626	400,530	354,064
	Total funding	$251.5M	$276.7M	$311.7M	$402.3M
Total	**Number of placement nights**	**633,004**	**669,263**	**779,056**	**827,395**
	Total funding	**$652.8M**	**$769.4M**	**$910.8M**	**$1176.7M**

Figure A.10: Median of daily cost by contract type [1]



Provider breakdown: for-profit and not-for-profit status (continued overleaf)

A.12. In Queensland, residential care is delivered by a mix of long-established not-for-profit charitable agencies as well as a growing number of for-profit companies. For-profit providers are defined as any organisation not registered as a charity with the Australian Charities and Not-for-profits Commission (ACNC). As can be seen in Figure A.11, the number of for-profit providers increased significantly (by almost 40%) from FY2021-22 to FY2023-24, with a small decrease in FY2024-25. In contrast, the number of not-for-profit providers consistently decreased (at lower magnitude) every year. In FY2024-25, for-profit providers accounted for 70% of total providers while not-for-profit providers accounted for 30%, shown in Figure A.12.

Figure A.11: Number of providers that are for-profit and not-for-profit [1]

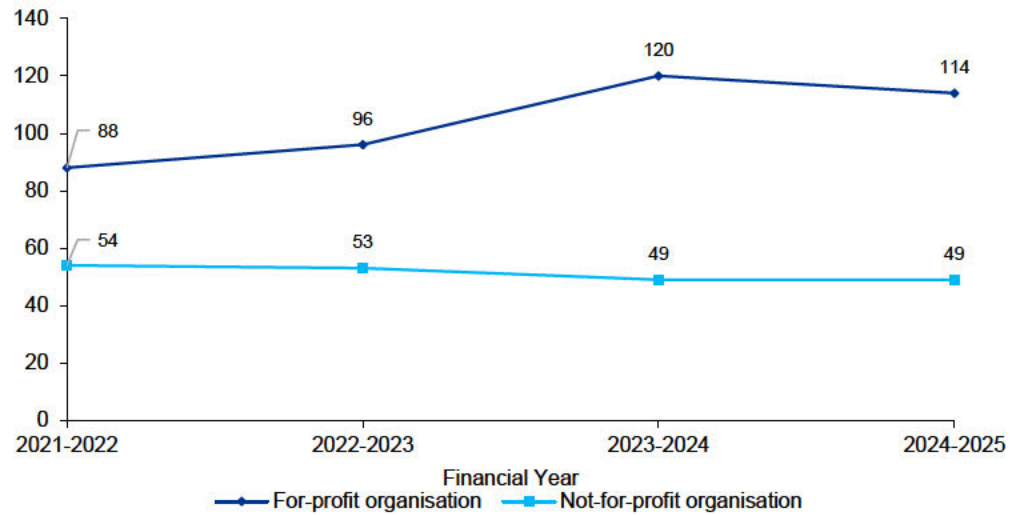
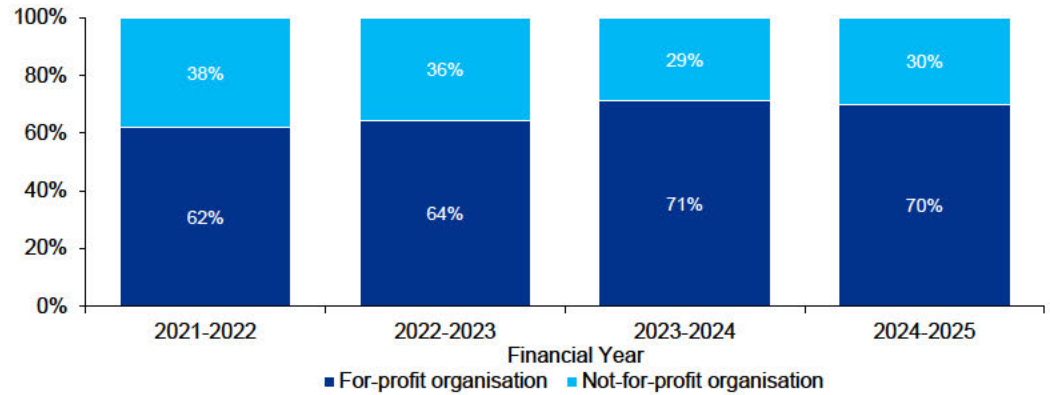


Figure A.12: Relative proportion of providers that are for-profit and not-for-profit [1]



Key examples of not-for-profit provider market exits

A.13. In June 2023, Churches of Christ – one of Queensland's major not-for-profit care providers – made a high-profile exit from youth residential care, supported independent living (SIL), and family support services. The Kenmore based organisation described its withdrawal as a "commercially necessary" decision [6].

A.14. In June 2024, Mercy Community Services, a significant not-for-profit provider operating across South East Queensland, South West Queensland, and the Brisbane and Moreton Bay regions, formally withdrew from residential care, foster and kinship care, and SIL. The withdrawal followed the discovery of a substantial wage underpayment liability, which rendered continued service delivery financially unviable [7] [8]. At the time of exit, Mercy was providing support to 863 children and young people. The Queensland government managed the transition of all affected children: 787 children in family-based care transitioned with their carers to other providers; 44 children in residential care and eight young people in SIL transitioned to new service providers; nine children were reunified with their families; and 85 children and young people were transitioned to First Nations service providers [7].

Provider breakdown: for-profit and not-for-profit status (continued)

A.15. By proportion, Figure A.13 shows that not-for-profit organisations received nearly half of total funding despite only comprising one-third of total providers in FY2024-25. At a per-provider level, the average not-for-profit provider received around double the funding of the average for-profit provider from FY2021-22 to FY2024-25, as can be seen in Table A.4.

Figure A.13: Relative proportion of total funding by providers that are for-profit and not-for-profit [1]

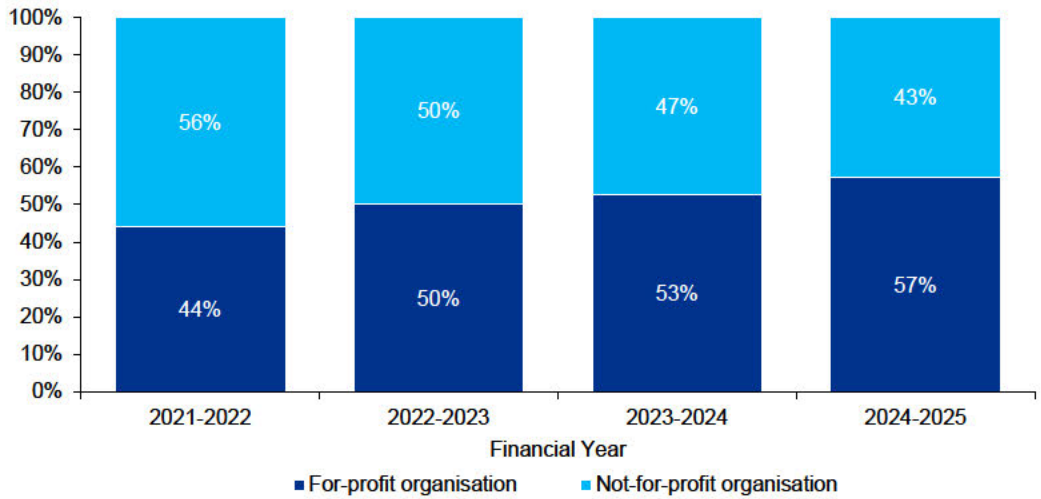


Table A.4: Average funding received for-profit and not-for-profit provider [1]

Average funding per provider	Financial Year			
	2021-22	2022-23	2023-24	2024-25
For-profit organisation	$3.3M	$4.0M	$4.0M	$5.9M
Not-for-profit organisation	$6.7M	$7.2M	$8.8M	$10.3M

Provider breakdown: by region

A.16. The number of providers per region was relatively stable for Brisbane and Moreton Bay, Far North Queensland and South West Regions between FY2021-22 and FY2024-25. In contrast, the number of providers in North Queensland, Sunshine and Central Coast, and South East Regions fluctuated across the four-year period, as shown in Table A.5.

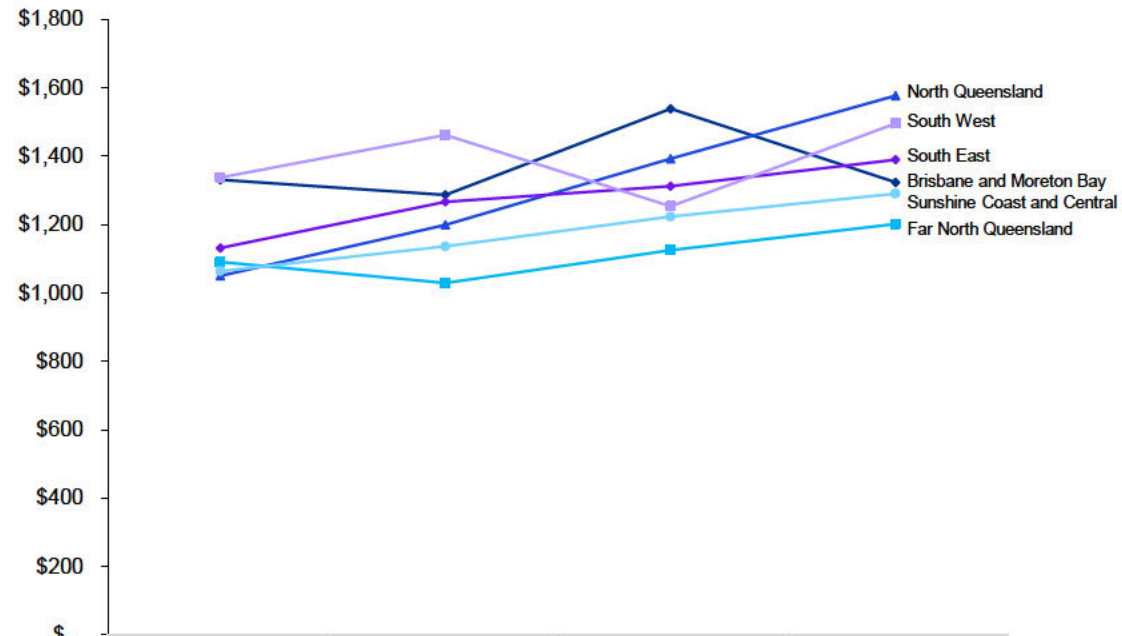
Table A.5: Count of providers and total funding per region [1]

Region	Measure	Financial Year			
		2021-2022	2022-2023	2023-2024	**2024-2025**
Brisbane and Moreton Bay	Number of providers	49	48	44	**46**
	Total funding	$123.8M	$154.9M	$184.3M	$196.0M
Far North Queensland	Number of providers	29	27	26	**31**
	Total funding	$79.4M	$79.5M	$95.1M	$117.6M
North Queensland	Number of providers	39	43	47	**46**
	Total funding	$59.5M	$87.3M	$138.6M	$243.7M
Sunshine and Central Coast	Number of providers	42	49	59	**54**
	Total funding	$103.4M	$103.8M	$108.0M	$116.5M
South East	Number of providers	36	36	50	**40**
	Total funding	$149.9M	$163.8M	$180.3M	$232.7M
South West	Number of providers	54	58	52	**48**
	Total funding	$136.8M	$180.1M	$204.5M	$270.1M
State-Wide*	Number of providers	0	1	0	0
	Total funding	-	-	-	-
Total	Number of providers^	142	149	169	**163**
	Total funding	**$652.8M**	**$769.4M**	**$910.8M**	**$1176.7M**

*There was one provider tagged as state-wide in FY2022-23 (Churches of Christ in Queensland), which may be a data error.
^Note that as providers operate in more than one region, the sum of providers per region is higher than the total number of distinct providers in the state.

A.17. Median daily costs for residential care differed significantly by region, as demonstrated in Figure A.14 below. North Queensland saw the highest cost escalation, moving from the lowest median daily cost in FY2021-22 to the most expensive by FY2024-25. The median daily cost rose from $1,050 per day in FY2021-22 to $1,577 in FY2024-25, a 50% increase.

Figure A.14: Median of daily cost by region [1]



	2021-2022	2022-2023	2023-2024	2024-2025
BMB	$1,332	$1,287	$1,539	$1,324
FNQ	$1,091	$1,029	$1,125	$1,202
NQ	$1,050	$1,199	$1,393	$1,577
SCC	$1,064	$1,137	$1,223	$1,291
SE	$1,132	$1,266	$1,312	$1,390
SW	$1,338	$1,462	$1,253	$1,496

Provider breakdown: Aboriginal-led provision

A.18. There were six Aboriginal and Torres Strait Islander Community-Controlled Organisations (ATSICCOs) operating in the residential care market in Queensland in FY2024-25, forming a small portion of total providers (shown in Table A.6 below). Note that there were other providers recorded as Indigenous-led organisations without full ATSICCO status.

Table A.6: Number of providers by ATSICCO status [1]

ATSICCO Status	Financial Year			
	2021-2022	2022-2023	2023-2024	2024-2025
ATSICCO	5	7	8	6
Other	137	142	161	157
Total	142	149	169	163

A.19. In total, there were 15,503 placement nights available in ATSICCO-delivered residential care in FY2024-25. This was a significant increase from FY2021-22, as evidenced in Table A.7 below, meaning that the ATSICCOs in the market rapidly expanded capacity over the four years. However, given that there were 1,298 children and young people of Aboriginal and Torres Strait Islander descent* in residential care over FY2024-25 in Queensland [1], supply remained below demand.

Table A.7: Number of placement nights delivered by ATSICCOs [1]

ATSICCO Status	Financial Year			
	2021-2022	2022-2023	2023-2024	2024-2025
ATSICCO	3,265	7,506	14,187	15,503
Other	629,739	661,757	764,869	811,892
Total	**633,004**	**669,263**	**779,056**	**827,395**

*Note that this was based on care types captured in Departmental-provided datasets, and on the Department's definition of residential care, family-based care and other services. The count of individual children was calculated using the number of unique ICMS IDs during the period.

Market stability

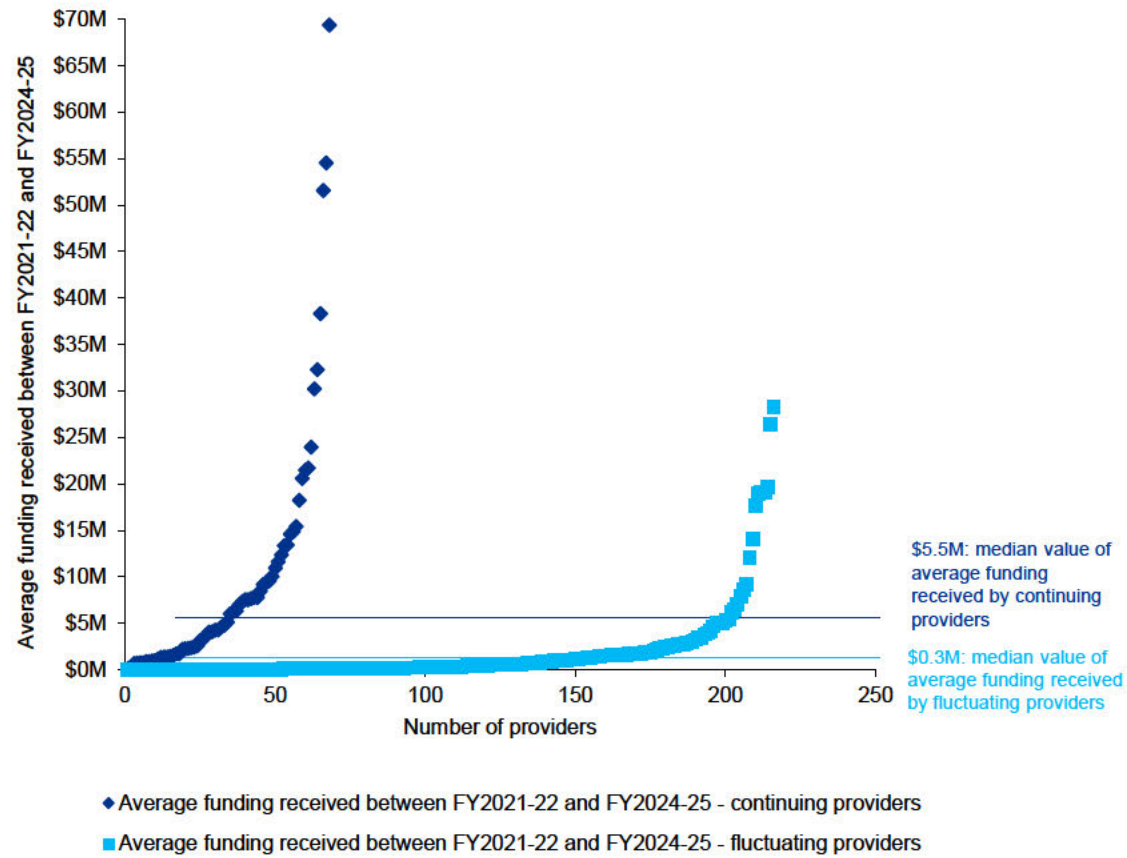
A.20. Available data does not allow inference as to the motivation of providers' entry or exit, nor whether decisions to commence or discontinue service delivery were at the discretion of the provider or the Department.* However, it is possible to analyse fluctuations in funding amount and average amount funded to test the stability of the market at a high level.

A.21. Across FY2021-22 to FY2024-25, providers that received a mixture of zero and non-zero funding across the four years were tagged as 'fluctuating', whereas providers that received non-zero funding across all four financial years were tagged as 'continuing'^. This analysis included providers that received OSD funding, IPS funding and/or both (i.e. dual funded).

A.22. Of the 284 providers that received any funding between FY2021-22 and FY2024-25, 216 fell into the 'fluctuating' category compared to 68 in the 'continuing' category. This indicated that more than 75% of residential care providers received zero funding for at least one year between FY2021-22 and FY2024-25. Around half of 'continuing' providers were initially tagged as 'OSD only' or 'dual funded' and around half were tagged as 'IPS only', noting that this categorisation may have shifted over the four years.

A.23. As can be seen in Figure A.15, average funding amounts for 'fluctuating' providers tended to be much lower than for 'continuing providers', indicating that larger providers (based on funding amount only) had a more stable market presence. The median of the four-year average funding amount was $0.3m for 'fluctuating' providers, compared to $5.5m for 'continuing' providers.

Figure A.15: Distribution of average funding received per provider between FY2021-22 and FY2024-25, grouped by 'continuing' or 'fluctuating' providers [1]



*While available data does show total funding amounts by provider, this does not allow reliable inference as entry or exit. For example:

- A provider may be inactive and receive no funding for several financial years before receiving funding again, or vice versa. If the quantitative dataset does not cover a large enough timeframe, this provider may erroneously be tagged as having entered or exited the market. Qualitative consultation is required to understand and validate provider intentions.
- Alternative quantitative datasets may have other limitations (e.g. date of ABN registration may not reflect true 'market entry' date, and providers may have registered initially to provide other types of care).

^For example, a hypothetical 'fluctuating' provider received $0.5m of funding in FY2021-22, no funding in FY2022-23, $0.7m in FY2023-24 and no funding in FY2024-25. A 'continuing' provider received funding for all financial years in scope.

Quality and performance

A.24. The level of service quality being delivered to children and young people by residential care providers in Queensland is difficult to quantify. The Queensland Care Services Outcomes Framework [10] identifies child/young person, supplier and organisational outcomes under five overarching domains: Safe & Nurtured; Connected; Achieving; Healthy; and, Resilient. The Department measures the effectiveness of OSD providers through Service Agreements with measures generally relating to throughput, volume and costs with less focus on quality of service delivery. The Department, according to the Individual Support Supplier Guidelines DOC, monitor and regularly review Child Safety's expectations towards achieving these outcomes [9].

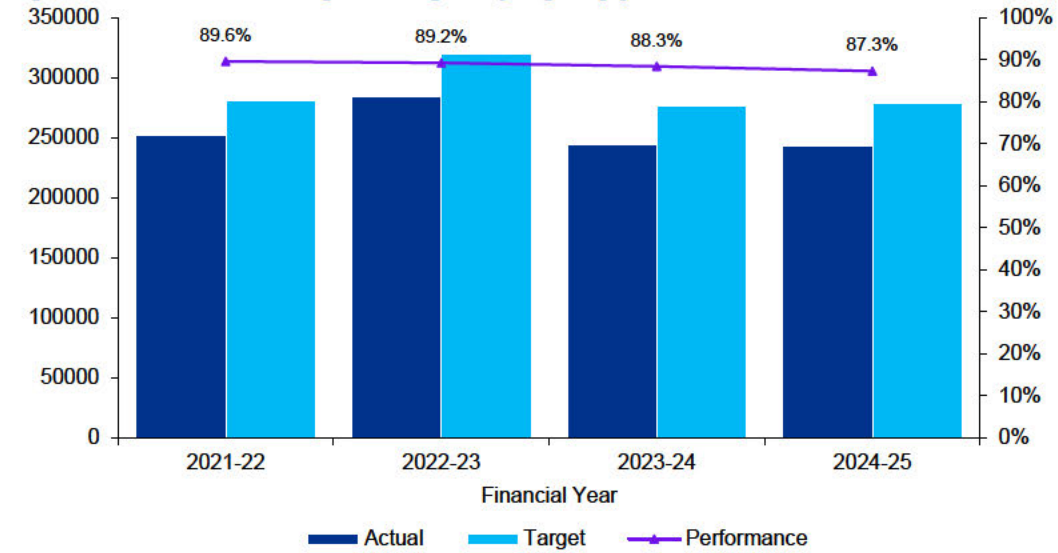
A.25. While the Commission sought information and records regarding the performance of providers of non-family based residential care, limited data was returned by the Department. The Child Protection Investment Specification describes the requirements for OSD-funded service providers, including performance expectations and measures to target investment and achieve intended outcomes. The lack of available data limits the ability to assess provider performance in upholding responsibilities to provide safe and supportive environments for young people to live.

A.26. Licenced providers are required to attain and maintain Human Services Quality Framework (HSQF) certification against the Human Services Quality Standards (that is, Governance and Management; Service Access; Responding to Individual Need; Safety Wellbeing and Rights; Feedback, Complaints and Appeals; and, Human Resources). Providers must go through a three-year certification cycle with an independent quality assessor which includes certification, maintenance and recertification audits. A review of a sample of 58 HQSS audit reports from 43 providers supplied by the Department showed that 32 (55%) achieved unconditional certification and 26 (45%) achieved certification with a condition that non-conformities are determined to be conforming within the required timeframe. At least six audit reports yielded overall outcomes of major non-conformity. HQSS assessments can cover a number of service types and are not restricted to residential care with many providers delivering services across the human and social services.

A.27. The Department received 76 complaints about residential care service providers between July 2021 and February 2026. Nine (11.8%) of these complaints were substantiated (or had components that were substantiated). Substantiated complaints related to standards of care and safety for young people and impact on neighbours. For an additional 14 complaints, further action was recommended including staff practice learnings.

A.28. Performance is recorded for OSD providers in relation to their progress towards target nights. Between FY2021-22 and FY2024-25, OSD providers combined to provide 1,023,280 residential care nights which was 88.6% of the total target for this period (1,154,714 nights) – see Figure A.16. Performance towards targets was relatively consistent across each region and in each year, with the greatest variability observed in North Queensland region which had an overall achievement of 84.7% which ranged from 78.9% in 2024-25 to 91.1% in 2021-22. This data relates to throughput information and does not reflect quality of service delivery.

Figure A.16: Performance against targets by region [1]



Queensland and interjurisdictional approaches to residential care services regulation

A.29. It is critical to understand Queensland's approach to residential care services regulation to contextualise market dynamics and understand enablers of entry/exit. A description of the Queensland sector regulators, provider registration agencies and worker screening agencies is set out below, as well as information for Victoria and New South Wales.

Table A.8: Queensland and interjurisdictional approaches to residential care regulation

Dimension	Queensland	Victoria	NSW
Overview	Regulation is distributed across multiple agencies in Queensland. This arrangement may require more complex coordination to maintain end-to-end oversight, risk identification and intervention.	Victoria has implemented reforms towards regulatory consolidation and independence. The Social Services Regulator (SSR), established in July 2024, consolidates worker screening, reportable conduct, and provider registration under one entity.	Similarly to Victoria, New South Wales consolidates regulatory functions within one entity, the Office of the Children's Guardian.
Sector Regulator	The Queensland Family and Child Commission has powers to monitor and report on the Child Safe Organisations system under the Child Safe Organisations Act 2024. The Department of Families, Seniors, Disability Services and Child Safety is responsible for child protection and investigating concerns of harm, including issues that occur at residential care services [12].	The Social Services Regulator is an integrated sector regulator that regulates the Social Services Standards and the Child Safe Standards across a range of settings, including out-of-home-care, disability, family violence, homelessness and secure welfare services. The Social Services Regulator is an independent statutory authority and reports directly to the Minister for Children; Minister for Disability [11].	The Office of the Children's Guardian oversees regulation of the Reportable Conduct Scheme and Child Safe Scheme and leads accreditation and child-safe practices in statutory out-of-home care, children's employment, and other child-related organisations. The Office of the Children's Guardian is a statutory government agency with powers and functions defined in its own Act, reporting to the Parliament and the Minister for Families and Communities; Minister for Disability Services [13].
Provider Registration	The Department of Families, Seniors, Disability Services and Child Safety oversees registration of residential care providers. Note that following registration, providers can be licensed or remain unlicensed [14].	The Social Services Regulator oversees registration for all social service providers in Victoria, including residential care providers. Providers must meet the six Social Services Standards, Child Safe Standards, and any custom requirements determined at registration [15].	The Office of the Children's Guardian oversees registration for all residential care providers [16].
Worker Screening	Blue Card Services within the Department of Justice leads worker screening and associated compliance and enforcement activities (including maintaining worker registers and issuing penalties, suspensions and revocations) [17].	The Social Services Regulator maintains responsibility for all elements of the Working with Children Check scheme, the Worker and Carer Exclusion Scheme, Reportable Conduct Scheme and the NDIS Check [18].	The Office of the Children's Guardian oversees the Working with Children Check scheme, with the support of Service New South Wales [19].

Availability of alternative providers

A.30. Market dynamics are shaped by the availability of alternative tertiary care providers that could provide appropriate services for children and young people. A summary of relevant alternative family-based care options is set out below, including descriptions, comparative strengths, risks, and relative cost.

Table A.9: Availability of alternative providers

Care option	Category	Definition	Strengths	Weaknesses	Evidence & stability	Relative cost
Standard residential care (focus of this report)	Non-family-based	Placement in a residential building with paid rostered staff, whose purpose is to provide placements for children. In Queensland, designated for young people over 12. Guided by the Hope and Healing Framework, which identifies needs for physical, emotional and cultural safety, nurturance, development and healing from trauma [25].	Provides 24/7 staffed care for young people with complex needs who cannot be safely placed in family-based settings. Can accommodate young people with histories of violence or absconding. Does not require individual carer recruitment, enabling faster placement responses.	Evidence consistently shows poorer outcomes vs family-based care. Queensland residential care population grew from 11.0% to 18.2% of all OOHC placements in 2024 [20]. Peer contagion effects in congregate settings [30]. High staff turnover and casualisation undermine relational continuity [21].	Lower stability than kinship-based care [27].	High
Kinship care	Family-based	Placement with a family member or person with a pre-existing relationship to the child (e.g. grandparent, aunt, neighbour). The Queensland Child Safety Practice Manual (CSPM) distinguishes "kin" (relatives) from "kith" (community members). Provisional approval available for urgent placements [24].	Maintains family and cultural connections, consistent with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) [31]. Children in kinship care experience fewer behavioural problems and fewer mental health disorders than those in non-related foster care [26].	Carers may receive less training and financial support than foster carers. Pre-existing family dynamics, including intergenerational trauma, may complicate the caregiving relationship. Kinship carers are disproportionately older and may face health and housing constraints.	Highest stability. "Placement in kinship care reduces the risk of a placement move and increases placement stability, especially for older children" [27].	Lowest
Foster care	Family-based	Placement in the private home of an assessed and approved carer receiving payment from the state. Carer assessment includes criminal history, domestic and family violence (DFV), child protection checks, Blue Card, pre-service training, and face-to-face interviews [24]. May be short-term (up to two years) or long-term (to 18+).	Normalised family environment supporting attachment and recovery. Treatment foster care is "a promising intervention for young people with behaviour problems, associated with decreases in antisocial behaviour and time in locked settings [28]. Assessment framework ensures baseline quality [24].	Declining carer supply: only 8,000 foster carer households nationally at 30 June 2024, half the kinship pool [23]. Challenging behaviour is linked to placement breakdown and carer intention to cease fostering; carers frequently report feeling unprepared and receiving insufficient support [29].	Lower stability than kinship-based care [27]. Promising evidence base for treatment foster care, though "less robust than that usually reported" [28].	Low
Family group homes	Family-based	"Homes for children provided by a department or community-sector agency which have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care" [33]. Sits at the intersection of family-based and residential care.	Family-like environment with consistency of live-in carers. Smaller group size reduces institutional dynamics [22]. Suitable for sibling groups who cannot be placed together in a single foster or kinship household [32].	Very limited availability in most jurisdictions. Capital-intensive (tends to require government-owned property and dedicated live-in staff). Live-in carer recruitment is challenging. Limited contemporary Australian evidence on outcomes [22].	Moderate stability - Limited evidence base.	Moderate

Availability of alternative providers (continued)

A.31. There are additional tertiary care options that are suitable for particular sub-sets of children and young people, including Indigenous children and young people, children and young people with disabilities, and children and young people with other specific needs.

Table A.10: Availability of alternative providers (continued)

Care option	Category	Definition	Strengths	Weaknesses	Evidence & stability	Relative cost
Therapeutic residential care (TRC)	Non-family-based	Time-limited (12 to 18 months) placement that "prioritises young people with complex to extreme needs who are unable to be placed in foster or kinship care" [24]. Staffed by care practitioners with enhanced intervention skills using trauma-informed models. Multi-agency network approach (Health, Education, Police) [24]. For young people aged over 12 [24].	Explicitly designed for trauma healing. "Emerging consensus about the effective elements... including: shared understanding of young people's needs; therapeutic input tailored to needs; best possible connection to family and culture; and prioritising relationship-based work" [34]. Mandated minimum qualifications for staff [35].	Time-limited design creates transition pressure if step-down placements are unavailable. Significantly more expensive than standard residential care. Much of what occurs within TRC services remains a "black box" - processes and activities are not transparent or well understood [34]. Limited availability relative to demand.	Time-limited by design. Emerging evidence. "A relatively recent development in out-of-home care service provision" [34].	Very high
Supported independent living (SIL)	Non-family-based	Residential setting for a small number of young people aged 15+, where "workers generally do not live in the house but provide external support through regular visiting" [24]. Focuses on developing life skills for transition to adulthood [24].	Develops practical independence (budgeting, cooking, self-care) in a less restrictive environment. Step-down pathway from residential care. Lower cost than standard or therapeutic residential care due to reduced staffing intensity.	A Cochrane review found no evidence from randomised controlled trials (RCTs) on the effectiveness of independent living programmes [36]. Requires self-regulation and maturity that may not be present in young people with complex trauma. Risk of social isolation. Limited safety net for crisis escalation.	Variable stability. No randomised controlled trial evidence; non-randomised studies show "generally favourable results" but with "weak methodology" [36].	Moderate
Indigenous community residential care (safe houses)	Non-family-based	"Residential services specifically designed to meet the particular needs of Aboriginal and Torres Strait Islander children" located "in Aboriginal and Torres Strait Islander communities, to enable children to safely remain in, or return to, their communities of origin" [24].	Enables children to remain connected to Country, community, culture, and language, consistent with the ATSICPP [31]. Community-controlled governance supports self-determination. Addresses over-representation of First Nations children [37].	Limited to specific geographic communities, restricting availability for urban/peri-urban First Nations children. Workforce challenges in remote communities (recruitment, retention, clinical access). Funding and infrastructure constraints in remote locations.	Moderate stability. Limited evidence base [38].	High
Other entity placements	Non-family-based	Under s82(1)(f) Child Protection Act 1999 (Qld) [39], other entities may provide care including unlicensed non-family-based providers, mental health facilities, disability services, and interstate providers. The CSPM notes these placements "are not monitored via a licencing arrangement or a carer approval process" [24].	Legal mechanism for specialist placements (e.g. mental health inpatient, disability respite) outside standard OOHC categories. Flexibility to respond to individual needs. Can facilitate interstate placements for highly specialised needs.	Explicitly lacks regulatory safeguards of licensed care [24] [39]. Growth of unlicensed providers in Queensland raises quality and safety concerns. Monitoring burden falls on individual child safety officers rather than systemic oversight.	Unknown stability. No evidence base.	Variable

Part 3.2

Market Dynamics

Demand factors

Overview: Demand in the residential care market

A.32. Demand for residential care services is inelastic: once a child reaches the established need threshold, the Queensland Government must procure care within a set time-frame regardless of price. Purchasing decisions are often constrained to immediate vacancies, irrespective of the alignment between the provider's model of care and the child's needs [3].

Inelastic demand is common across the human and social services sector. Examples include:

- Emergency health and ambulance services: Patients seek care based on their medical needs rather than competitive pricing or assessment of alternative options. Increasing unit costs does not reduce demand for services; rather, it contributes to higher system spending.
- Disability supports: National Disability Insurance Scheme (NDIS) participants with severe or profound disability access NDIS supports out of necessity rather than preference, and as such, demand is minimally responsive to price changes. Participants cannot 'shop around' for core services. Efforts to constrain prices have had unintended consequences of spurring provider exits, without reducing demand for services [40].
- Residential aged care: As there are limited suitable alternatives and services are linked to statutory obligations and clinical needs, demand for residential aged care is also inelastic. Attempts to regulate prices can result in cost shifting to other parts of the system [41].

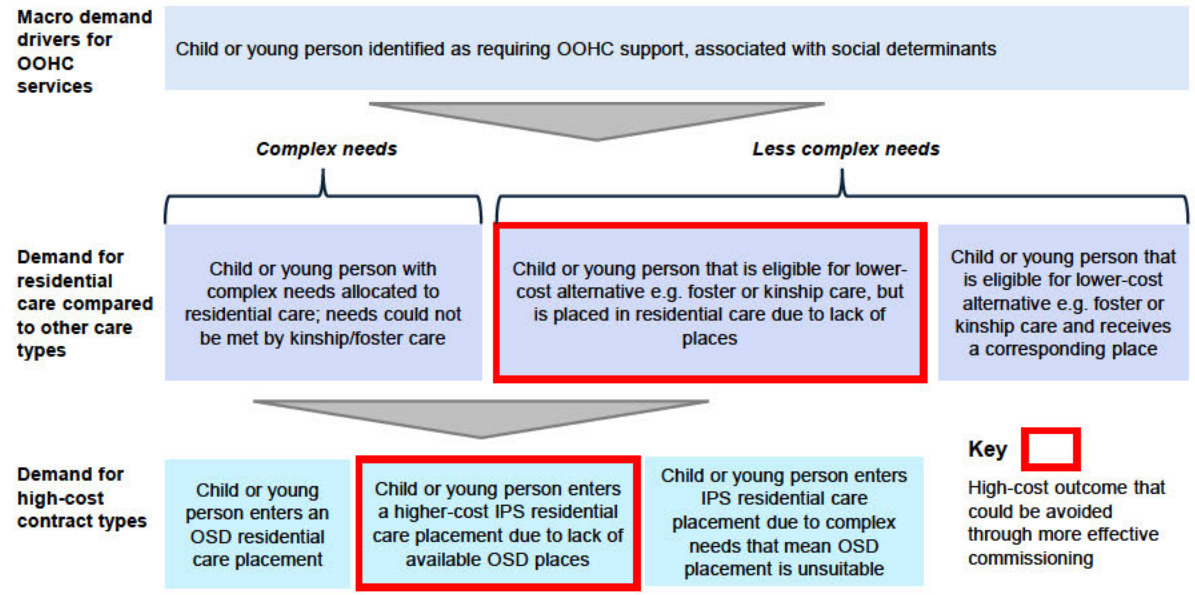
In the context of inelastic demand, there is limited flexibility for government to reduce the volume or change the mix of residential care services it procures, even in the face of price increases.

A.33. At the same time, underlying demand for residential care services has increased over the last decade. Changes in demand can be defined across three layers.

1. **Macro demand for OOHC services:** Social drivers such as domestic and family violence, homelessness, poverty and poor mental health, coupled with limited early intervention supports, may be associated with more children and young people requiring OOHC over the last decade.
2. **Demand for residential care compared to other care types:** Within OOHC, some children or young people have specific higher-threshold needs that can only be met by residential care. In other cases, a child or young person may be suitable for foster care or kinship care, but due to the limited availability of these supports, be placed in residential care. This cycle may drive greater demand for residential care services.
3. **Demand for high-cost contract types:** Within residential care, a child or young person may enter an IPS placement (short-term provider contract at high cost) or an OSD placement (provider with a longer-term contract, with greater quality and safety oversight mechanisms). Government has increased its reliance on IPS contracts as a flexible surge mechanism [3].

These three demand layers are set out in Figure A.17 below.

Figure A.17: Layers of demand drivers



Macro demand for OOHC services

A.34. The number of children and young people requiring child protection services, including OOHC services, increased over the past decade in Queensland. Per 1,000 children aged 0-17 years, between 2015-16 to 2023-24, the number of notifications increased from 17.6 to 29.2; the number of substantiations increased from 5.0 to 5.8; and the number of care and protection orders increased from 8.4 to 10.9, as seen in Figure A.18. All three measures showed a consistent upwards trend throughout the decade. While national rates of OOHC declined over FY2019-20 to FY2023-24, in Queensland they trended upwards and surpassed the national average each year since 2021-22, as shown in Figure A.19.

Figure A.18: Notifications, substantiations and care and protection orders per 1,000 children aged 0-17 years [20]

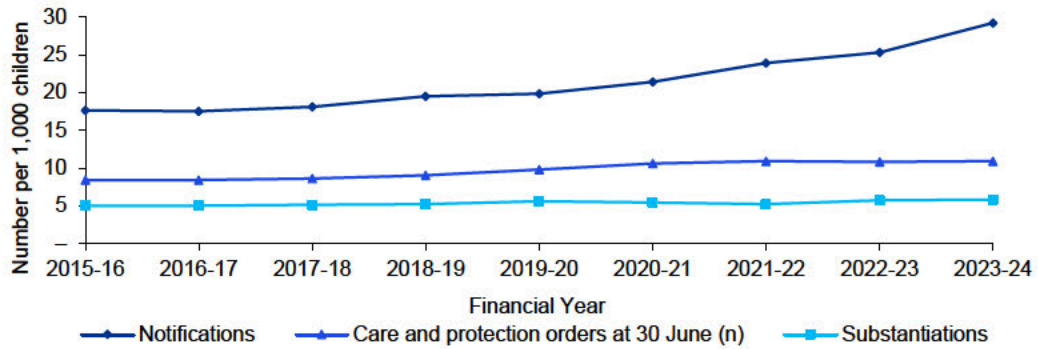
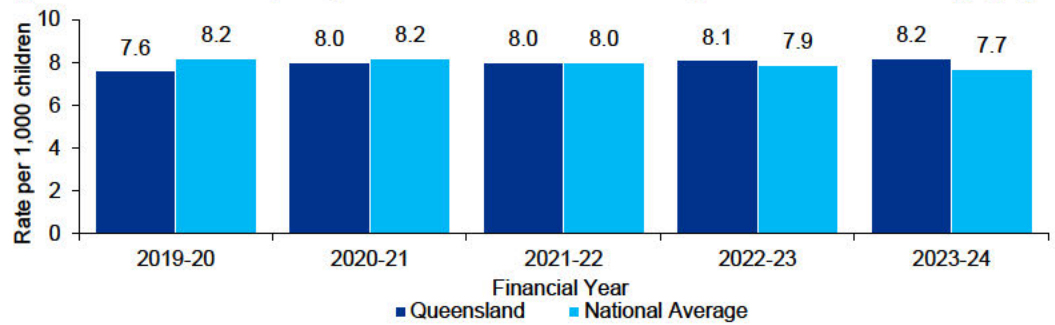


Figure A.19: OOHC rate per 1,000 children - Queensland compared to national average [20]



A.35. In its Buyer Beware report, the QFCC noted two key factors driving increased demand for OOHC services:

1. Increasingly complex and interdependent needs: The increasing number of children entering the child protection system may be linked with worsening social drivers such as domestic and family violence, homelessness, poverty, unemployment, drug and alcohol issues, and poor mental health [3].
2. Limited investment in early intervention: Investment in early intervention is comparatively low and delays in investigations can push the system toward reactive crisis management (including entry to residential care) rather than proactive support [3].

Increasingly complex and interdependent needs

A.36. The QFCC's *2024-25 Annual report* noted that children and young people increasingly face overlapping and complex life challenges. In 2024, half of the surveyed cohort of children and young people in OOHC had limited relationships or significant relationship problems with family, an increase of almost 10% from 2023; 31% had limited to severely limited intellectual functioning or developmental delay; 20% of respondents had a diagnosed or suspected mental illness; and 28% had extreme instability and/or extreme emotional responses that limit functioning [44].

A.37. As at June 2024, 634 children under 12 years of age were living in residential care, with 46 children under the age of five years [45]. There is evidence that more children are entering than exiting care, indicating that children may be remaining in care for longer durations [42].

Limited investment in early intervention

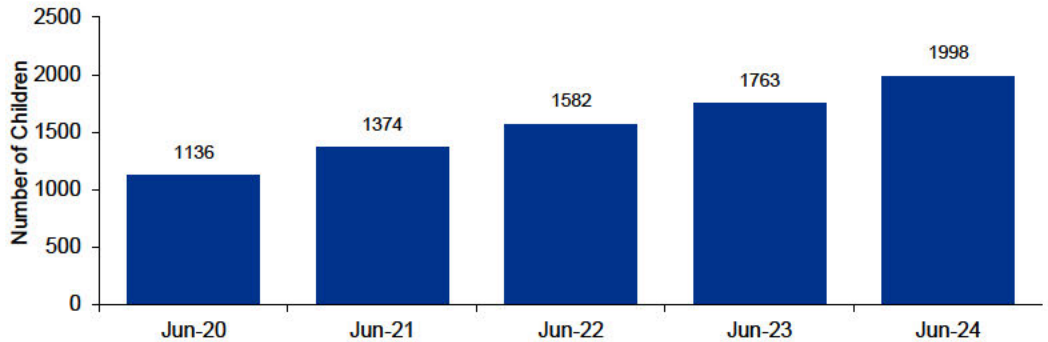
A.38. Early intervention programs reduce the incidence of children and young people entering the OOHC system and improve ongoing wellbeing. In Queensland, key early intervention programs include Intensive Family Support services and Aboriginal and Torres Strait Islander Family Wellbeing services [43]. Queensland Government also manages a holistic system of programs focussed on domestic and family violence, interactions with the justice system, homelessness, poverty, disability, mental health challenges, substance use, and education disengagement [44].

A.39. However, investment in early intervention remains low compared to other jurisdictions. In FY2021-22, Queensland invested the least in intensive family support services of any jurisdiction except Western Australia and Tasmania [43]. A QFCC annual report found that in FY2023-24 the average investment in intensive family support was $9,667 per child, below the national average of $11,403 [44].

Demand for residential care compared to other care types (continued overleaf)

A.40. Once it is determined that a child or young person requires out-of-home care, there are a range of family and non-family based care options available. Standard residential care is suitable for children and young people with more complex needs that may not be met by kinship and foster care [47]. However, a portion of children with less complex needs that are suitable for foster and kinship care are unable to access these places due to limited availability, resulting in rapid growth in residential care placements [42]. While there was a 12% increase in approved FBC families between FY2019-20 and FY2023-24, this was outpaced by demand growth (refer to Figures A.20 and A.21 below). Residential care is significantly more expensive than foster and kinship care, costing the Queensland government around $500,000 per child per year, compared to $50,000 for foster care and $20,000 for kinship care [50].

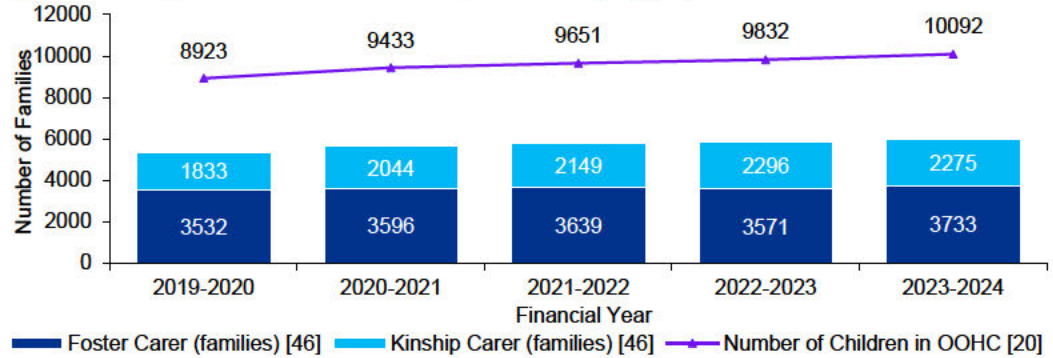
Figure A.20: Children in residential care at the reference date in Queensland [49]



2,388
Individual children in residential care (as of the 18th of February 2026) [48]

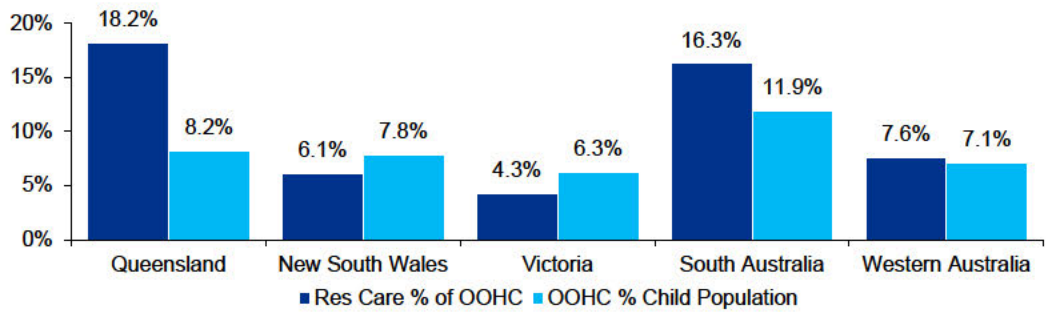
14.2%
Compound annual growth rate (period from June 2020 to February 2026) [48] [49]

Figure A.21: Approved carer families in Queensland [20], [46]



A.41. Queensland has higher rates of residential care placements than other jurisdictions. 2023 data showed despite only having 21% of the nation's children in care, Queensland had 40% of Australia's residential care placements, signalling disproportionate entry into residential care compared to alternative care types [3]. Based on 2024 data (shown in Figure A.22 below), almost one in five Queensland children in OOHC were in residential care, which was the highest proportion in the country. By comparison, New South Wales and Victoria had 6.1% and 4.3% of children in OOHC in residential care respectively.

Figure A.22: Residential care proportion of OOHC and OOHC rate by state jurisdiction in 2024 [20]



Demand for residential care compared to other care types (continued)

A.42. The Queensland Government's ambition to decrease expenditure in residential care is challenging given emerging shifts towards greater incorporation of therapeutic supports within residential care, which generally constitute a more expensive care type [51].

A.43. The Australian Institute of Family Studies states that there is growing consensus about the effectiveness of therapeutic residential care integrated into standard residential care arrangements [34]. Benefits include greater understanding of young people's needs, more tailored placement and therapeutic inputs, and strengthened connection to family and culture.

A.44. Other Australian jurisdictions are increasingly adopting therapeutic residential care [34]. For example, Victoria has committed to enabling access to therapeutic supports for all young people in residential care by FY2025-26 through several mechanisms [52]:

- Funding growth: From 1 January 2024, around 75% of base four-bed residential care homes that did not already have a therapeutic loading attached received additional funding for therapeutic supports [52];
- Implementation of additional contractual requirements and monitoring: The Department of Families, Fairness and Housing conducts audits of residential care homes to ensure additional requirements for therapeutic care are met under renewed audit frameworks [52]; and
- Establishment of workforce strategies: The Department of Families, Fairness and Housing has developed a Residential Care Learning and Development Strategy in collaboration with the Centre for Excellence in Child and Family Welfare, which includes guidance on delivery of therapeutic care [53].

Demand for high-cost contract types

A.45. Within residential care services, government is increasingly procuring IPS contracts at higher cost and with reduced accountability mechanisms [3]. Due to the inelasticity of demand and time-criticality of placement, if there is no immediate OSD funded capacity available, the child or young person's referral will be distributed to IPS-funded providers to locate the most suitable placement option [54].

A.46. Data shows that in the six-year period from 30 June 2016 to 30 June 2022, the shortfall between the number of children requiring a placement and OSD funded places increased from 502 to 1177 (134.5%) [55]. In addition to volume, the total value of IPS packages is growing due to higher unit costs, increasing the cumulative financial value of the arrangements [55].

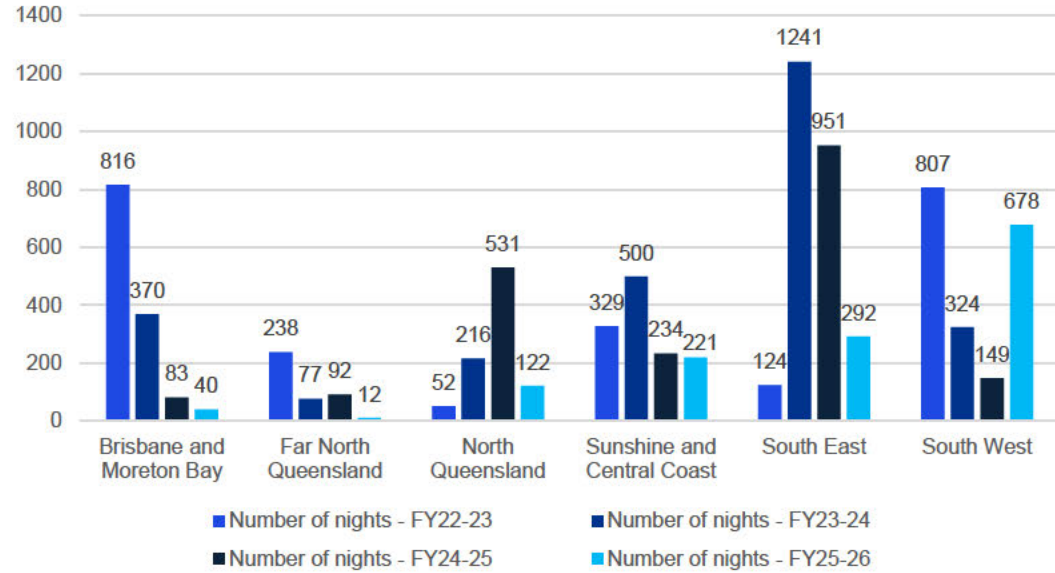
A.47. IPS cost escalation is especially significant for children and young people that have long-term service requirements or are likely to require care until they turn 18 years old. For this cohort, the Department may be paying a premium of at least 7% to 10% for short-term three- to twelve-month placements that may need to be renewed several times [42].

A.48. As shown in Figure A.23, between July 2022 and February 2026, a total of 1,181 emergency accommodation placements were made across Queensland, resulting in young people spending 8,541 nights in emergency-type accommodations, including hotels. This included 921 nights for young people aged up to ten years. The total cost of accommodations during this period was $2.1m, with the cost of servicing these emergency accommodations exceeding $10.0m. Emergency placement usage varied between regions.

A.49. To this end, Queensland Government has acknowledged the need to develop an approach to strategic commissioning that is flexible, adaptive to dynamic market conditions, and able to deliver quality care placements within tight timeframes [5]. This will support Queensland to more intentionally shape its demand profile.

A.50. The Queensland Government is undertaking a process to support IPS providers transition to OSD arrangements that would offer providers greater security while also building a stronger base of stable residential care providers and supporting cost reductions for the State. There is a potential risk for the Queensland Government that providers may self-select out of residential care delivery if there is perception that they are being pressured to convert to less profitable arrangements or to accept lower prices than would allow them to sustainably deliver operations, which could further impact supply.

Figure A.23: Emergency placement nights per region [1]



Supply factors

Labour and non-labour cost increases

A.51. Supply side constraints in Queensland residential care are predominantly driven by the availability of a skilled workforce. Labour is the largest operating cost for suppliers, with around two-thirds of provider revenue spent on direct wages [58]; additionally, the Social, Community, Home Care and Disability Services (SCHADS) Award, which covers residential care workers, increased minimum wages by 3.8% in 2024 and 3.5% in 2025* [56]. The pool of available workers is further reduced through competition with the disability sector (which is also governed by the SCHADS Award) [57]; OOHC is often seen as a stepping stone to NDIS roles [59].

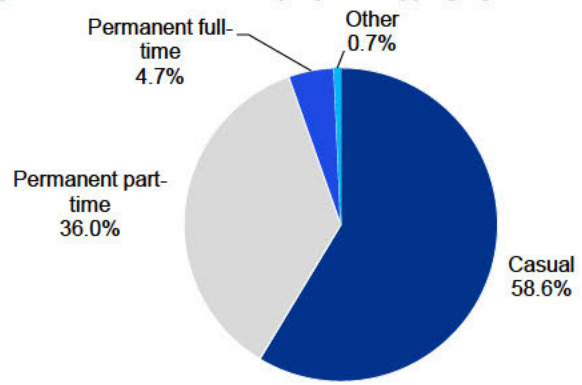
*KPMG has been advised by the Commission that notwithstanding these increases, the benchmark pricing in the IPS Business Rules has seemingly not been updated since in or around late 2020.

Workforce capacity

A.52. Providers need a large enough pool of trained staff to cover continuous rosters and manage high complexity behaviours in children and young people. However, the supply of consistent, stable ongoing labour is constrained. In 2024, 58.7% of workers in residential care in Queensland were on casual contracts, as can be seen in Figure A.24 below [21]. Casualisation may be incentivised within IPS contract structures due to significant fluctuations in placement requirements and demand [21].

A.53. Casualisation can reduce continuity of care and increase risk, particularly for children with trauma, disability or complex behaviours [60]. Additionally, casual workers incur a 10% to 15% loading and can therefore be more expensive over the same period compared to an ongoing worker [42].

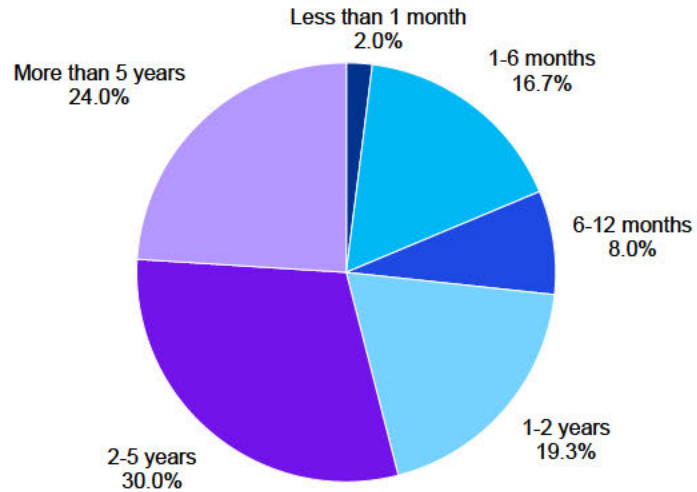
Figure A.24: Workforce employment type [21] 2024



Workforce capability

A.54. A PeakCare report, *Insights and Opportunities: Queensland's Residential Care Workforce,* noted that current workforce capability is insufficient to manage escalating complexity [21]. Three-quarters of Queensland's frontline workers have fewer than five years' tenure [21], as shown in Figure A.25 below. Children and young people participating in Residential Care Expert Advisory Council workshops identified a lack of training in mental health, disability support, trauma-informed care, cultural capability, time management, and English communication as urgent capability gaps to be addressed [61]. In response, Queensland is investing in further training for workers. Residential care staff at licenced providers must hold or be enrolled in and working towards a recognised Certificate IV qualification, and must have completed additional mandatory training introduced in 2019 (Hope and Healing for Residential Care) [35]. The extent to which providers are ensuring that employees are working towards these qualifications, and the Department's visibility of this progress, is unknown.

Figure A.25: Proportion of workforce by tenure [21] 2024



Labour and non-labour cost increases (continued)

A.55. Beyond labour, providers are facing challenges including limited stocks of suitable housing, increasing electricity and utilities costs, and rising insurance premiums. Financial analysis found that costs exceeded revenues for a selected sample of residential care facilities from FY2019-20 to FY2021-22, resulting a net sector deficit across all three years [64]. This suggests that cost escalation is a challenge for the sector [64].

Housing costs

A.56. Providers require suitable housing stock that meets safety requirements; delays in sourcing compliant houses can slow capacity growth [62]. Nationally, housing cost increases (which rose 6.8% in the 12 months to January 2026) were the largest contributor to Consumer Price Index increases [65]. While there is limited data pertaining to residential care housing, rental market data suggests that overall vacancy rates in Queensland are low and the property market may be under-supplied [66]. Fluctuations in property prices can significantly impact residential services providers' operational sustainability [62].

Electricity and utilities costs

A.57. Across Australia, electricity costs rose 32.2% in the 12 months to January 2026. This increase was primarily related to Commonwealth and State Government electricity rebates being used up by households [65]. As residential care services operate 24/7, they consume high volumes of electricity and other utilities compared to other sectors [62]. Residential care providers also reported increases in costs for repairs, maintenance, and preparing or reinstating houses to align with legislated requirements [62].

Insurance premiums

A.58. Residential care providers face reputational and operational risks, including serious incident exposure and workers' compensation claims. Providers reported significant increases to insurance premiums in recent years [62].

A.59. Between 2016 and 2021, providers saw a 93% increase in workplace violence claims in residential care settings [21], an average WorkCover premium rate of $2.635 per $100 of salary paid [63]. On average, residential care workers submitted 29.6 time-lost claims per 1,000 workers (versus a 19.7 average for the social assistance sector) [21]. These claims represented a significant operational cost for providers.

A.60. Providers across Australia also reported challenges in obtaining coverage for insurance claims related to sexual abuse or other types of abuse, as well as cost increases for General Organisation insurance, Public Liability insurance, and property and contents insurance [62]. In relation to these factors, providers may be adjusting their acceptable-risk thresholds, and in serious cases, exiting the market completely.

Under-supply of services for specific cohorts

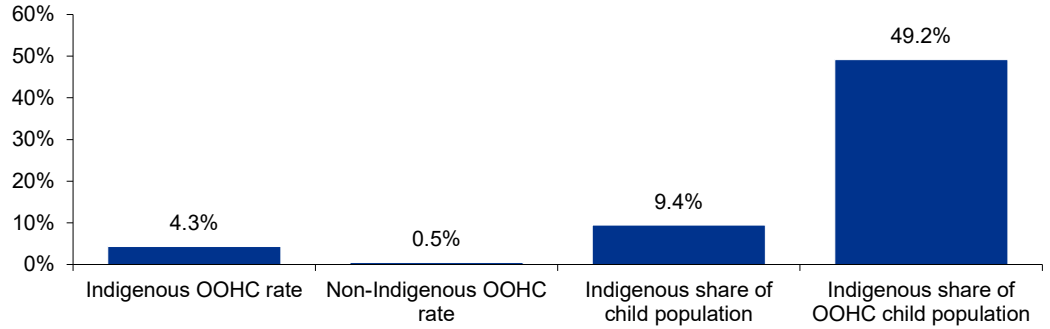
A.61. In addition to the overarching supply issues identified across the residential care sector, access for specific cohorts of children and young people is particularly affected by supply constraints. Two cohorts are explored in further detail below: First Nations children and young people, and children and young people living in regional and remote areas.

First Nations Children and young people

A.62. First Nations children and young people represent a significant share of residential care demand. Departmental point-in-time analysis as at May 2025 revealed that 1,164 children, or 47.8% of all children in residential care, identified as Aboriginal and/or Torres Strait Islander [5]. However, there are a limited number of providers delivering First Nations-specific residential care supports that are tailored and culturally responsive [5]. In FY2024-25 only six Aboriginal and Torres Strait Islander Community Controlled Organisations received funding to deliver residential care, providing around 15,000 placement nights [1]. Through consultations with the QFCC, Residential Care Expert Advisory Groups noted several examples of the current system failing to deliver culturally safe care, including removals of items of cultural significance (e.g. fishing spears), lack of culturally diverse staff, minimal effort from providers to connect young people to culture, and limited cultural support for young people and their family members at contact [60].

A.63. Cultural connection and culturally safe placements through residential care are critical to support social and emotional wellbeing, healing and ongoing connection to culture, Country and community. This is aligned with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) and greater efforts must be made to support market entry for Aboriginal-led providers to deliver culturally grounded residential care. Culturally safe placements are associated with improved placement stability, reduced placement breakdown and absconding, stronger engagement with education, health and other supports, and improved transitions from care [69].

Figure A.26: Indigenous over-representation in OOHC [20], [23] FY2023-24



Children and young people in regional and remote areas

A.64. Children in regional and remote areas may also be under-serviced without effective market shaping and intervention. Provider availability varies across Queensland and localised supply and demand gaps can result in costly and disruptive placement choices. Based on research conducted in the Queensland disability sector, which operates with similar workforce and infrastructure requirements, providers in regional and remote areas face higher operating costs, including housing, travel, and staffing premiums [67]. In particular, travel is a stronger cost pressure for regional and remote residential care providers than for metropolitan providers [62]. An NSW regional residential care provider cited an example of a young person's family contact arrangements requiring one to two staff to travel for two or three days to facilitate access visits.

A.65. Geographic gaps can be filled through more robust forecasting by local government area (LGA) to predict where future demand will arise, considering factors such as age, culturally and linguistically diverse (CALD) backgrounds, sibling groups, and children and young people with disability, to support strategic mapping of provisioning needs [68]. A more comprehensive commissioning approach that considers regional differences may also help to set more sustainable provider rates, build stronger capacity for licensed provision and reduce reliance on high-premium emergency arrangements.

Consideration of potential market interventions

Market interventions: key mechanisms to shape supply and demand

A.66. As set out in the previous section, due to the inelastic nature of residential care demand, providers have greater discretion to pass on underlying cost increases, resulting in greater costs to government [3]. In some cases, providers appear to be taking advantage of procurement systems to increase profit margins. In May 2025 the Queensland government ordered a full forensic audit into a for-profit residential care provider, after finding that dividends paid to their three shareholders totalled $5.25 million in one financial year [71].

A.67. In this context, it is critical that government implements an effective commissioning approach to actively shape the market and ensure service quality, safety and sustainability. This section sets out a range of potential commissioning reforms Queensland could consider, informed by reforms in New South Wales and Victoria. Potential mechanisms are grouped by increasing complexity of design and implementation in Figure A.27 below.

Figure A.27: Mechanisms to shape supply, ordered by complexity of design and implementation

Strengthening contractual performance frameworks

A.68. Procurement and evaluation reform may form a significant opportunity for Queensland. Recent QFCC analysis noted that all new contracts since March 2024 were single sourced procurements, and that 173 placements were procured with single staff coverage, no explicit outcomes or monitoring or minimum qualifications [3]. This provides limited levers for intervention should services be sub-standard. Although the Queensland government currently requires all providers to adhere to a Supplier Code of Conduct, departmental policies, procedures, and guidelines, funding requirements, and the Human Services Quality Framework (HSQF) [5], evidence of compliance is mixed [21].

A.69. In response, Queensland is shifting from a traditional procurement method (i.e. accessing existing Queensland Government Supply Arrangements) to a 'limited agile procurement' approach, where the Department invites a selection of providers of its choice to apply for funding. These suppliers have met pre-established quality and safety criteria, as well as other criteria relating to probity, transparency and key selected outcomes (e.g. economic, environmental and social obligations) [5] .

A.70. This shift is aligned with NSW's approach. The NSW Government recently announced its commitment to ensure provider accountability by strengthening procurement policies, outcome monitoring and performance analysis [74]. Queensland is also considering transitioning to fully open tendering at a future stage through a public sourcing strategy, which encourages new suppliers to enter and boost sector diversity [5].

Exiting/winding down contracts that are not delivering value

A.71. Queensland could also consider discontinuing existing contracts where safety and quality standards are not being met. In NSW, government is winding down the 'Permanency Support Program' for outsourced OOHC delivery. This decision was based on internal audits that uncovered poor outcomes for children and low return-on-investment [73] – for example, output measures demonstrated that service provision volumes fell despite increased funding [73]. Analysis also found that this decision may result in some provider exits [73], providing an opportunity to reset the supply mix in NSW.

Strengthening regulatory powers

A.72. Queensland has a distributed regulatory approach split across multiple agencies [3]. Queensland could consider ways to strengthen regulatory coordination and information-sharing to ensure the ongoing effectiveness of residential care delivery.

A.73. Victoria introduced the integrated Social Services Regulator to lead a consistent approach across social services and ensure proactive information-sharing and risk identification. The Social Services Regulator's powers were recently strengthened in response to the Victorian Rapid Child Safety Review, which noted the importance of joining up 'breadcrumbs' of risk indicators that can be missed when monitoring and oversight responsibilities are distributed across several agencies [72]. The Rapid Child Safety Review also noted potential points of failure between sectors (for example, the potential for perpetrators of abuse to move between sector workforces), and the need to further integrate OOHC, early childhood education and care, disability and aged care regulation [72].

Direct government delivery of residential care services

A.74. Queensland could also consider bringing residential care delivery in-house to ensure visibility and maintain required standards. The NSW Government recently committed to funding 44 government-owned, purpose-built or upgraded residential care homes for children over 12 years of age with complex needs [70]. Note that this mechanism could result in significant change, including disruption to existing providers, reduced market diversity, design and implementation complexity, and reputational risk.

Strengthening a commissioning approach to residential care services

A.75. As set out on the previous page, there are several points within the commissioning cycle where Queensland could consider reforming its approach, including proactive service planning, reconsidering volumes and types of services procured, and embedding robust approaches to measuring outputs and outcomes. A best-practice commissioning cycle for residential care services (represented in Figure A.28) could include the following stages:

Planning and policy

- Assessing population-level needs for residential care services in the current and future state, including identifying the relevant inputs, parameters and constraints to effectively forecast demand (explored in more detail in Part C of this report), including the impact of preventive and diversionary actions; and
- Understanding stakeholder landscape, policy priorities, place-based and budget considerations.

Market and service design

- Confirming the quality and viability of the market to meaningfully and responsibly respond to current and emerging needs and demands;
- Understanding the cultural and other demographic factors across each region/location to allow tailored service design considerations;
- Identifying whether needs will be met by existing body of contracted services or alternative mechanisms, which might include considering the role for government delivery;
- Agreeing volume, types and delivery partnerships for services that will meet population needs; and
- Developing commercial strategy and funding approach and mechanisms. This might include mechanisms to incentivise OSD provision or improve availability in underserved areas.

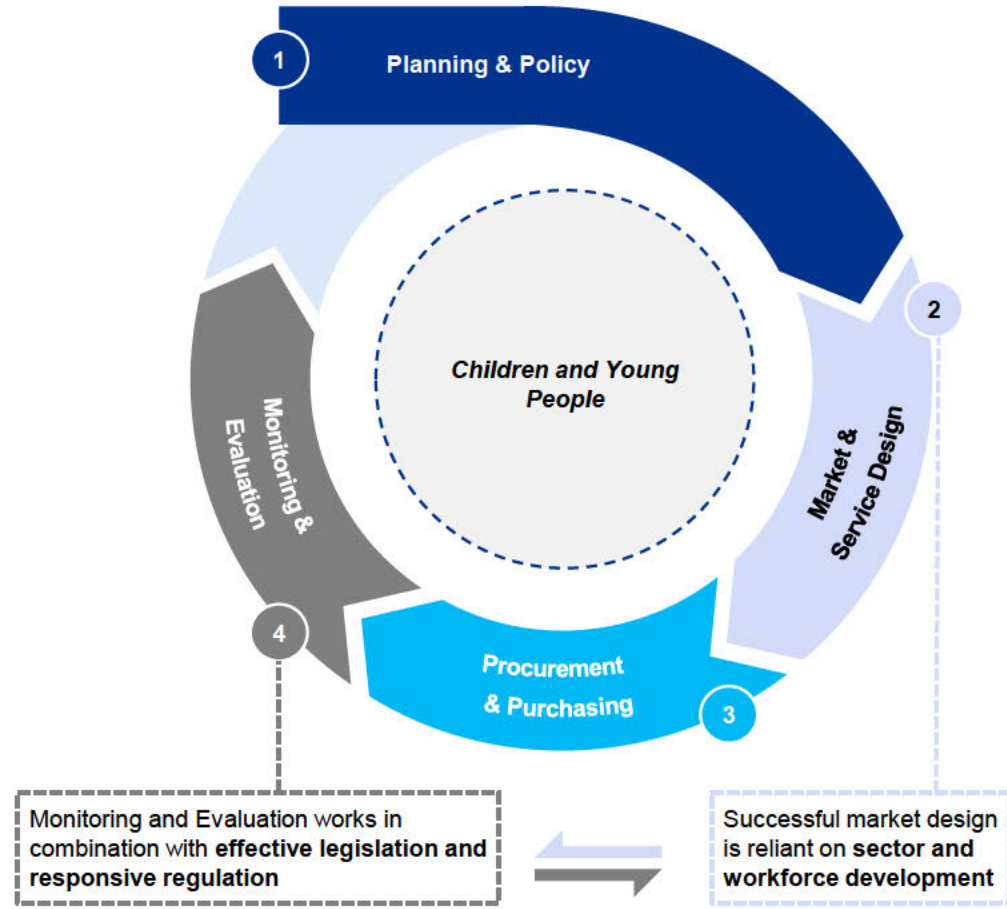
Procurement and purchasing

- Procuring services from public, private or non-government organisations and establishing contractual arrangements;
- Ensuring a consistent contracting approach with clear KPIs and outcomes; and
- Developing robust compliance and oversight processes.

Monitoring and evaluation

- Assessing provider and system performance on a continuous basis;
- Evaluating service interventions; and
- Reviewing and adjusting services, using feedback to inform the planning and policy stage.

Figure A.28: High-level commissioning model for residential care services



04

Provider financial analysis

Part B. Scope of Work & Purpose

Scope of work

The purpose of Part B is to analyse the profit margins generated by 20 Providers selected by the Commission of Inquiry as a representative cross-section of suppliers and comment on the reasonableness of those margins, having regard to:

a. The input costs incurred by Providers (including labour and overheads);

b. The different models of care offered by residential care Providers;

c. The procurement practices of the Department;

d. The availability of alternative suppliers in the market (covered in Part A); and

e. Any other factors deemed relevant.

Suppliers were selected by reference to the following criteria: for-profit v not-profit; licensed v not licensed; large Providers v small Providers; Providers in different regions; and Providers with different focus areas or models of care.

Confidentiality

While we have anonymised the Providers, the level of detail contained in this report means that individual Providers—and broader sector performance—could still be inferred. Accordingly, this detailed section of our report has been provided to the Commission on a confidential basis to preserve Provider confidentiality.

Purpose

Part B presents the financial analysis of a sample of 20 non-family-based residential care Providers, drawing on information submitted to the Commission, including financial statements, IPS Pricing Schedules, payroll data and Provider Witness Statements. The work focuses on identifying and comparing key profitability indicators, such as youth worker margins, IPS contract margins and funding per placement per day.

The purpose of this analysis is to determine definitive Provider-specific profitability and identify sector-level patterns, risks and explanatory themes relevant to the Commission.

Part B. Limitations

Limitations

Our financial analysis has been performed using information submitted to the Inquiry by 20 Services Providers (the "Providers"). While we have applied appropriate professional judgement, the scope and reliability of our findings are limited by the completeness, consistency and granularity of the information submitted by those Providers.

The absence of granular financial information limited our ability to reconcile financial performance to the operational activity in the payroll report, IPS Pricing Schedules or the rosters where they were provided. **As a result, our work focused on identifying broad themes rather than validating Provider-specific profitability or efficiency on a bottom-up basis.**

Information requests

Our review of the Provider information is limited to the assessment of 20 Providers that complied with the Notice to Produce Documents and Provide Information dated 19 December 2025. While we sought additional financial information to supplement and improve our findings it was received on 9 March 2026 and, due to the limited time available to complete the report, it could not be incorporated into the analysis.

Financial information limitations

The financial information provided was not sufficient to support a detailed assessment of Provider input costs, particularly labour and overhead costs to determine the underlying drivers of profitability. The data submitted was largely limited to high-level financial statements, with minimal supporting disclosures in the notes to the financial statements.

Specific detail on the limitations of the financial information is included in the confidential annexure provided to the Commission.

Consolidated reporting

Several Providers submitted financial information on a consolidated basis, reporting the performance of more than one service.

Where consolidated data was provided, it was not possible to reliably disaggregate revenues, costs or margins attributable to either IPS or OSD. This has limited our ability to accurately compare the financial results across Providers and has constrained our conclusions.

Alignment of Witness Statements and financial data

There are instances of the Witness Statements not aligning to the financial information provided and, in some instances, not all questions posed were addressed or fully answered. Of note, information relating to salaries and wages was not submitted by all Providers reducing the precision of our conclusions regarding the adequacy of input costs and margin reasonableness.

IPS Pricing Schedule sample size

Each Provider submitted five IPS Pricing Schedules, as requested by the Commission; however, we consider the sample to be small to support a robust or representative comparison.

Our analysis of the Pricing Schedules showed mean price per placement per day of $1.9k and $1.4k for-profit and not-for-profit Providers respectively. In comparison the [redacted] had a significantly larger dataset, [redacted], and reported a mean price of $1.2k for for-profit Providers and $0.9k for not-for-profit Providers [1].

Rosters, payroll and pricing data

To analyse the Residential Youth Worker margins, we reviewed the IPS Pricing Schedules, payroll reports and rosters submitted to the Commission. However, the underlying time frame did not align to enable comparison; the Pricing Schedules were FY26 while the payroll and roster information related to 30 June to 7 July 2025.

The different financial years result in different pay rates due to annual pay uplifts, while the Pricing Schedules could not be linked to the payroll or rosters. For many Providers, the payroll lacked sufficient detail to determine pay rates or hours worked.

As an alternative, we compared the amounts claimed by the Providers in the IPS Pricing Schedules to the average wage bands detailed in the Witness Statements. However, this analysis was limited by the need to average the pay rates which could not be weighted due to a lack of information on workforce composition.

Implications for interpretation

Taken together, these limitations mean that our findings should be interpreted as themes and observations rather than definitive assessments of individual Provider profitability or appropriate pricing. Where corroboration was not possible, we have avoided drawing conclusions beyond what the evidence reasonably supports.

Notwithstanding these constraints, the limitations themselves highlight material issues relating to data transparency, financial reporting and consistency, which are directly relevant to the Commission's consideration of funding adequacy, value for money and system governance.

Part 4.1

Key Findings

Part B. Key Findings

The detailed findings from the provider-level review are set out in a separate confidential annexure due to the commercially sensitive nature of the information and to preserve provider confidentiality. This section presents the key findings of the analysis and excludes the underlying detailed financial data.

	Findings
1	**Procurement processes provide limited assurance on the reasonableness of IPS Pricing Schedules.** **IPS Pricing Schedules routinely exceed benchmark rates, particularly for labour. Percentage-based overhead allowances can amplify margins, while limited validation of tenders reduces confidence that pricing reflects efficient costs.** • Our assessment of the IPS Pricing Schedules submitted to the Commission found that Providers regularly exceed the benchmark amounts detailed in the Individualised Placement Support (IPS) Business Rules. • Benchmarks are exceeded across all cost categories; however, the most material differences relate to salaries and wages. Of the 95 IPS Pricing Schedules submitted to the Commission, all were above the staff cost benchmarks. Providers state there is a need to cover additional costs, including unforeseen overtime, Workcover claims and premium increases, and vacant rental properties [2]; working capital pressures that arise from delays in departmental invoice payments [3] and the need to factor in CPI and inflationary increases. We note that the IPS Business Rules suggest that operating cost benchmarks have been applicable since August 2020 and December 2020 for salaries and wages [4]; the Commission has sought an explanation from the Department as to why this is the case but has not received an explanation. However, we have used the current SCHADS SaCS 3.4 Award benchmark for staff margin calculations. • It has not been possible to determine whether theses costs flow through to Providers' profit and loss statements, as the financial information submitted is high-level and cannot be reconciled to the assumptions in the Pricing Schedules. • However, we observed that labour input costs recorded in the IPS Pricing Schedules are higher than amounts paid to staff. This has the effect of increasing margins in two ways, as organisation and administration costs are calculated as a fixed percentage (14%) of staff costs [4]. As a result, higher staff cost assumptions automatically increase both staff cost recovery and the associated organisation and administration allowance. • We were unable to establish what level of scrutiny or validation is applied to IPS Pricing Schedules once submitted for tender, or whether Providers are meaningfully challenged on their cost assumptions. We also observed that once staff cost assumptions appear to have been accepted, they are not revised in later submissions, as staff cost inputs remain identical across multiple Pricing Schedules. Consequently, the current procurement process provides limited assurance that IPS Pricing reflects efficient and reasonable costs.

Part B. Key Findings

	Findings
2	**Reported net profit is not a reliable indicator of a Provider's financial performance.** **Financial statements are provided at a high-level and aggregate key cost categories, making it difficult to analyse service delivery. Economic returns are frequently realised through owner salaries, related-party transactions, acquisitions of non-core assets and dividend payments rather than reported profit.** • Provider profit and loss statements submitted to the Inquiry are a high-level view of the input costs and do not offer sufficient detail to assess the reasonableness of direct service delivery costs. Labour and overheads were often reported in aggregated categories, with no clear separation between direct care costs and indirect or discretionary expenditure. As a result, the financial information received by the Commission does not enable an accurate assessment of whether reported margins reflect efficient service delivery. • In addition, we found that net profit is not an accurate indicator of Provider performance as the analysis shows owners and related parties extract value through various mechanism, which allows cash to be withdrawn from the business irrespective of reported profitability. These transactions are concentrated among the IPS-only Providers in our sample (with one exception noted below) and include the following: o Above-market remuneration; including instances of CEOs being paid salaries of up to and between $400k to $679k, In one instance the salary represents 21% of revenue; o Related party charges, including B.15's (a not-for-profit Provider delivering IPS and OSD services) $4.1m management fee for intellectual property and systems fees (12% of revenue); o Acquisitions of non-core assets including B.7 holding investments in gold and cryptocurrency, stated on the FY25 balance sheet at $242k and $100k respectively. The company also has 2 Mercedes Benz cars, and the owners were paid a dividend of $140k in FY25; o Director and related party loans, including B.10, an IPS-only Provider having 5 different loans for a total of $5.2m at FY25 (25% of revenue), which increased to $8.2m in December 2026; and o Dividend payments, included a $5m payment by B.3, which represents 12% of FY25 revenue. Accordingly, low or modest net profit outcomes do not necessarily indicate weak financial performance or limited capacity to generate surplus cash.
3	**Labour and contract-level margins provide insight to Provider profitability.** **Youth worker margins and IPS arrangement margins are informative indicators of underlying performance.** • IPS contract margins have been prepared using actual wage rates and the Business Rules Benchmarks, and provide an informative measure of a Provider's underlying performance. However, they do not capture the Provider's central corporate overheads, governance costs or group-level allocations meaning they reflect profitability at the arrangement level only. • Our analysis shows that funding per placement per day varies materially and there is not a strong correlation between high funding per day and contract margins. IPS-only Providers generally show stronger revenue growth than Providers operating across both IPS and OSD.

Part B. Key Findings

	Findings
4	**IPS Providers are more profitable compared to IPS and OSD Providers.** **IPS businesses demonstrate rapid revenue growth over short periods, often without significant working capital or business investment. Growth appears driven by placement access and pricing schedules rather than demonstrated efficiency or service maturity.** • The financial information submitted to the Inquiry shows IPS businesses exhibit higher IPS contract margins, whilst not-for-profit Providers (which are typically IPS and OSD providers) have lower IPS contract margins. The lower contract margins for IPS and OSD Providers may be associated with a better understanding of contracting requirements and having access to a fixed term workforce, given that 50% of IPS Providers in our sample utilise a flexible workforce of labour hire or casual staff rather than fixed term employment. • IPS funding per placement per day varies significantly in our sample, with a ~450% difference between the lowest and highest. We observed that for-profit Providers receive materially higher IPS funding per placement, an increase of 34.7% compared to not-for-profit Providers which equates to ~$182k per placement per annum. Drivers of the difference could be the use of labour hire staff amongst for-profit Providers. • Using the model of care and staff training information detailed in the Provider Witness statements, there is no clear relationship between the stated models of care or training levels and the funding per placement per day. From our sample, Providers with strong models of care have a range of funding levels which may demonstrate Providers are adept at articulating a desired training suite and model of care but are not yet delivering it. • The higher margins for IPS contracts are generally driven by labour input costs. Our analysis found that for-profit providers (primarily IPS-only Providers) claim an average hourly rate that is 16.5% higher than the not-for-profit sample average.

Part B. Key Findings

	Findings
5	**Financial transparency and consistency of information provided to the Commission is limited.** **Financial statements, payroll data and Witness Statements could not be reliably reconciled, limiting Provider-specific conclusions. However, high salaries, dividends, acquisitions of non-core assets and related party loans suggest many of the underlying businesses are highly profitable.** • The financial information submitted by a number of Providers lacked sufficient transparency and consistency to support reliable reconciliation to their Witness Statements and in several cases, assertions made could not be reliably validated or conclusions drawn. For example: ○ **B.3** declared a $5.0m dividend in FY25 yet we calculated comparatively low youth-worker margins for the same period, an outcome that could not be reconciled to the profit and loss statements; ○ **B.9** provided workforce and organisational information in its Witness Statement that did not align to the financial and payroll data, including inconsistencies in reported staffing structures; ○ **B.10** did not submit IPS Pricing Schedules despite reporting significant IPS revenue, preventing any assessment of whether funding levels, labour costs and reported financial outcomes were aligned; and ○ **B.18** reported substantial related-party loans or balances in their financial statements that were not clearly explained in Witness Statements. • Across the sample, labour, overheads and related-party transactions were frequently aggregated into high-level expense categories, meaning claims made in Witness Statements regarding cost pressures, staffing intensity or funding adequacy could not be reconciled to underlying financial performance.

Part B. Key Findings

	Findings
6	**Appetite for procurement under OSD rather than IPS agreements.** **The summary of key financial information shows that IPS-only Providers generate stronger staff and total margins than Providers who deliver OSD agreements, offering little incentive to transition from IPS delivery. Consistent with this, not-for-profit Providers—typically operating across both IPS and OSD—record lower margin outcomes than smaller IPS-only Providers.** • Witness Statements from IPS Providers indicate that, while Providers generally acknowledge OSD as a policy objective, their stated appetite to procure OSD agreements is consistently conditional rather than an active intention to transition under current settings. • Across the cohort, Providers describe a willingness to consider procuring OSD agreements in principle, but only where commercial viability and regulatory requirements could be satisfied. For example: ○ **B.4** confirmed that no IPS agreements have been converted and that any consideration of conversion would only occur after licensing is obtained [5]; ○ **B.6** indicated that conversion has not been contemplated within its current operating model [6]; and ○ **B.20** explicitly linked its position to financial viability, stating that its cost structure relies on IPS funding and that conversion to OSD is not commercially sustainable under current conditions [7]. • Other IPS Providers similarly framed OSD conversion as contingent on changes to funding, cost recovery or regulatory settings, rather than as an immediate or planned transition pathway. • Across the IPS cohort, Providers confirmed that no IPS agreements have been converted in practice, with the exception of B.13, which converted 16 IPS agreements to OSD. Even in this case, B.13 stated that further conversion was constrained by unresolved compliance matters and the closure of the relevant procurement process, rather than by lack of interest.

05

Demand and cost modelling analysis

Part 5.1

Overview

Part C. Scope of Work & Purpose

Scope

The Commission identified projected demand and cost models for non-family-based care (NFBC) through to 2030 for KPMG to review. Part C assesses the robustness of these existing projections based on their documented methodology, assumptions and stated use. It examines underlying model methodology, identifies opportunities for further sensitivity testing of key demand and cost drivers to strengthen forecasts, and provides reasoned commentary on the reliability of projections, including key uncertainties and risks.

In addition, Part C summarises the context, purpose and intended use of each model as presented in the source reports, including how the models are positioned within broader reform objectives and decision-making processes. This is intended to support appropriate interpretation of the modelling results prior to detailed methodological assessment.

Purpose

Part C assesses the extent to which the projections can be relied upon for their stated purposes, and identifies material limitations, uncertainties and risks. This is achieved by testing whether the existing models and forecasts to 2030 are sufficiently robust, transparent and credible, and by identifying where assumptions, data sources or sensitivities may materially affect projected outcomes.

Part C also seeks to clarify how the models are intended to be read and used, including the distinction between illustrative planning tools and projections relied upon for funding, policy or reform decisions. It clarifies the level of uncertainty and risk inherent in the projections and highlights opportunities to strengthen forecasts where they are relied upon to inform such decisions.

Limitations

This review was undertaken without direct access to live or executable versions of the models, and without the ability to run alternative scenarios or sensitivities. Accordingly, the review does not validate model outputs or independently confirm model logic or parameter interactions. Instead, it assesses whether the methodologies and stated assumptions, as documented in the source reports, support the level of reliance implied for the projections. Findings should therefore be interpreted as commentary on credibility, limitations and sources of uncertainty, rather than as a re-modelling, calibration or assurance exercise.

Model Introduction and Review Framework

The Part C Review considers several models, which are therefore defined, grouped and referenced throughout this report as:

a. **Rennie Advisory Models – Demand (1.A) and Cost (1.B)**
Buyer Beware report authored by Queensland Family and Child Commission and prepared by Rennie Advisory included a demand and cost model. The demand and cost models are grouped because they are presented within the same report and are designed to operate sequentially. The demand model provides an estimate of future placement volumes, and the cost model translates these volumes into expenditure under stated assumptions;

b. **The Demographics Group – Demand model (2)**
Authored by The Demographics Group for PeakCare, this model is used within a workforce analysis context to illustrate potential future NFBC demand;

c. **PeakCare / Social Vantage Advisory – Demand model (3)**
Authored by Social Vantage Advisory for PeakCare, this model is used to support residential care workforce strategy development. It provides indicative demand pathways to illustrate the scale of adjustment implied by policy targets and observed trends; and

d. **SAM-to-PBFM model system – Demand (4.A) and Cost (4.B)**
The SAM (authored by Insight Acumen) and PBFM (used by DFSDSCS and Queensland Treasury) are reviewed separately due to their complexity and central role. However, they are referenced collectively as the SAM-to-PBFM model system, (4.A) and (4.B), because SAM outputs are used directly by PBFM to translate demand into funding estimates.

An overview of each model's existing projected FY30 outputs, together with its limitations and the context in which it should be read, is provided on the following page.

Part C. Interpreting the existing model outputs

The existing models point in a broadly similar direction when projecting future NFBC demand and cost growth. Under their respective assumptions, each indicates continued growth in OOHC demand, NFBC demand and associated costs to FY30 or the nearest available projection year. However, the models were developed for different purposes, apply different methods and assumptions, and should therefore be interpreted with appropriate caution.

Rennie Advisory Models – Demand (1.A) and Cost (1.B)

Projects the highest demand and cost growth of the models reviewed, with FY30 outputs of:

a. **5,747 NFBC** placements, **17,051 total OOHC** placements; and

b. **Costs of $7.06 billion** in FY30 alone.

This output is best interpreted as a whole-of-state, unchanged-system pressure scenario that illustrates the scale of risk if OOHC demand continues to grow and FBC supply remains constrained.

It is useful as contextual signalling but should not be treated as a precise estimate. Rather the model is likely to represent an upper limit to future demand and cost. Results are highly sensitive to key assumptions, particularly placement mix. For example, holding other assumptions constant and keeping placement mix at the FY24 level (rather than modelling a decline in foster care as a share of total OOHC placements) would reduce the FY30 cost to approximately **$4.5 billion**.

The Demographics Group – Demand model (2)

An intentionally illustrative, trend-based projection of FY30 NFBC placement demand, using simple linear and exponential extensions of observed data:

a. Linear **NFBC** demand of **3,090** vs Exponential demand of **3,450.**

PeakCare / Social Vantage Advisory – Demand model (3)

Projects NFBC and total OOHC demand to FY29 by extending recent historical growth trends, while also illustrating how NFBC demand would differ under the target policy setting. A KPMG extension to FY30, using the existing model's assumptions, is included for comparison:

a. Trend-based projection: **NFBC** of **4,208** and **OOHC** of **14,841 (FY29);**

b. Policy-aligned scenario: **NFBC** of **1,039 (FY29)** (i.e. reflecting target / desired placement mix);

c. KPMG extrapolation of the trend-based projection (using existing model assumptions) for comparison: **NFBC** of **4,880** and **OOHC** of **15,494** (**FY30**) (i.e. producing an FY30 projection that falls within the range of demand outcomes forecasted by models (1.A) and (2).

SAM-to-PBFM model system – Demand (4.A) and Cost (4.B)

The current presented outputs from both SAM (4.A) and PBFM (4.B) are conditional on specified settings and assumptions, with their limitations considered further in the subsequent pages of this analysis. The latest available outputs are:

a. SAM **total OOHC** demand: **15,628** in FY30. [10] However, this projection is based on a model output from FY19, with more recent projections not provided to the Commission;

b. PBFM funding required (policy-aligned placement mix): **$2.066 billion** in FY29, based on an FY25 model output; [11]

c. PBFM funding required (placement mix adjusted to reflect observed figures from FY25): **$2.781** billion in FY29, based on an FY25 model output;

d. The PBFM funding projection implies a more moderate growth in NFBC compared to other demand models.

Overall Commentary

Taken together, the existing models are directionally consistent in indicating strong growth in demand and cost if current pressures persist. At the same time, each model has important limitations, and none should be read in isolation as a definitive view of future demand or funding.

The remainder of this report sets out the review findings and targeted enhancements recommended to support a clearer and more decision-useful view of future demand and cost. In turn, this is intended to provide decision-makers with a more transparent basis for assessing the direction and potential effectiveness of further intervention in Queensland's child protection and OOHC system, and for better estimating the potential cost implications and savings associated with those interventions.

Part C. Summary Findings

Previous modelling included work undertaken for a specific purpose, with the methodology adopted and results produced relevant to that context and point in time. As such, these models are not suitable for ongoing system management and planning.

The modelling developed to inform the *Buyer Beware* report and the work undertaken and commissioned by PeakCare represent useful agenda-setting baselines. They help quantify the potential scale of future NFBC demand (at a statewide level) and resulting cost pressures if recent trends persist, and they clearly signal that the system trajectory is challenging under an unchanged system.

However, these baselines are not designed to explain why outcomes change or how results would respond if conditions shift. Their reliance on trend extrapolation, fixed assumptions and single-point estimates limits their suitability for:

a. diagnosing key demand and cost drivers;

b. understanding constraints and substitution effects, particularly placement supply mix;

c. understanding demand and placement supply mix at a local level; and

d. supporting funding, workforce or reform decisions that require scenario testing and uncertainty ranges.

Despite its current limitations, the Part C Review concluded that a strengthened SAM-to-PBFM model system offers the most credible pathway to decision-useful analysis among the models reviewed.

The SAM simulates system pathways and demand, while PBFM translates demand into funding requirements for different services under defined assumptions. The Part C Review considers that, with targeted enhancements, the combined model system could support:

a. a defensible reference forecast of demand (by location, service type, client cohort) and required funding to meet this demand within existing system parameters (supply mix, service availability and cost);

b. intervention testing to understand the impact of policy levers within influence; and

c. sensitivity testing to understand the impact of external risks and uncertainty.

To achieve these outcomes, the Part C Review identified a range of targeted enhancements to strengthen the SAM-to-PBFM model system and better meet the varying needs of key Queensland Government stakeholders.

The recommendations below focus on the minimum enhancements required to strengthen the SAM-to-PBFM as a tool for ongoing system management and planning:

a. Include a **driver-based intake module** that links intake volumes to observable drivers, reducing the reliance on trend-only inflows;

b. Establish **formal governance over probability distributions** to ensure pathways within the SAM remain representative of system behaviour;

c. Include a **supply/capacity module** to make placement mix and substitution dynamics explicit within the model;

d. Expand PBFM reporting to include a **standard set of sensitivity ranges** for materially significant parameters;

e. Implement **two standard PBFM reporting outputs**: a “base case” used for control and acquittal, reflecting approved target-driven parameter settings; and a “reference case” used for planning and risk analysis, drawing on the enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model; and

f. Establish **formal governance over cost escalation assumptions** to ensure cost parameters remain reflective of reality.

The SAM and PBFM are already embedded in the Department’s forecasting and budget processes, with SAM providing a structured simulation of system pathways and PBFM translating demand into funding under defined parameters. The key limitations identified in this review relate less to the existence of these models and more to the current treatment of critical drivers and constraints, notably future intake drivers and placement supply mix.

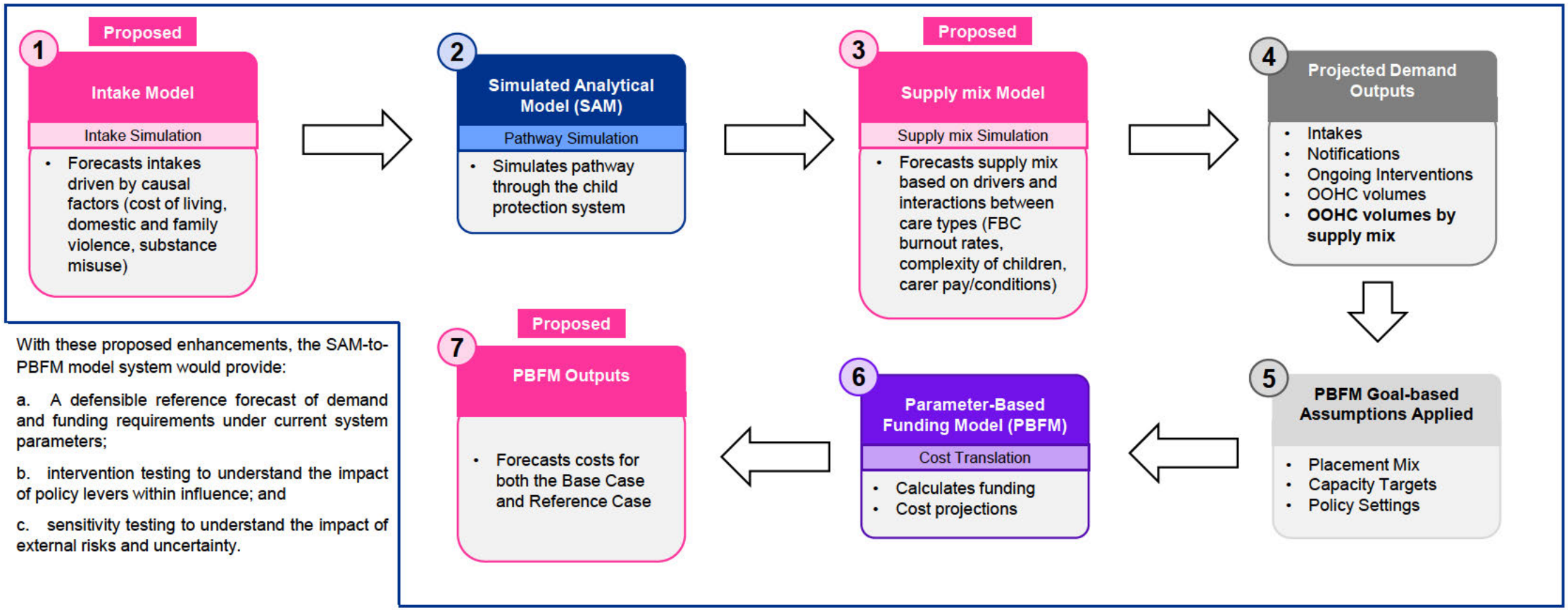
Targeted enhancements to inputs, governance and supply-side representation would allow the existing model system to provide a defensible reference case and a practical platform for intervention and sensitivity testing, without requiring wholesale replacement of the modelling architecture.

Part C. Key Findings

#	Finding	Model
1	The Rennie Advisory demand and cost models extrapolate recent trends into medium-range forecasts, but their reliance on fixed, highly sensitive assumptions, single-point estimates and forecast outputs that do not clearly reconcile to the stated assumptions materially limits its suitability for forecasting future demand or costs beyond high-level strategic signalling.	(1.A) (1.B)
2	The Demographics Group demand model is intentionally illustrative and trend-based, designed to frame discussion about NFBC workforce sustainability rather than to operate as a technical forecasting tool. However, its reliance on simple historical extrapolation, fixed assumptions and single-path projections, without causal modelling or validation, materially limits its ability to explain or anticipate future changes in demand. Accordingly, this review finds that the model is not fit for purpose for sustained forecasting or decision-making beyond high-level strategic signalling.	(2)
3	The PeakCare / Social Vantage Advisory model provides a point-in-time illustration of future OOHC and NFBC demand under extrapolated recent trend growth and an alternative policy-target scenario. Its methodological simplicity, including trend extension without behavioural, demographic or system-constraint modelling, means it does not capture the drivers or uncertainties shaping future demand. As a result, this review concludes that the model does not constitute a durable or sustainable demand forecasting model for long-term planning or decision-making.	(3)
4	The SAM relies on externally specified future intake inputs that are generated using population growth-based assumptions rather than a driver-based intake forecast, meaning its outputs are conditional on a simplistic trend continuation and are not robust to changes in economic, policy or system drivers. It is recommended that future intake inputs to SAM should be replaced or supplemented with a defensible driver-based intake forecasting module, with those forecasts then used as the inflow to the existing simulation.	(4.A)
5	The SAM's probability distributions (likelihoods of a child passing through each stage of the child protection system) are derived largely from historical system behaviour and may not remain representative if system dynamics have materially changed. A formal review and governance process should therefore be applied to material PD inputs used for forward projections.	(4.A)
6	The SAM-to-PBFM model system does not explicitly represent how factors within the SAM influence placement capacity (including the availability of carers). In particular, there is no explicit representation of dynamics such as carer recruitment, retention or burnout, limiting confidence in cost projections where supply constraints materially influence outcomes. While the SAM contains information relevant to these dynamics, this information is not currently used to forecast carer availability. It is recommended that a driver-based supply mix, capacity and carer availability module should therefore be developed and integrated into the SAM-to-PBFM process. This module should draw on existing SAM inputs to model the underlying factors influencing placement availability and substitution, including testing scenarios such as changes in carer payment levels and their potential impacts.	(4.A) (4.B)
7	PBFM outputs are often reported as single point estimates, which can obscure how much funding results would change even if key assumptions were adjusted within reasonable bounds. It is recommended that PBFM reporting should include a standard set of sensitivity ranges (including alternative cost escalation assumptions for major cost components) and present outputs as funding ranges rather than single figures.	(4.B)
8	There is a governance and interpretation risk that the PBFM outputs are misread as forecasts of funding required to meet real-world demand, rather than as funding benchmarks produced under target-driven parameter settings. This risk is heightened where supply mix assumptions are manually specified and not fully constraint-aware, limiting transparency over how capacity and substitution dynamics influence outcomes. To mitigate this risk, this review suggests that routine reporting should clearly separate two outputs: a "base case" for control and acquittal, reflecting approved target settings, and a "reference case" that draws on the enhanced intake model and forecasted, driver-based, constraint-aware supply mix and capacity model. Both outputs should be supported by a standard interpretation statement clarifying their conditional nature and preventing misplaced reliance.	(4.B)
9	The PBFM escalates base-year costs using indexation settings that are embedded as parameters rather than regularly tested assumptions. This creates a governance risk that escalation settings persist without systematic reassessment, even where placement-specific cost pressures diverge materially from indexation. This review recommends that escalation assumptions should be subject to periodic governance review and explicitly tested through escalation sensitivity analysis.	(4.B)

Proposed Enhanced SAM-to-PBFM Flow

Figure C.1 Proposed enhanced SAM-to-PBFM model system



"Reference case" refers to a causal-model driven cost forecast; "Base case" refers to a goal-based cost forecast. Both cases are conditional on stated assumptions; neither is an unconditional 'funding required' forecast. This is an illustrative schematic only. It shows one practical pathway to address the limitations identified in Part C; it is not itself a validated model design.

Part 5.2

Model Context & Reviews

(1.A) Rennie Advisory – Demand Model (*Buyer Beware* Report)

(1.B) Rennie Advisory – Cost Model (*Buyer Beware* Report)

(2) The Demographics Group – Demand Model (The Future Residential Care Workforce – Demographics Analysis Report)

(3) PeakCare / Social Vantage Advisory – Demand Model (Insights and Opportunities – Queensland Residential Care Workforce Report)

(4.A) Insight Acumen – Demand Model (Simulated Analytical Model SAM)

(4.B) DFSDSCS – Cost Model (Parameter-Based Funding Model PBFM)

(1. A) Rennie Advisory – Demand Model

Context

C.1. The *Buyer Beware* report includes a simple, point-in-time, trend-based demand model designed to provide a forward-looking estimate of how many children are likely to require Out of Home Care (OOHC), and how those children may be distributed across placement types, through to FY30, in Queensland as a whole. The model is intended to move beyond retrospective reporting and support consideration of future system pressures, capacity requirements and risks. [1]

C.2. The projected increase in NFBC demand arises from the interaction of several trend-based trajectories embedded in the model assumptions. These stated assumptions include continued overall growth in the OOHC population (3.5% p.a), factoring in forecasted population growth, assumed ongoing decline in foster care availability (-5% p.a), and growth in kinship care placements (2% p.a).

C.3. Under these assumptions, the model implicitly requires NFBC to expand to absorb unmet demand where FBC options are constrained. The projected growth in NFBC therefore reflects pressure within the placement system rather than an explicit forecast of increased suitability or preference for NFBC placements. [1]

Purpose and framing

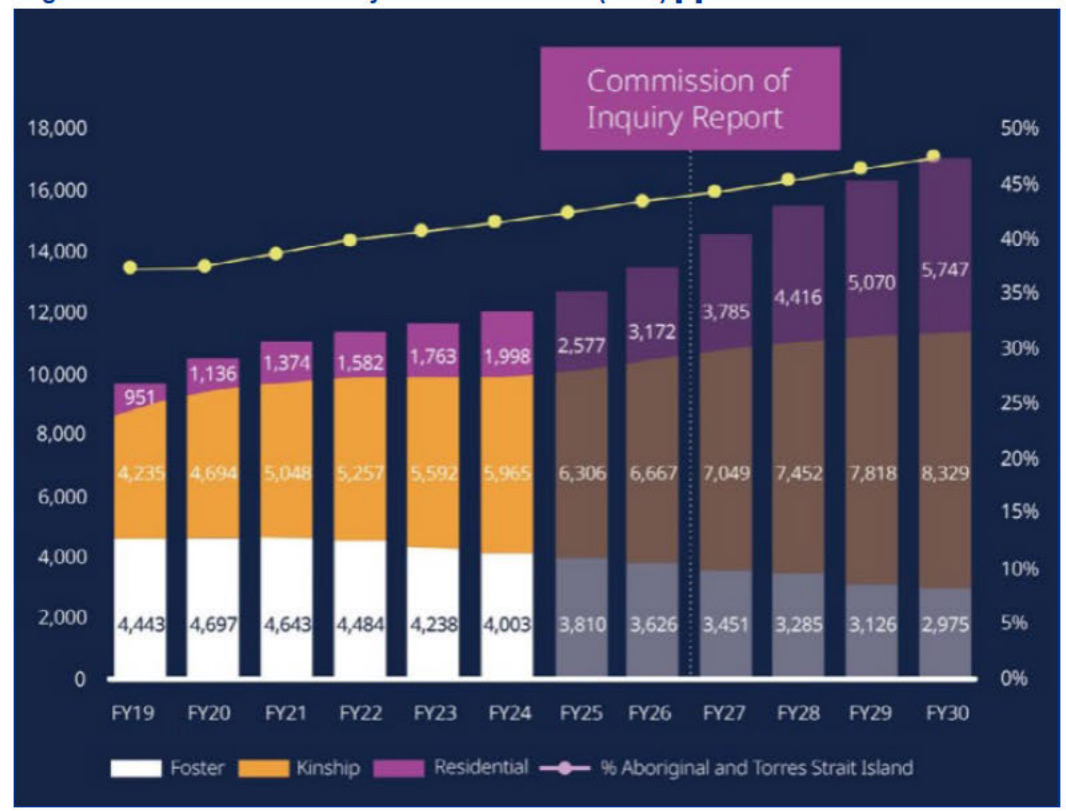
C.4. The demand model is best understood as illustrating the projected trajectory of OOHC demand under current system settings. It is not designed to model the effects of reform or alternative policy interventions, but rather to demonstrate how demand may evolve if the system continues to operate broadly as it has to date. In this sense, the model functions as a baseline or "unchanged system" scenario, providing a reference point for understanding future demand pressures and associated risks. [1]

Forecast findings:

- NFBC demand is projected to reach 5,747 children by FY30 as per Figure 1 from the *Buyer Beware* report, with total OOHC reaching 17,051 by the same period.
- Aboriginal and Torres Strait Islander representation is projected to reach 47% by FY30. [1]

C.5. The model is applied at a whole-of-state level and does not account for geographic variation in placement availability or constraints. In practice, the availability of FBC differs significantly across regions, which are not visible in the whole-of-state projections.

Figure C.2 The Rennie Advisory Demand Forecast (2025) [1]



(1. B) Rennie Advisory – Cost Model

Context

C.6. The *Buyer Beware* report identifies NFBC as the most resource-intensive form of OOHC, accounting for a disproportionate share of total child protection expenditure relative to the number of children placed in that setting. Expenditure on NFBC has increased significantly over time, reflecting both growth in placement numbers and rising average costs per placement. [1]

C.7. The cost model has been developed to translate projected demand into projected expenditure under existing funding and pricing arrangements. It applies assumptions regarding average costs per placement, growth in unit costs over time, and the interaction between placement mix and total expenditure. Its purpose is not only to estimate future spending, but to illustrate the budgetary consequences of maintaining current system settings in the context of rising demand and constrained alternatives. [1]

C.8. The cost model therefore provides a link between projected demand, service configuration and public expenditure, enabling consideration of financial sustainability under set assumptions and scenarios.

Purpose and framing

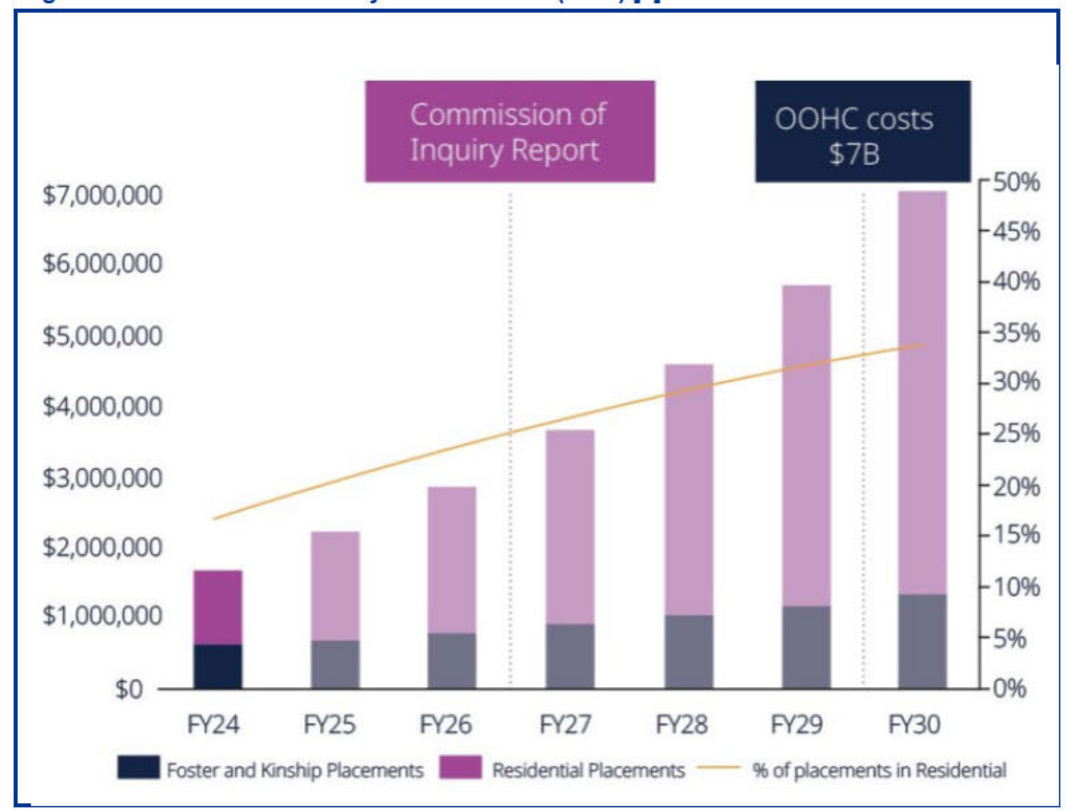
C.9. The cost model is intended to demonstrate the financial consequences of projected demand under an unchanged system. It does not estimate the cost of an improved or reformed system, but rather illustrates the expenditure trajectory that may arise if current funding, pricing and procurement arrangements remain in place. Accordingly, the model serves as a baseline view of fiscal exposure and sustainability risk, against which the potential impacts of future reforms could be assessed.

Forecast findings:

- OOHC system costs are forecast to rise by approximately 289% from current levels in FY24 to around $7 billion per year by FY30 as per Figure 1 from the *Buyer Beware report*.
- Cost growth is driven by continued increases in overall OOHC demand, constrained growth in FBC options, and the resulting expansion of NFBC placements, which carry significantly higher unit costs and are required to scale to meet residual demand. [1]

C.10. These cost outcomes are mechanically driven by the demand trajectories described in Section (1.A), rather than by independent cost modelling.

Figure C.3 The Rennie Advisory Cost Forecast (2025) [1]



(2) The Demographics Group – Demand Model

Context

C.11. *The Future Residential Care Workforce – Demographics Analysis Report* was prepared by PeakCare, with demographic analysis undertaken by The Demographics Group, to inform discussion about the sustainability of Queensland's **NFBC system**. The report is primarily concerned with whether the NFBC workforce can realistically expand to meet future demand, and the cost and feasibility implications of doing so. [2]

C.12. Within this report, a very simple, illustrative NFBC demand model is included to provide high-level context. The modelling is intentionally basic, relying on straightforward trend extrapolation rather than detailed forecasting, and is used to indicate the potential order of magnitude of future NFBC demand as an input to discussion about future workforce requirements in Queensland. [2]

Purpose and framing

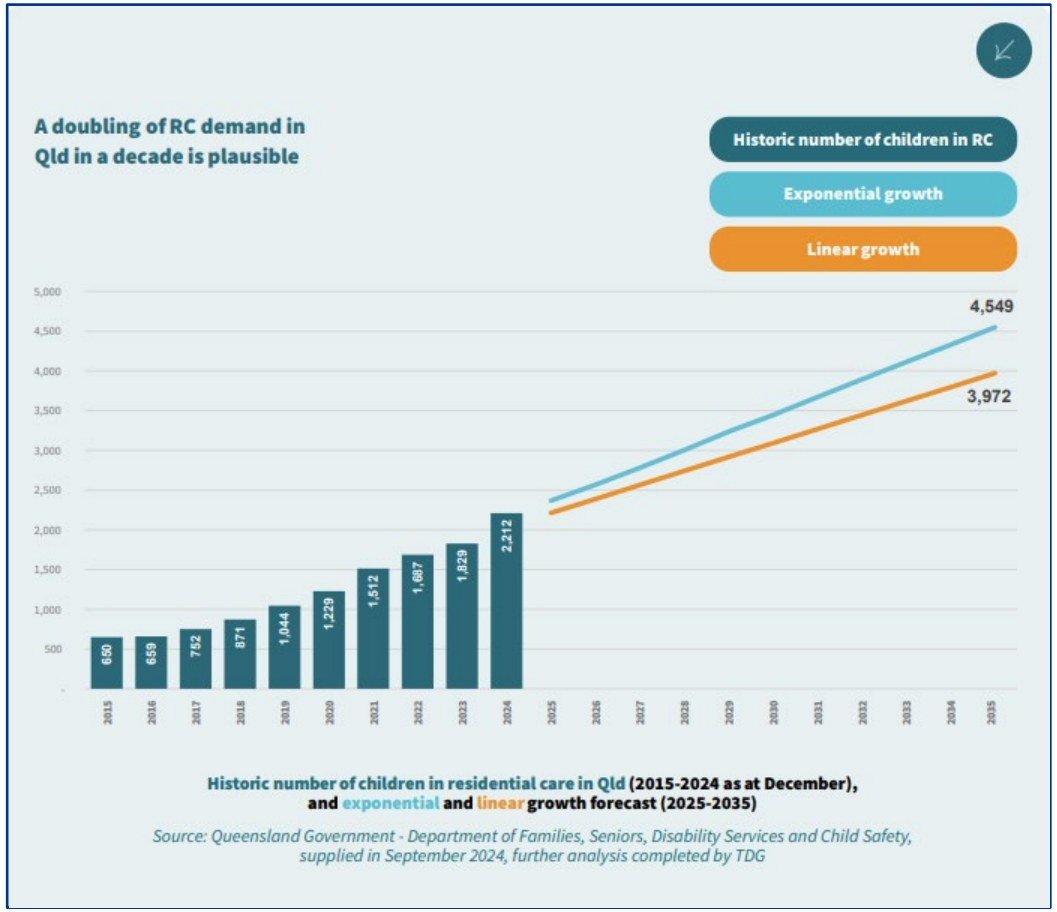
C.13. The NFBC model is included as a contextual tool rather than a technical forecasting exercise. Its role is to provide a simple baseline against which the report examines the scale of workforce growth that would be required if NFBC demand continues to increase broadly in line with recent trends. [2]

C.14. The model is not intended to inform operational planning or policy design, and it does not account for future reforms, behavioural change, future placement mix constraints, or preventative investment. Instead, it is used to frame the report's core analysis of workforce availability, recruitment challenges, and financial sustainability risks associated with continued reliance on NFBC within the OOHC system. [2]

Forecast findings:

- NFBC demand is expected to increase by 40-59% in FY30 under the model's linear and exponential growth scenarios, to reach between 3,090-3,450 by FY30, approximately.
- Workforce requirements increase disproportionately relative to child numbers due to the high-touch nature of NFBC, including 24/7 staffing and an assumed 2.5 carers per placement. [2]

Figure C.4 The Demographics Group Demand Forecast (Sep 2025) [2]



(3) Peak Care/Social Vantage Advisory – Demand Model

Context

C.15. The *Insights and Opportunities – Queensland Residential Care Workforce* report was prepared by PeakCare under the Catalyst for Care program, with consultation and development led by Social Vantage Advisory, and commissioned by the Queensland Department of Families, Seniors, Disability Services and Child Safety. The report is intended to inform the development of a Residential Care Workforce Strategy by providing an evidence-based picture of current conditions and future pressures facing the workforce. [3]

C.16. Within this report, a high-level demand projection is included to provide context for workforce planning. The projection is deliberately simple and uses recent historical growth rates in OOHC and NFBC placements to illustrate potential future demand. It is not a standalone forecasting model, but an indicative extrapolation used to frame discussion about whether the NFBC workforce can realistically meet future need, and how current demand trajectories compare with stated reform objectives. [3]

Purpose and framing

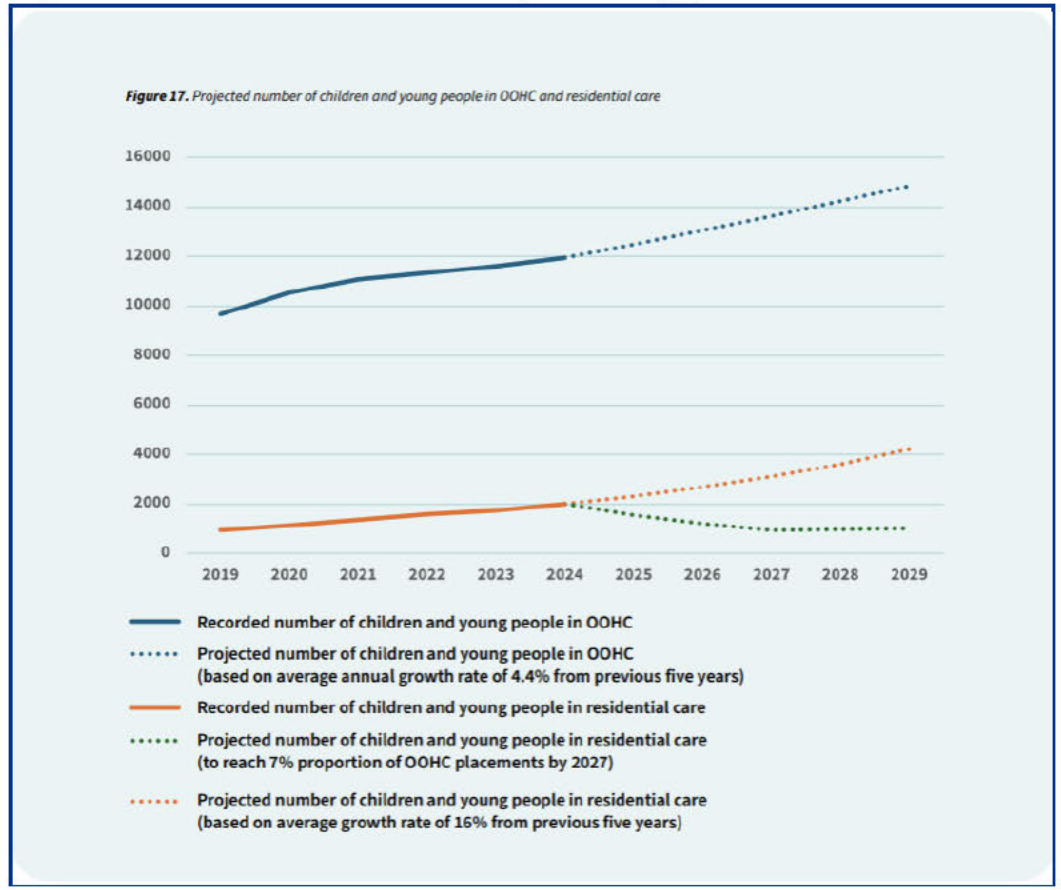
C.17. The demand projection is included as a contextual planning input rather than a detailed forecasting or economic modelling exercise. Its role is to provide a simple baseline that highlights the divergence between policy intent to reduce reliance on NFBC as a proportion of the placement mix, and the actual growth trends observed in NFBC demand in recent years.

C.18. The projection does not attempt to predict outcomes with precision and does not model the effects of future reforms, policy commitments, behavioural change, or preventative investment. Instead, it is used to make visible the scale of adjustment that would be required to achieve reform goals, and to frame the report's core analysis of workforce capacity, skills, and system readiness in the context of current, rather than aspirational, demand trajectories.

Forecast findings:

- Under extrapolated trends, NFBC placements are projected to reach 4,208 by FY29, with total OOHC demand expected to reach 14,841 in the same period.
- Under the policy-target scenario, achieving a reduction of NFBC to 7% of total OOHC by FY27, the model provides a NFBC demand forecast of 1,039 placements by FY29. [3]

Figure C.5 The Peak Care demand Forecast (March 2025) [3]



(4.A) Simulated Analytical Model (SAM) – Demand Model

Context

C.19. The Simulated Analytical Model (SAM) was originally developed in 2014 for the Queensland Government following the *Queensland Child Protection Commission of Inquiry (Carmody Inquiry)*. It was commissioned to support system-level reform planning by simulating child pathways through the child protection system and testing the impacts of alternative policy and service delivery settings over time. [5]

C.20. Developed by Insight Acumen in collaboration with the Queensland Government using the ExtendSim platform, the role of the SAM has evolved. While initially used as a reform and scenario-testing model, it is now the primary demand input to the parameter-based funding model (PBFM). Its outputs therefore form the core quantitative basis for estimating future service demand and informing funding allocations across the child protection system. [4][5]

Purpose and framing

C.21. In its current application, the SAM functions as the primary demand input currently used for funding estimates, conditional on externally specified intakes, PD tables, and other stated assumptions. [4][5]

C.22. However, the model remains a simulation-based representation of a complex system rather than a deterministic demand forecast. Its outputs are shaped by model structure, embedded assumptions and administrative data. While point estimates are relied upon for funding decisions, they remain contingent on assumptions about system behaviour, policy settings and external inputs affecting future demand. [4]

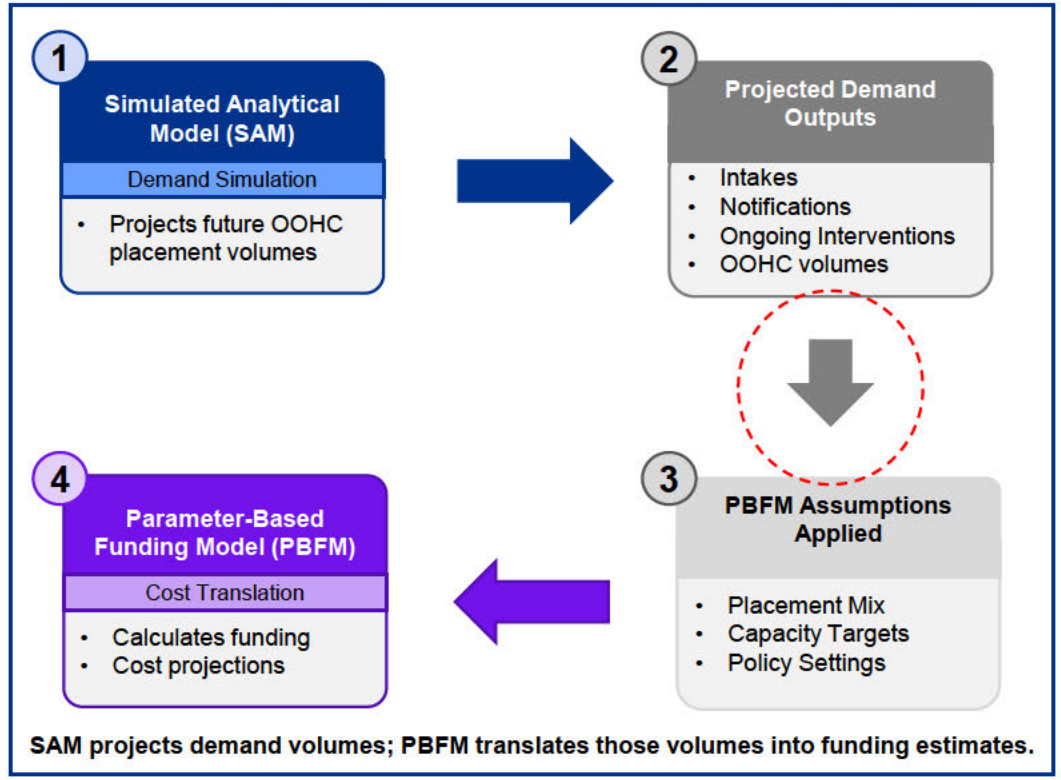
C.23. Accordingly, the SAM provides a structured and internally consistent conditional estimate of future demand for funding purposes, subject to externally specified inputs and stated assumptions. Given its central role in the PBFM framework, this underscores the importance of transparency around assumptions, limitations and sensitivities, and careful interpretation where outputs are used to inform long-term budgetary or reform decisions.

Model Outputs:

- The SAM produces projected child volumes and flows at each stage of the Queensland child protection system, including intake, notification, intervention and OOHC, which are used as demand inputs to downstream funding and planning models. [4]

C.24. Figure C.6 provides an illustrative, high-level schematic of the SAM-to-PBFM linkage, illustrating how simulated demand outputs from SAM are translated into funding estimates within the PBFM (highlighted within the red dashed outline).

Figure C.6 Existing High-level SAM-to-PBFM model system (KPMG derived from [10])



SAM projects demand volumes; PBFM translates those volumes into funding estimates.

(4.B) Parameter-Based Funding Model (PBFM) – Cost Model

Context

C.25. The PBFM is used by the Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS) and Queensland Treasury to translate projected child protection service demand into funding requirements. It allocates funding based on expected volumes of activity across the child protection system, rather than historical expenditure or incremental budget adjustments. [8][9]

C.26. The PBFM draws its primary demand inputs from the SAM (as shown in Figure 1 of the previous page), applying cost and resourcing parameters to projected numbers of children at different stages of the child protection system. In doing so, it operates as the financial translation of the demand dynamics modelled in the SAM, converting projected demand into budget estimates for service delivery. [8]

Purpose and framing

C.27. The PBFM provides a structured, transparent and repeatable method for producing funding benchmarks under approved demand, supply-mix and cost parameters, to support budget setting, control and acquittal. [9]

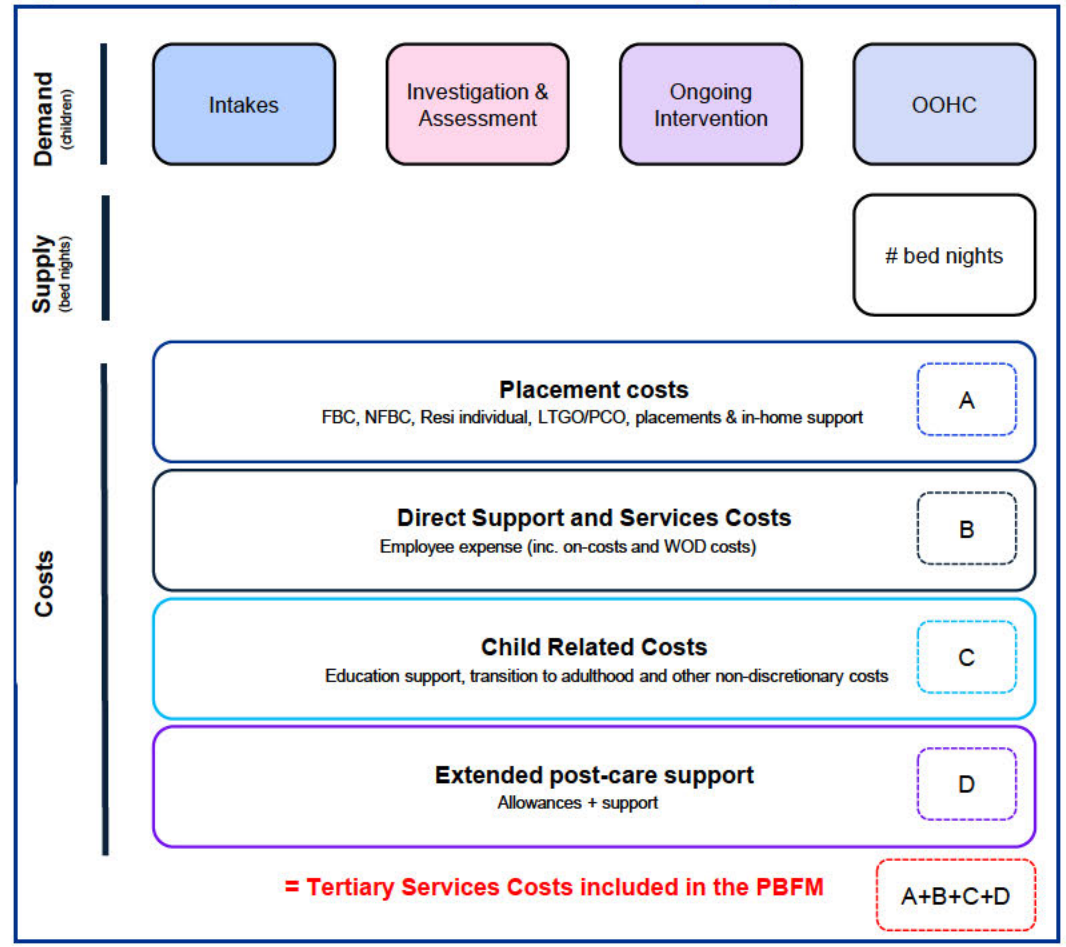
C.28. In practice, the PBFM operates primarily as a budget management and control tool rather than as a predictive funding forecasting model. [8] Funding outcomes are generated under approved policy, supply-mix and cost assumptions and are relied upon for budget setting, acquittal and forward planning. Outputs should therefore be interpreted as conditional funding benchmarks, not as unbiased projections of funding required under real-world constraints.

C.29. Given its central role in informing budgetary decisions, this underscores the importance of transparency around parameter assumptions, sensitivity to changes in demand and cost drivers, and careful interpretation where outputs are used to inform long-term funding.

Model Outputs:

- The PBFM converts projected demand into funding estimates across defined tertiary cost categories, including OOHC placement costs, direct support and services costs, child-related costs and extended post-care support, as specified in the model scope. [9]

Figure C.7 The focus of the PBFM on the Child Protection System [9]



Part 5.3

Model Issues Identification

Models (1)-(3) Specific Limitations

Table C.1 Detailed commentary of models (1)-(3)

Finding	Issue	Commentary
1	Rennie Advisory model is a deterministic trend-extrapolation baseline (CAGR) that produces single point estimates & unclear model output replicability	The approach is described as a simple, point-in-time, whole-of-state, trend-based forecast to FY30 intended to illustrate future system pressure under an unchanged scenario. It projects future placement volumes using assumptions about entry rates, placement mix, population growth and system behaviour continuing broadly in line with recent trends, and then applies assumptions on average costs per placement and unit cost growth to translate demand into expenditure, producing deterministic outputs. As documented in the source report, the method is not designed to model reform effects. Its reliance on point-in-time trend extrapolation, without causal structure or quantified uncertainty, means it is suitable only for high-level directional signalling rather than robust forecasting. The demand forecast shown in the *Buyer Beware* report could not be reproduced from the assumptions stated in the accompanying methodology note. To the extent that the published cost outputs are derived from that demand forecast, those outputs also could not be reconciled to the disclosed assumptions. The published series implies materially different growth in total OOHC and kinship placements than is disclosed in the note, reducing transparency and reproducibility. The illustration used in *Buyer* Beware to forecast **NFBC demand reaches 5,747 placements by FY30**, with total **OOHC reaching 17,051** in the same period. OOHC system costs are forecast to rise to around $7 billion per year by FY30.
2	Demographics Group model is an illustrative linear/exponential extension of past NFBC counts with a fixed workforce multiplier	The model is explicitly framed as intentionally illustrative and trend-based, included to support discussion about workforce sustainability rather than operate as a technical forecasting tool. Methodologically, it extends historical whole-of-state NFBC population counts (2015–2024) using simple linear and exponential curves to 2035, then converts projected children to workforce needs using a fixed 2.5 carers per placement ratio. It does not incorporate behavioural, demographic, policy or system-constraint modelling, consistent with the presentation that the model is a contextual tool rather than decision-grade forecasting. This models forecasts **NFBC demand is expected to reach between 3,090-3,450 by FY30**, approximately.
3	PeakCare / Social Vantage Advisory projection uses simple trend growth rates plus a policy target pathway, without modelling drivers or constraints	The projection is described as a deliberately simple whole-of-state trend extension to FY29 to provide context for workforce strategy, rather than a standalone forecasting model. It extrapolates OOHC and NFBC demand using observed FY19–24 headcount data, applying five-year average annual growth rates to produce a 'historical trend continuation' trajectory, alongside a second pathway that computes the NFBC cohort implied by achieving a 7% of OOHC target by FY27 and a smoothed reduction path. The method is transparent but does not model drivers, behavioural responses or constraints, aligning with the broader Part C framing that such models are suitable for directional signalling under trend continuation rather than durable forecasting. This model forecasts **NFBC placements are to reach 4,208 by FY29**, with total **OOHC reaching 14,841** in the same period, under the trend-based extrapolation. *If extrapolating using noted methodology to FY30, NFBC placements reach 4,880, with total OOHC reaching 15,494 (KPMG-derived).

Models (1)-(3) Recommendations and Conclusions

Table C.2 Detailed review of models (1)-(3)

Finding	Issue	Recommendation
1	Rennie Advisory model is a deterministic trend-extrapolation baseline (CAGR) that produces single point estimates & unclear model output replicability	Treat this model as an illustrative baseline for signalling direction of travel only. It should not be relied upon as a robust estimate of the magnitude of future demand or costs, particularly where the forecast outputs cannot be readily reproduced from the stated assumptions.
2	Demographics Group model is an illustrative linear/exponential extension of past NFBC counts with a fixed workforce multiplier	Use this projection only as an illustrative 'do-nothing' trend range to indicate direction of travel and the approximate order of magnitude of NFBC and workforce pressures under an unchanged-system assumption. Do not rely on it to quantify the magnitude of future demand or workforce requirements, nor as a basis for operational planning, funding decisions, or performance targets.
3	PeakCare / Social Vantage projection uses simple trend growth rates plus a policy target pathway, without modelling drivers or constraints	Treat this projection as an indicative trend and gap-to-target framing tool under a "current trends persist" assumption. It should not be relied upon for quantifying future demand levels, or for forecasting OOHC or NFBC caseload.

Conclusion for models (1)-(3)

C.30. Taken together, the limitations of the three models mean they should be treated as illustrative, point-in-time trend baselines only. Their shared reliance on extrapolating recent trends, the lack of an explicit causal structure, and the absence of quantified uncertainty materially constrain their capacity to produce reliable estimates of future demand or costs for funding allocation or long-term planning.

C.31. For these reasons, the role of models (1)–(3) should be limited to agenda-setting and signalling, while decision support would more appropriately rely on the SAM-to-PBFM model system, once enhanced, to enable driver-based forecasting, constraint-aware supply mix, and routine scenario and sensitivity testing.

Simulated Analytical Model (SAM) – Methodology Overview

This section summarises, at a high level, how the current SAM converts inputs into system-wide outputs through probabilistic simulation.

Inputs

C.32. The model uses structured input datasets (primarily Excel workbooks) which establish initial conditions and parameters for each run. [4]

C.33. Inputs comprise: [4][5]

a. historical "actuals" for completed financial years (child-level intake and pathway records);

b. Ongoing Intervention (OI) records to pre-populate the model at the run start date;

c. probability distributions (PDs) that define transition likelihoods by financial year, region, age, Indigenous status and entry status;

d. "future demand" intake volumes used where actuals are unavailable; and

e. scenario levers and work packages that apply user-specified adjustments to baseline parameters.

Simulation

C.34. SAM is a discrete-event Monte Carlo simulation implemented in ExtendSim, representing system pathways as connected process flows. [4]

C.35. Each child or young person is represented as an entity with attributes (for example age, region, Indigenous status and entry status) which determine PD look-ups and transitions. [4]

C.36. Actuals, future demand and OI cohorts are merged and filtered for run settings (for example region), then progressed through pathways using PDs and timing assumptions. [4]

Outputs

C.37. The model produces counts of children and young people at key system stages, disaggregated by year, region, pathway and cohort, and exports summary outputs to Excel. [4][5]

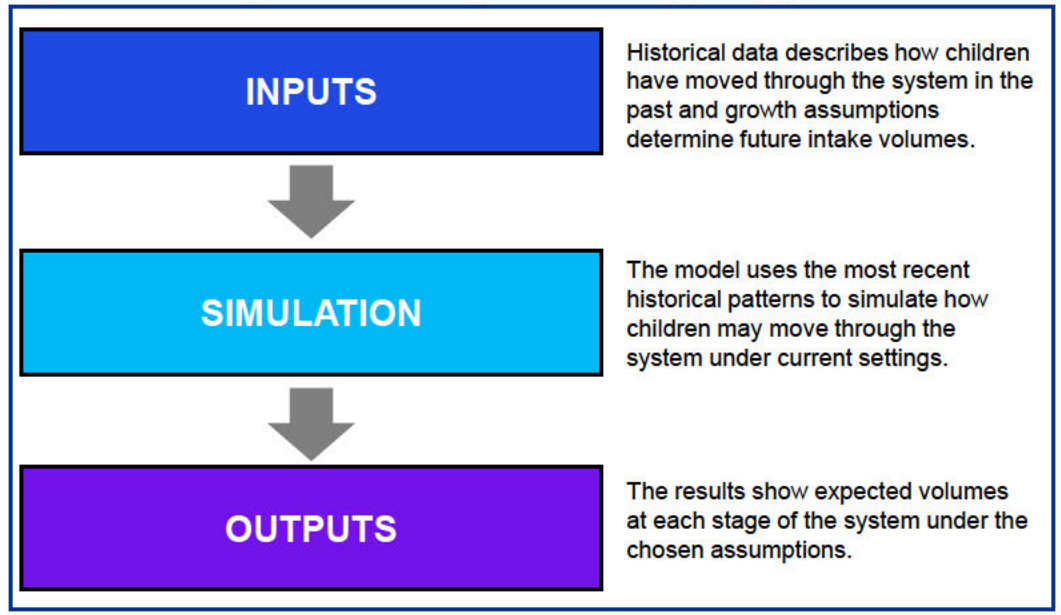
C.38. Output files also record scenario/work package configuration for traceability. [6][7]

C.39. Outputs are presented as indicative model results under the specified assumptions and configuration. [4]

Conceptual view

C.40. The SAM is a system-level model that uses past patterns of movement through the child protection system to estimate how volumes may evolve under current settings. [4][5] Figure C.7 below summarises this logic at a high level.

Figure C.7 The three phases of the SAM (KPMG based on [4] and [5])



Simulated Analytical Model (SAM) – Demand Model Review

Table C.3 Detailed review of the SAM (4.A)

Finding	Issue	Model Area	Commentary	Recommendation	Severity
4	Future intakes are externally specified, not driver-based	Input	The SAM does not generate future intakes endogenously from causal drivers within the model. Instead, future intake volumes are specified externally using growth-based assumptions (for example, population growth or historical trend extrapolation) and then injected into the simulation. This means that SAM does not explain why intakes change, nor can it test how changes in policy settings, practice reforms, economic conditions or social drivers would alter intake demand. As a consequence, SAM outputs are inherently conditional on the continued validity of externally imposed assumptions, and forecast results cannot be interpreted as an independent or self-contained demand forecast. This limits transparency, weakens causal interpretation, and reduces confidence when forecasts are used to inform downstream funding or service planning decisions.	*Develop a driver-based intake forecasting capability, either within SAM or as a formally integrated upstream module, that links intake volumes to observable drivers (such as economic stress, demographic change, reporting behaviour, policy thresholds or diversion pathways). At a minimum, clearly delineate and document SAM's reliance on externally specified intakes and restrict its use to conditional scenario testing rather than independent demand forecasting	High
5	Probability distribution tables embed historical system behaviour	Simulation	SAM currently relies on extensive PD tables derived from historical system behaviour to determine how children transition through the system. While this approach reproduces past pathways, PDs are largely carried forward into future years without systematic reassessment or adjustment for structural change. This creates a risk that historic dynamics, decision thresholds or service availability patterns are implicitly assumed to persist, even where reforms, practice changes or external shocks have materially altered system behaviour. Without explicit governance, validation or recalibration, PDs may embed outdated assumptions, mask emerging trends, and give a false sense of precision in future projections.	In the absence of a detailed view of the makeup of the PD tables, it is recommended to establish a formal governance framework for PDs, including regular review cycles, explicit tests for structural breaks, documented rationale for carry-forward assumptions, and transparent sign-off processes. Where material system change has occurred, PDs should be recalibrated or stress-tested rather than automatically extended into future years.	Medium
6	SAM does not represent placement supply or capacity constraints	Output	SAM simulates demand flows through the child protection system but does not explicitly model placement supply, workforce capacity or market constraints. Instead, supply mix outcomes and capacity limits are imposed outside the model through static targets or manual adjustments in downstream processes. As a result, SAM cannot capture how supply shortages, shifts between placement types, or capacity bottlenecks create price pressure, trigger cost escalation, or increase the risk of overspends. As a result, the translation of SAM demand outputs into funding and cost projections relies on additional assumptions and does not systematically surface early indicators arising from supply constraints or emerging market conditions. This creates a risk of misalignment between projected demand, feasible system capacity and funding outcomes.	*Extend SAM, or the SAM-to-funding interface, to include an explicit representation of placement supply, capacity constraints and substitution dynamics. This could include modelling limits on placement availability, workforce growth rates and substitution rules, enabling demand forecasts to reflect operational feasibility and improving the robustness of downstream cost and funding estimates.	High

*The proposed enhancements to the SAM-to-PBFM interface have been visualised in Figure C.1.

Parameter-Based Funding Model (PBFM) – Methodology Overview

This section describes, at a high level, the manner in which the current PBFM converts inputs into cost outputs through parameter setting and escalation.

Inputs

C.41. The model ingests structured financial, demand and policy parameters, primarily through a central Excel model, to establish the funding baseline for each run. [9]

C.42. Inputs comprise: [9][10]

a. demand forecasts for children at key system points (intakes, notifications, ongoing intervention and out-of-home care), sourced from SAM;

b. supply parameters, including forecast out-of-home care bednights and placement mix targets by region;

c. base-year cost data for placements, frontline staffing and child-related costs, drawn from financial and contract records;

d. indexation parameters for price escalation; volume settings derived from demand forecasts and policy settings (for example population growth, wage and CPI-based indices); and

e. policy-set assumptions, including locked-in placement mix targets and unit cost assumptions.

Processing

C.43. PBFM is a deterministic, parameter-based funding model implemented in Excel. [9]

C.44. Forecast demand volumes are used to index base-year costs through predefined volume and price escalation rules. [9]

C.45. Placement costs are calculated by applying forecast bednights to an assumed supply mix and escalated unit costs. [9][10]

C.46. Non-placement costs (including frontline staffing and child-related costs) are escalated using demand-linked or policy-specified indexation rates. [9]

C.47. Selected parameters are subject to annual acquittal, whereby forecast parameters are compared to actuals and funding adjustments calculated. [8]

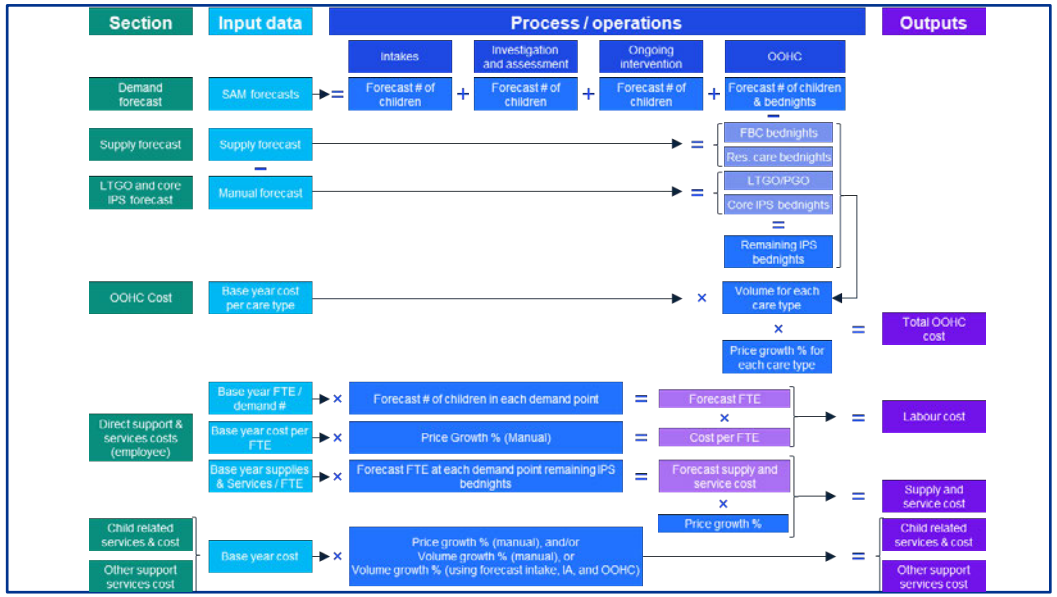
Outputs

C.48. The model produces forecast funding requirements for tertiary child protection services, disaggregated by major cost category and financial year. [9]

C.49. Summary outputs include total placement costs, non-placement costs, workforce funding and aggregate funding impacts across the forward estimates. [9][10]

C.50. Outputs also support annual acquittal and end-of-year reconciliation processes, identifying funding variances attributable to parameter movements. [8]

Figure C.8 KPMG flow chart summarising steps described in [9]



Parameter-Based Funding Model (PBFM) – Cost Model Review

Table C.4 Detailed review of the PBFM (4.B)

Finding	Issue	Area	Commentary	Recommendation	Severity
7	Single-point reporting obscures sensitivity to key assumptions	Output	PBFM outputs are typically reported as single point estimates derived from applying cost and resourcing parameters to SAM demand volumes. This approach obscures how materially funding results can change under plausible variation in key parameters and assumptions, including demand drivers, supply mix settings and cost escalation rates. As a result, decision-makers have limited visibility of uncertainty and downside risk, particularly where model processing is intentionally aligned to target or policy settings, which may understate funding pressures, rather than a best-estimate representation of system behaviour.	Require PBFM reporting to include a standard set of sensitivity ranges for materially significant parameters, including alternative cost escalation assumptions for major cost components. Outputs should be presented as funding ranges rather than single figures to better reflect uncertainty and support informed decision-making.	Medium
8	PBFM outputs may be misinterpreted as forecasts of funding required	Governance, Output interpretation	There is a governance and interpretation risk that PBFM outputs are misread as forecasts of funding required to meet demand, rather than as funding benchmarks produced under approved, target-driven parameter settings. This risk is heightened where supply-mix assumptions are manually specified and not fully constraint-aware (which is the case with the current model), limiting transparency over how capacity constraints and substitution dynamics influence outcomes. PBFM outputs are also conditional on demand and pathway inputs sourced from the SAM, and therefore inherit the SAM's current limitations by design. In practice, this can lead to misplaced reliance on PBFM outputs for planning and decision-making beyond their intended purpose.	*Explicitly separate and label two standard reporting outputs: a "base case" used for control and acquittal, reflecting approved target-driven parameter settings; and a "reference case" used for planning and risk analysis, drawing on the enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model. This separation improves transparency. It makes clear which demand, supply and policy drivers explain differences between "base" settings and "reference case" outcomes, and better supports decisions about potential interventions, such as workforce expansion or provider and carer incentives. Both outputs should be accompanied by a standard interpretation statement. This statement should clearly explain the conditional nature of the results and prevent misinterpretation as unconstrained forecasts.	High
9	Cost escalation is indexation-driven and conditional	Processing, Parameter governance	The PBFM escalates base-year costs using indexation settings embedded within the model. As a result, projected funding outcomes are conditional on the ongoing appropriateness of these escalation assumptions. Where placement-specific price pressures, workforce shortages or market conditions cause costs to move materially above indexation, funding projections may no longer reflect underlying cost drivers. In the absence of a structured governance process, escalation settings risk persisting by default rather than being actively reviewed, challenged and updated in response to observed system behaviour.	Establish formal governance over cost escalation assumptions, including defined ownership, periodic review and explicit decision points for updating indexation settings. Escalation assumptions should be treated as conditional parameters and supported by targeted escalation sensitivity testing for materially uncertain cost components, with impacts clearly documented to inform funding and policy decisions.	Medium

*The proposed enhancements to the SAM-to-PBFM interface have been visualised in Figure C.1.

06
Appendices

Appendix. Part A

Part A Data limitations

#	Finding	Data source reference
1	The main source of data used for the market scan analysis includes data between July 2021 and December 2025 (i.e. four and a half financial years' worth of data). As only half of FY2025-26 is covered, this year has been excluded from analysis.	[redacted]
2	There was limited opportunity to validate categorisations and definitions with data owners. Noting the complexity of categorising service groupings and that particular services may cross multiple service types, analysis has aligned with Departmental-provided categorisations.	
3	Many data categories within Departmental-provided data were incomplete and displayed partial overlap ([redacted]). Where this occurred, the categories with the most non-blank values were selected, noting that there may be discrepancies with other overlapping categories. For this analysis, classification into 'Residential Care' was selected based on 'Placement and Support Classification'.	[redacted]
4	For calculation of median daily cost, the category [redacted]' from the Departmental-provided data was used. Zero and blank values were excluded from the median calculation. The Department advised that for this category, the median is a more appropriate measure for analysis than the mean due to the wide variation in placement costs.	[redacted]
5	Volume measures were complex to calculate given differences in IPS and OSD contract output measurements; as a result, placement nights were used as a proxy for volume, as advised by the Department.	[redacted]
6	Figures and charts within the supply and demand sections, where based on alternate sources e.g. ABS, ROGs etc. may define periods differently (e.g. point-in-time calculations as at June of each year, rather than full financial year figures as per the Departmental dataset). Comparability may be limited.	Various
7	This review was undertaken without consulting providers. As a result, while patterns are identified in terms of net increases and decreases, there is limited data on the rationale for these changes. Additionally, the quantitative data provided does not support analysis of attribution or causality.	Various

Appendix: Part A References (Continued overleaf)

Ref #	Reference
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Ref #	Reference
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Appendix. Part B

B. Appendix: References

Ref #	Document ID
1	[redacted]
2	[redacted]
3	[redacted]
4	[redacted]
5	[redacted]
6	[redacted]
7	[redacted]

Appendix. Part C

Appendix: Part C References

Ref #	Reference
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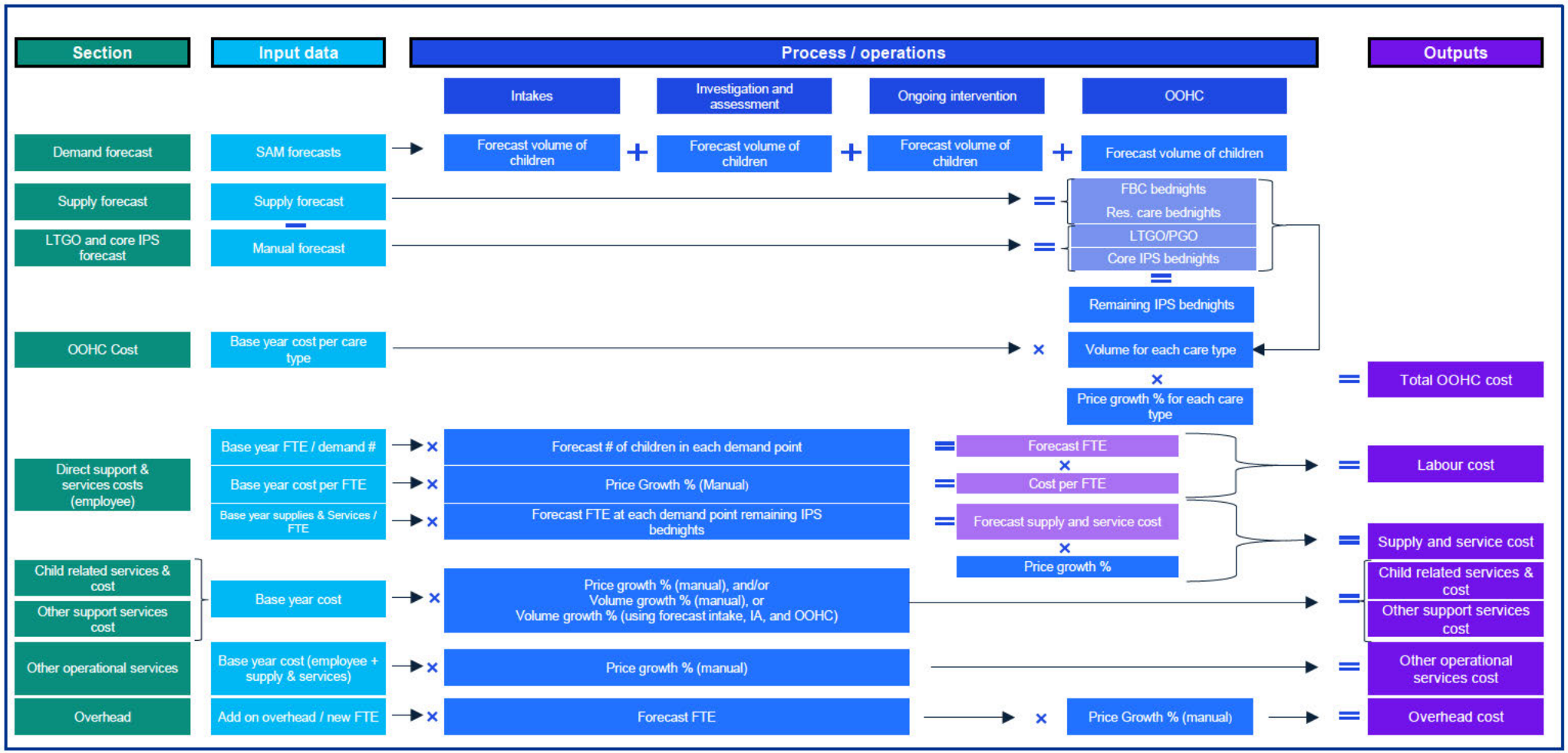
8	[redacted]
9	[redacted]
10	[redacted]
11	[redacted]

Appendix: Enlarged figure

Figure C.8 KPMG flow chart summarising steps described in [9] - Enlarged



Appendix: Comparison of existing FY30 outputs and key limitations

These are the principal outputs reviewed in Part C. They point in a similar broad direction, but are derived differently, serve different purposes, and carry material limitations. For that reason, no single existing output can presently be endorsed as the most accurate forecast of future demand or cost.

Table C.5 Interpreting the existing model outputs to FY30

Model	Forecast to FY30		Limitations / Notes
(1.A) Rennie Advisory Demand and (1.B) Cost	**(1.A) Demand:** • NFBC - 5,747 • OOHC – 17,051	**(1.B) Cost:** • $7.06 billion	Whole-of-state, unchanged-system trend baseline only. Uses deterministic trend extrapolation, fixed assumptions and single-point estimates, without causal modelling or uncertainty analysis. Results should therefore be treated as high-level directional signalling rather than robust estimates of future demand or cost magnitude. The forecast outputs could not be readily replicated from the assumptions stated in the methodology note, suggesting that some underlying assumptions or calculation steps were not clearly disclosed. These projections are based on a FY24 model.
(2) The Demographics Group – Demand Model	**Demand: (FY30)** • NFBC (linear) – 3,090 • NFBC (exponential) – 3,450		Intentionally illustrative only. Extends historical whole-of-state NFBC counts using simple linear and exponential trends and a fixed workforce multiplier, without behavioural, demographic, policy or system-constraint modelling, so it is suitable only for indicating broad order-of-magnitude pressure, not forecasting. These are based on a FY24 model.
(3) PeakCare – Demand Model	**Demand:** • NFBC – 4,208 (FY29) • OOHC – 14,841(FY29) --- • NFBC – 4,880 (Extrapolated to FY30) • OOHC – 15,494 (Extrapolated to FY30)		Simple trend extension for workforce strategy context, not a standalone forecasting model. Does not model drivers, behavioural responses or constraints, and the source projection is to FY29, so any FY30 extrapolation should be treated as indicative only. These are based on a FY24 model.
(4.A) Insight Acumen – SAM Demand Model	**Demand:** • OOHC – 15,628 (FY30 based on FY19 model outputs)		SAM provides conditional demand estimates based on externally specified intakes, historical pathway assumptions and stated settings; it does not currently model key drivers endogenously or explicitly represent supply and capacity constraints. This forecast is based on model outputs from FY19 *(QTC 2020 Review of OOHC Placement Services)*. Since then, the model has been updated. As a result, a current-day reprojection would be expected to produce different results.
(4.B) DFSDSCS – PBFM Cost Model	**Cost: (2028-29)** • Funding - $2.066 billion (supply mix target) --- • Funding - $2.781 billion (adjusted supply mix)		Outputs are funding benchmarks under specific demand, supply-mix and cost assumptions, not unconstrained forecasts of funding required. Results are sensitive to supply-mix settings and escalation assumptions, and single-point reporting may understate uncertainty. Adjusted supply mix forecast based on proposed adjustment of supply mix to actual share mix observed – from *the "Budget 2025-26 – New – Sought".* These are based on outputs from a FY24-25 model.

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This deliverable has been prepared as outlined with the Department of Justice in the Scope Section of the engagement contract dated 30 January 2026. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this deliverable are based on a review of data and documentation provided by the Department and the Commission of Inquiry, and publicly available information. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by the Department of Justice as part of the process.

KPMG have indicated within this deliverable the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

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