

LaingBuisson

The healthcare experts

THE POTENTIAL FOR DEVELOPING THE CAPACITY & DIVERSITY OF CHILDREN'S SOCIAL CARE SERVICES IN ENGLAND

Final Report for the Department for Education

Prepared by LaingBuisson

in association with COBIC and CICADA

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1. EXECUTIVE SUMMARY

1.1 Context

This report considers the potential for developing the capacity and diversity of provision of children's social care services in England.

The economic and policy context of the report can be summarised as:

- Growth in demand for public services generally, including children's social care;
- Austerity and pressures on public funding which will continue for the foreseeable future, creating an imperative for better performance within constrained funding envelopes;
- A concern that there is insufficient progress on improving outcomes for vulnerable children receiving social care and more should be done to accelerate this.

The Advisory Panel at the Department for Education (DfE) encouraged the authors of this report to be ambitious and we have sought to be so, while being aware of the need to balance the desirability of considering bold solutions against the imperative to have fully understood the risks of new and inevitably not fully tested ways of working to deliver better children's social care services.

It has been pointed out to us by colleagues at our 'challenge' meeting that change is disruptive and it is important to be aware of any associated costs. We appreciate that any transformation comes with risks but believe these risks can be managed as evidenced by the experience of other public sector transformation programmes and more recently with the setting up of the Trust model for children's social care in Doncaster.

In addition, transformation itself brings longer-term benefits for the service user. We do not therefore believe that these understandable concerns should stand in the way of measured reform, which gives an expectation of improved outcomes in the medium to long term.

We present in this report a range of options ([Section 1.12](#), [Table 1](#)), which, depending on the extent and pace of implementation, could transform the children's social care sector into one of the leaders in the public sector for commissioning and service innovation. This cannot be achieved in the short term. Realistically, the transformation we envisage would be a process consisting of incremental steps over several years, and would need a coherent long-term vision and a consistent policy framework.

1.2 Interpreting the remit

The remit of this report has been to explore the potential for developing capacity and diversity of provision of children's social care services in England, and to provide options for consideration by the DfE (as opposed to recommendations) on the best approach to developing capacity and diversity.

Throughout this report, we have drawn attention to the two separate, but related, elements of our brief ([Section 2](#)), in which we were asked to inform DfE thinking on options available to:

- a) 'Ministers intervening in cases of local authority inadequacy', on the one hand, and;
- b) 'Local authorities seeking new partnerships to improve delivery', on the other.

1.3 Outsourcing

1.3.1 Extent of outsourcing

Outsourcing of children's services to the independent sector (as defined in [Section 4.11, Box 1](#)) is currently largely restricted to placements of looked after children. According to the latest available spending out-turn figures, local authorities outsourced 66% of residential care by value in 2012/13, 47% of foster care and 29% of leaving care support services. More extensive outsourcing has been constrained by the 'in-house first' policy that we believe is applied by all councils when sourcing placements for looked after children services ([Appendix 2, Evidence Review, Section 4.4.2](#)).

Outsourcing to independent sector providers was below 10% by value for all other expenditure heads, and only 3% of the expenditure lines of 'social work (including child protection), commissioning and strategy'¹ ([Figure 3](#)).

Behind these numbers there is also substantial *de facto* outsourcing of highly skilled staff groups, in the sense that many local authorities rely heavily on staffing agencies. On average, authorities across England employ 14% of their staff through agencies and in some authorities this can exceed 40% ([Section 8.3.2.3](#)). The sector is therefore utilising 'for-profit' companies in areas of most sensitivity but this is done as a last resort and almost always in an unplanned fashion.

Official statistics also identify the amount of money spent by local authorities on the provision of children's social care by other public sector bodies, which can be viewed as a form of externalisation. The share was £150m, or 2.2% of the total spend of £6.9bn in 2012/13. Nearly all represents partnerships between neighbouring local authorities or coterminous health bodies.

1.4 Children's social care protected from cuts

Children's social care budgets have generally been protected from cuts since austerity measures began in 2011/12, and according to figures collated by the Department of Communities and Local Government, planned spending on children's social care has continued to rise in nominal terms by 2% a year up to 2014/15 ([Figure 1](#)). But this is equivalent to roughly standstill in real terms, at a time of rising demand. The financial environment for children's services, therefore, remains challenging.

1.5 Existing independent sector capacity and market structure

The great majority of independent sector providers active in the children's social care space are small to medium sized enterprises (using the European Union definition of up to €50m annual turnover). There are no truly large-scale organisations, i.e. with revenues in excess of £1bn per year ([Section 4.6 and Table 4](#)).

There are only a handful of existing providers with balance sheets strong enough to allow them prudently to bid for large-scale tenders where there may be a significant commercial risk.

The supply side is moderately fragmented at a national level, children's homes more so than foster care ([Section 4.5](#)).

¹ Because expenditure lines vary across different statistical returns we refer to those service lines variously described as 'social work, child protection, safeguarding, commissioning and strategy', where in-house supply is the general rule, collectively as 'Assessment and Care Planning' Services.

Local markets are more concentrated, but there are still sufficient suppliers in most areas of the country to make a competitive market for most placements in foster care or children's homes.

At the high needs end, in contrast, the supplier market can be 'thin', with few choices available for service commissioners, lending monopoly characteristics to this niche area.

Larger independent sector providers are typically diversified, though nearly always within the broad health and care sector. Most operate a range of children's services, including children's homes, special education and foster care, and some operate other health and care services for adults. But none is significantly diversified outside health and care. There are no general outsourcing or logistics companies with a significant presence in the children's social care sector.

1.5.1 Conclusions on existing independent sector capacity

In addition to our desktop analysis of market structure and the capacity of individual players, we had the benefit of hearing providers' own views on their appetite for expanding into core 'Assessment and Care Planning Services' areas of children's social care, from the stakeholder event held in September, and one-to-one telephone interviews with providers (Section 8.2). Although the current policy direction by ministers is not to generate a whole-scale marketisation of children's social care, we concluded that it is hard to envisage how significant additional capacity and diversity could be created without more services being exposed to market forces.

Our conclusions from this evidence are that:

1. Subject to central government policy change, there is appetite within the independent (for-profit and not-for-profit) sector in most parts of the country to respond to any tenders that local authorities may issue for small to medium sized segments of the full range of social care services, so long as these are free from the administrative and bureaucratic burdens characterised by current local government procurement regimes.
2. It is unlikely there would be sufficient capacity at present to run an effective competitive tender process for a larger scale or 'whole system' tender because of:
 - a) Current lack of direct experience of delivering 'Assessment and Care Planning' Services, and
 - b) Commercial risk in the light of limited balance sheet strength.
3. Capacity for taking on smaller to medium sized contracts exists within voluntary, not-for-profit organisations, public service mutuels (PSMs) and a wide range of small to medium size enterprises and a handful of larger ones, all of which share the following characteristics:
 - a) Visibility on how 'Assessment and Care Planning Services' processes work and their impact on 'downstream' placements of looked after children;
 - b) Employment of personnel with qualifications and experience similar to those of local authority staff, particularly social workers.

Most, but by no means all of this existing independent sector capacity is in the hands of children's home providers such as Advanced Childcare and Keys Group; foster care providers such as Core Assets, National Fostering Agency and Acorn Care and Education; and suppliers of locum social work staff such as Sanctuary Personnel Ltd.

New entrants may come from a variety of backgrounds, including other segments of the broad health and social care sector where there is a wide range of small to medium sized organisations with potentially transferrable skills and several well capitalised operators with an appetite for exploiting new opportunities for expansion and diversification.

1.6 Lessons from international outsourcing of social care services

Because its exposure to contestable markets is limited, there is little evidence from the English children's social care sector itself as to how best to stimulate capacity and diversity. We have looked, therefore, to experience from overseas and from other parts of the broad health and social care sector in the UK, both of which offer some valuable precedents and lessons.

We carried out an evidence review of international experiences in outsourcing of children's social care services, mainly in English speaking countries, with a particular focus on examples of outsourcing of child welfare services, [Section 5](#). We looked at examples with particular regard to the reasons for their success or failure.

The principal findings from this review, [Section 5.6](#), are:

1. There is significant outsourcing of a broad range of children's services in the countries we looked at, including North America, Canada, Australia and New Zealand.
2. The core function of child protection is usually retained by the state sector, though there are some examples of outsourcing of elements of this function as well.
3. There are two main models of outsourcing:
 - a. The State contracts with one or more lead agency to provide specified services for a target population
 - b. The State outsources a particular service and enters directly into performance-based contracts (most common example being placement services for children in care).
4. There have been both successes and failures, which we describe ([Appendix 2, Sections 5 and 6](#)).
5. Success typically takes several years to materialise, and the key determinants are:
 - a. Compatible cultures, trust and partnership between commissioner and outsourced service provider;
 - b. Preparation time and careful planning and implementation;
 - c. High quality procurement;
 - d. Good data for measuring outcomes.
6. The primary benefit of initiatives regarded as successful tends to be quality of services and outcomes rather than cost savings.
7. The most important conclusions we have drawn from the international survey of evidence is that outsourcing of a wider range of children's services than is usual in England can be successful if carefully planned and properly resourced, and that policy makers must be patient since it typically takes several years for positive outcomes to become clearly apparent.

1.7 Lessons from outsourcing in health and other care services in England

In [Section 6](#) we have described some of the government initiatives to develop capacity and diversity in other segments of the publicly funded health and social care space in England, looking at health care, social care and Ministry of Justice (probation) services in turn. In this executive summary, we have drawn on this and other information in the body of the report and re-analysed it according to 'types of intervention' based on the following five categories:

1. Pilots, pump priming and exhortation: while valuable, this approach has generally not led to step changes in service delivery in any of the many sectors in which it has been used across publicly funded health and care. In the children's social care space, experience from the Social Work Practices (SWP) pilots to date appears to confirm this general conclusion and is discussed in more detail in [\(Section 4.9\)](#). However, findings of the same review point out that staff within SWPs were more likely to work directly with children, had a better perception of their workplace culture and felt encouraged to take innovative actions.

2. Central government procurement: There are several examples of central initiatives to develop diversity and capacity in the NHS. Leaving aside the ISTC and Equitable Access to Primary Care programmes ([Sections 6.1.1 and 6.1.2](#)), which we do not consider have any direct relevance to children's social care, the central procurement with the most resonance for children's social care services is the Lead Provider Framework (LPF) tender process being run in the latter part of 2014 by NHS England to recruit independent sector and other organisations to join a framework agreement for provision of commissioning support to Clinical Commissioning Groups (CCGs) ([Section 6.1.4](#)). The initiative is potentially relevant to the task of developing capacity and diversity in children's social care, first of all because it effectively amounts to partial externalisation of aspects of the NHS commissioning function, while CCGs remain accountable for their statutory functions, demonstrating that the entirety of commissioning of public services does not have to be provided in-house. Second the establishment of an accredited list of specialised commissioning support providers is potentially relevant as an approach to the essential task of strengthening commissioning within the children's social care sector ([Section 7.3](#)).

The recent Transforming Rehabilitation Programme run by the Ministry of Justice during 2014, which outsourced lower tier probation service functions to 21 community rehabilitation companies throughout England, drawn from the voluntary, community and social enterprise sector, mutuals and the private sector, is also highly relevant to the options that might be considered for children's social care, particularly its 'tiered' segmentation of the market ([Section 6.3](#)).

3. Regulation: By 'regulation' we mean national rules that direct local bodies on how they spend their resources. In adult social care, the former Conservative administration used a condition on central government grant spending to require councils to spend 80% of the new, post-1993, 'STG' (Special Transitional Grant) funding on independent sector providers. This ensured that councils outsourced the bulk of home care services and also reinforced outsourcing of residential care ([Section 6.2.1](#)).

The most effective regulatory stimulus to markets can be characterised as simply stated national policy directions which leave local management with discretion of how to implement them, without central micro-management and without creating gaming behaviour on the part of regulated bodies.

4. Specific encouragement of particular types of provider: The major example here is the 'Right to Request' policy implemented during the 'Transforming Community Services' initiative, which came to a conclusion in April 2011 ([Section 6.1.3](#)) and led to the establishment of a cohort of about 20 significant Public Service Mutual companies (PSMs) to operate what were previously publicly provided community health services. A Public sector service mutual is an organisation that has left the public sector but

continues delivering public services and where employees control significant part of the organisation. We have considered whether a similar 'Right to Request' policy would be appropriate for children's social care services and have presented it as an option in the context of the new architecture we propose for dealing with failing authorities, which would involve a requirement for the successors of failed authorities to outsource all services as soon as practicable ([Section 7.2](#)).

We would not, however, expect any new PSMs to make a substantial contribution to capacity and diversity in children's social care services outside their home areas, at least in the short to medium term. This conclusion is based on a) their relatively weak balance sheets which constrain rapid expansion and b) on early experience in other sectors that most PSMs remain rooted in their own localities and only a handful have succeeded in making the transition to becoming fully commercial, not-for-profit organisations seeking major opportunities for expansion of their businesses either regionally or nationally ([Section 6.4.3](#)). If children's social care PSMs were to follow the same pattern then they would remain largely tied to their home geographies and therefore make only a limited contribution to the capacity and diversity available to respond to tenders in other localities, for either DfE interventions or ordinary local authority partnership arrangements.

5. Policy vacuums and knock-on effects of wider policies: A consequence of the removal of out-of-hours responsibilities from NHS GPs in the 2004 revised GP contract was the rapid expansion of independent sector out-of-hours services to fill the vacuum as Primary Care Trusts (PCTs) outsourced their new responsibility for arranging out-of-hours which they had inherited from GPs ([Section 6.1.6](#)). The result was a massive expansion of demand for incumbent or newly formed GP 'cooperatives'. There are 23 GP cooperatives, most formed in the 1990s. Their relevance to the issue of developing capacity and diversity in the children's social care sector is that, just like PSMs in health and social care, most have remained rooted in their own geography, and have therefore not contributed to market capacity more widely. Only a handful have developed into more commercial organisations with an ambition to expand. All this may be indicative of a similar course of market development if PSM spin-offs were to be encouraged in children's social care services.

The most far reaching example of capacity creation out of a policy vacuum was the massive expansion of the adult care home market in the 1980s, fuelled by income support which had become the principal public funding source by default ([Section 6.2](#)). This is not a precedent that has any merit for the creation of diversity and capacity in the children's social care sector.

In our concluding section of the Executive Summary ([Section 1.12](#)), we have set out the range of options that are available to the DfE to stimulate capacity and diversity. Each of them has a role to play, but we judge that the approach most likely to bring rapid results in developing capacity and diversity is 'regulation', in the form of national rules on how central government grants are spent.

1.8 Need for a step change in commissioning practices

The evidence we gathered, from published reports and providers of outsourced services whom we interviewed, indicates that the way local authorities commission constrains the entry of providers into service segments where they could potentially contribute capacity and diversity ([Appendix 2, Evidence Review, Section 4.4.2](#)).

We are convinced that opening up the market to competition must be complemented by an effective programme to support and develop local commissioning capacity. The DfE is well placed to operate such a programme and one of the options we give in [Section 1.12](#) for DfE consideration is that it could be undertaken by the '*National Children's Social Care Commissioning Board (NCSCC)*' that we propose. We do not believe that one can achieve transformation without the other. Simple exhortation to commission

better will not in our view achieve significant change. In the course of our work senior managers of independent sector providers reported back: that 'the last thing we want is another report recommending better commissioning'. We interpret this as meaning that there is no belief that exhortation alone to improve commissioning will work. We believe that more purposeful action to guide or even regulate commissioning patterns will be necessary. We also consider that the capitated, outcomes-based, incentivised approach to commissioning, which is being adopted in leading edge NHS 'pathway' contracts, is a robust model that can be promoted in the children's social care sector as well ([Section 8.4.1](#)).

As an example of how open supply side competition alone is insufficient to foster a successful market, without intelligent, strategic commissioning as the other side of the coin, we cite the market in social care for older people, [Section 6.2.1](#).

1.9 Appetite for market entry

Notwithstanding the bar on provision of core assessment and planning services by for-profit providers, we tested out the appetite for market entry through the stakeholder event and by targeted interviews with senior management of for-profit and not-for-profit organisations we considered may be prospective entrants into a new market for 'Assessment and Care Planning Services' in children's social care.

Our key conclusions ([Section 8.2](#)) are:

- There is strong interest by incumbents active in existing markets for looked after children (foster care, children's homes and social work staffing agencies) to expand their range of business into 'Assessment and Care Planning Services' processes that they consider they have strong insights into;
- None of the incumbents would currently be capable of bidding for large scale, whole system contracts of the type that could emerge as an option for failing authorities;
- But several would be capable of, and enthusiastic about, bidding for any small to medium sized tenders that were to be issued;
- Incumbents are open to partnering with other organisations (possibly new entrants) which strengthen their financial and operational capacity to bid for tenders;
- New entrants may come from a variety of backgrounds, including other segments of the broad health and social care sector where there are several well capitalised operators, as well as public service mutuals with an appetite for exploiting new opportunities for expansion and diversification
- The principal perceived barrier to market entry is risk, according to senior managers interviewed:
 - Reputational risk;
 - Commercial risk, especially where reconfiguration of services is involved;
 - Risk that government policy might change, reducing the value of investments they have made in building and mobilising capacity.
- Availability of capital to invest in assets is not a major barrier for potential new entrants, since Assessment and Care Planning Services are 'asset light';
- The only other significant barrier mentioned by interviewees is the perceived unwillingness of commissioners to engage with providers in 'co-production' and reconfiguring of services;
- There is a recognition that commercial risk can best be mitigated by sensible risk sharing in contracts;

- Reputational risk is more difficult to deal with. One private equity investor we spoke to described this as a 'Marmite test' – some organisations will be highly averse to the risk of front-page scandals if something goes wrong. Others are more phlegmatic;
- The large, broad-based outsourcing companies we spoke with said they were highly averse to reputational risk and would be unlikely enter this market were policy to change to allow them to.

In conclusion, desk-top analysis of incumbents and potential new entrants, supported by interviews, indicate that a competitive market could be established in most areas of the country, given a flow of tenders from commissioners. Initially, capacity would not extend to large scale, whole system contracts, but that level of capacity could reasonably be expected to develop as the market matures.

1.10 Developing the Market through Children's Social Care Trusts

The options we propose for consideration by the DfE, which are summarised in [Section 1.12](#), are set within the framework of a new system architecture which is describe in detail in [Section 7](#). The architecture is designed to support '*Ministers intervening in cases of local authority inadequacy*', which is one of the twin objectives of the brief. It will equally support '*Local authorities seeking new partnerships to improve delivery*', which is the other objective of the brief. It is designed to facilitate segmentation and market testing and to encourage opportunities for:

- A range of smaller providers, including Social Work Practices
- Consortia to work together to deliver new solutions
- Local authorities to bid for tenders, either alone or with a partner, in much the same way as NHS trusts bid alone or in consortia for the growing number of competitive tenders in the NHS.

1.10.1 Department for Education intervention to re-provide services in failing local authorities

In the case of intervention, the architecture allows for the failing local authority to delegate their provision to a third party, a not-for-profit Trust or Social Enterprise. This is similar to the 'Doncaster solution'. (The option would also be open to all other local authorities on a voluntary basis – the Kingston and Richmond/Achieving for Children solution).

We propose that these solutions be taken one step further through the formation of what we have called a Children's Commissioning Trust (CCT), [Section 7.2](#). The key distinguishing features of a CCT would be:

- A governance structure that enhances its legitimacy (addresses the 'democratic deficit' issue); and
- Crucially, the CCT's founding articles would define it as a primarily commissioning body. Following the transfer of local authority functions, the CCT would be expected to market test all children's social care services and outsource them as appropriate and as soon as practicable.

1.11 Developing the Market beyond Trusts and Mutuals

We consider that transforming the delivery of children's care services must involve a greater role for market testing and outsourcing, and that the key to success will be appropriate segmentation ([Section 8.3.2](#)) alongside intelligent, strategic commissioning. This will allow a range of smaller providers to enter at points at which they feel confident.

We describe four key aspects of segmentation; service, tiers of need geography and function – which we believe will develop capacity in the market. We also believe local authorities should be required to market test their in-house services where there is a contestable market. This could be successfully delivered by

either statutory guidance or regulation, and we illustrate the options open to government from compulsory outsourcing to a range of incentives.

There may be a concern in respect of this proposal, that suppliers would limit their interests to the more easy to deliver or profitable service areas leaving the local authority with the more complex and difficult services. While we appreciate the concern, this fear was not supported by the evidence as to how the market has developed to date, or the appetite expressed within our supplier interviews, or indeed the behaviour of suppliers in other healthcare markets such as adult social care and mental health hospitals, where independent sector suppliers have positioned their services at the most complex and challenging end of the spectrum.

Finally, to deliver an effective market, the evidence suggests that commissioning needs to undergo a radical shift towards capitated outcomes-based incentivised contracts, [Section 8.4.1](#); how to implement the capacity and infrastructure to develop this is an option that needs further consideration.

1.11.1 Strengthening national capacity to support and develop local commissioning

We believe, if these reforms are to be successful, that there needs to be more national capacity to support and develop effective outcomes-based contracts based on local commissioning. This will be essential to the successful delivery of children's social care services on an increasingly externalised basis. The two key, linked innovations we propose are:

- A National Children's Social Care Commissioning Board (NCSCCB), [Section 9.1](#)
- National Approved Leaders, [Section 9.2](#)

The National Children's Social Care Commissioning Board would:

- Be a body reporting directly to the Secretary of State
- Act as a holder of expertise and capacity to put in place new delivery models and drive service out-sourcing (including legal / procurement / project management / financial expertise)
- Support local authorities with effective commissioning by providing national templates and guidance and advice relating to:
 - National frameworks
 - Model contracts
 - Segmentation strategy
- Possibly commission specialist services on a national basis
- Provide a strategic framework for the effectiveness of the new delivery models
- Coordinate the response to intervention and the roles of the Children's Social Care Commissioner and National Approved Leader.

Nationally Approved Leaders would be partnerships accredited by the National Children's Social Care Commissioning Board. The partnerships would be a consortium made up of a local authority allied with a commercial provider and where appropriate national voluntary organisations. The National Approved Leaders would:

- Undertake intervention on behalf of the Secretary of State (ranging from part of an authority's service to the full service); and
- Build long-term capacity for continuous improvement in a local authority area.

We do not envisage this central capacity as centralisation in any way. Rather it is locally delivered but centrally supported. We believe that strong local commissioning capacity is essential to achieving the desired transformation. Though it is possible that the NCSCCB may mandate certain basic system features, such as a national framework list for providers of children's homes and foster care providers, to replace the multiplicity of local framework lists, which we were told were a significant cost burden on providers, we see the NCSCCB as being essentially to support local authorities.

1.12 Summary of Options

In line with our brief, we have developed a number of options for consideration by DfE. Each of these options is presented in context within the body of the report. They are summarised in [Table 1](#).

Table 1

Options for developing diversity and capacity in children's social care services

	OPTION	COMMENTS
1	Develop a single template to be used in all future interventions which result from serious and persistent failure, alongside a small team with the relevant legal, procurement and project management expertise. The template to involve the transfer of local authority functions to a new body, including the option of adopting and refining the proposed 'Children's Social Care Trust' (Section 7.1) and 'Children's Commissioning Trust' (Section 7.2) models. Or seek individual solutions based on local factors	The alternative is 'one off' local solutions. Benefits of a single template is cost (less need for professional advice, legal fees, etc.) and speed of implementation
2	Boost grant funding (through the DfE's Innovation Programme, or through similar funding streams) and other support for pilot programmes hosted by local authorities and their partners to develop innovative approaches to children's services, and seek to disseminate learning from those that are successful through existing or new channels: a) As the sole approach b) As a supplementary approach Section 4.9.2	Past experience is that pilot programmes do not generally lead to a step change in service delivery nationwide. A sole focus on this option is likely to result in slower transformation than with other options. There nevertheless remains an important role for pilot programmes as a supplementary approach to developing diversity and capacity
3	Seek to develop diversity and capacity through national rules (regulation) on how central government grants are spent Section 8.3.1	Experience in other parts of the publicly funded health and care system suggest that regulation which promotes externalisation is the most effective lever central government has to stimulate diversity and capacity rapidly

4	If regulation were to be adopted at the main approach to stimulating diversity and capacity, there is a whole range of options on how it might be implemented. These include:	
4a	<ul style="list-style-type: none"> i) Use conditions on grant funding ii) Use some other rule <p>Section 8.3.1</p>	A condition on grant funding represents the simplest approach. It was used successfully in adult social care after the 1993 community care reforms to ensure that councils spent 80% of their Special Transitional Grant (STG) funding on independent sector providers
4b	<ul style="list-style-type: none"> i) Frame the regulation such as to encourage a particular form of market segmentation in tender specifications ii) Leave market segmentation to the discretion of local authorities <p>Section 8.3.1</p>	<p>We were particularly attracted to the model of 'tiered' segmentation applied in the recent national procurement of probation services, where independent sector providers across England have won contracts to run 21 Community Rehabilitation companies to provide support services, leaving the highest level functions only for public sector in-house supply (Section 6.3)</p> <p>By analogy, a similar segmentation could be applied in children's social care services, 'Tiered' elements might be delivered by 'Early Help' companies which would contract with local authorities to provide preventive services, family support, targeted youth services, substance misuse and under-fives provision (as described in Section 8.3.3.2).</p>
5	<p>Establish a National Children's Social Care Commissioning Board reporting to the Secretary of State to develop and support local commissioning capacity</p> <p>Adopt some other means of promoting commissioning excellence</p> <p>Section 9.1</p>	<p>We have argued (Section 8.2.1) that transformation of delivery through tendering will not be achieved without a parallel transformation in commissioning.</p> <p>We believe there is a strong case for locating support with the Department for Education and for the NCSCCB to be well funded.</p>
6	<p>Implement the Nationally Approved Leaders proposal</p> <p>Develop some other route to developing leadership capacity to respond to calls for alternative service suppliers</p> <p>Section 9.2</p>	We make the case for this proposal in Section 9.2 of the report

7	<p>Encourage spin-off of public service mutuals (PSMs) from statutory children's services as a means of developing diversity and capacity:</p> <ul style="list-style-type: none"> a) By introducing a 'Right to Request' similar to that adopted in the <i>Transforming Community Services</i> initiative in the NHS b) No specific encouragement in children's services, other than general official sponsorship of the of public service mutual model <p>See Section 6.1.3</p>	<p>While we do not consider that the creation of large numbers of public service mutuals alone would be sufficient for the rapid development of capacity and diversity in children's social care services, it could play a significant part.</p> <p>See Section 6.4.3</p>
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2. PURPOSE OF THE REPORT

This report was commissioned as a result of a report by Le Grand et al (2014) – *On Ways Forward for Children's Social Care Services in Birmingham*. One of the recommendations of the report was that:

The Department for Education commission a specific study on developing capacity to assist in the intervention options, involving the possible splitting of commissioning from provision, that are available to the Secretary of State in responding to a failure of a local authority to secure services which protect children and young people.

The purpose of this report is to provide an analysis of the existing mixed market in the provision of children's social care services in England, and the potential for developing the capacity and diversity of provision in England.

It was the remit of the project team (members listed in [Appendix 1](#)) to provide options for consideration by the DfE, as opposed to recommendations, on the best approach to developing capacity and diversity. This was achieved by finding a balance between the desirability of considering bold solutions and the imperative to have fully understood the risks of new and inevitably not fully tested ways of working to deliver better children's social care services.

In order to achieve this we provided an analysis and overview on the following elements:

- Describe the current diversity of provision within the children's social care market.
- Identify potential providers.
- Identify barriers that exist to market entry.
- Identify the potential for establishing new organisations for the provision of children's social care services.
- Outline a small set of options for delivering increased capacity and diversity in the system. We looked at what both for-profit and not-for-profit organisations could offer, whether in cases of intervention by the DfE or in partnership with the great majority of authorities that are not subject to intervention. We have also looked at any enhanced role that higher performing local authority children's departments might develop in offering additional capacity and diversity for other children's departments which have a need for such capacity, whether as part of a competitive market or not.

We are aware of concerns about introducing the profit motive into the core of children's social care services, concerns which gave rise to the provision in *The Children and Young Persons Act 2008 (Relevant Care Functions) (England) Regulations 2014* that bars local authorities from delegating relevant care functions to for-profit companies. The regulations, however, still leave scope for for-profit providers to provide a broader range of services under contract. Throughout this report, we have focused on the two separate, but related, elements of our brief in which we were asked to inform DfE thinking on options available to:

- a. 'Ministers intervening in cases of local authority inadequacy', on the one hand, and;
- b. 'Local authorities seeking new partnerships to improve delivery', on the other.

Greater capacity and diversity for one purpose will be equally available for the other, so our advice on the two elements of the brief should be fully aligned. However, we have emphasised the need for a coherent strategy that explicitly recognises these twin objectives, bearing in mind that they may have different time lines for achievement. We also note that the element of the strategy that relates to giving ministers a

wider range of options in cases of intervention could not stand alone from developing capacity and diversity more generally. This is because the quantum of intensive interventions by the DfE in a small percentage of local authorities would be too small in itself to transform diversity and capacity throughout England. Achieving a national transformation in diversity and capacity would depend on stimulating parallel moves among local authorities to seek new partnerships to improve delivery.

We did not discuss the merits of outsourcing and competition as a means of driving desirable change, since it is hard to envisage how additional capacity and diversity could be created without more services being exposed to market forces ([Section 7.1](#)).

3. METHODOLOGY

This report was commissioned in June 2014. Over a period of four months we used a combination of extensive desk research and engagement with stakeholders across the public, private and voluntary sectors, and the analysis was drawn together using the following processes:

1 Stakeholder engagement:

- a. Semi-structured interviews were carried out with a range of public, private and voluntary sector organisations involved or willing to enter into provision of children's social care services. This provided insight into the perceived barriers and enablers with respect to market entry for these organisations, and also provided insight into the appetite for these groups interested in entering any new market opportunities.
- b. A national conference was held on September 2, 2014, chaired by Lord Norman Warner. It included a range of stakeholders from across the sector – this provided an opportunity for feedback and comment on the emergent findings at this stage, and to gauge the interest of organisations in this market.
- c. A roundtable challenge event with a small group of key stakeholders held on October 22, 2014.

2 Review of evidence and literature with a focus on:

- a. The international experiences of outsourcing children's social care services.
- b. An overview of key developments and lessons from outsourcing in health and other care services in England.
- c. A review of existing delivery models in place.
- d. A review of relevant data sources.

3 Department for Education Advisory Panel:

- a. An Advisory Panel was established by the DfE specifically for this report, whose remit was to provide insight, guidance and advice around the findings and options for consideration as they developed. The panel met four times and attended the conference and challenge event. A list of advisory panel members can be found in Appendix 1.

4 Market expertise – options for developing the market:

- a. LaingBuisson and COBIC consultant advisors provided expertise for developing the options and how to stimulate the market.

4. MARKET OVERVIEW OF CURRENT CHILDREN'S SOCIAL CARE IN ENGLAND

In this section we describe the current market in children's social care in England. We explain how children's social care is currently structured and analyse how the market has grown in some areas but not in others, and how regulation and legislation have influenced these developments.

Our main findings are:

- Local authorities continue to provide most 'Assessment and Care Planning Services' (see [Section 1.3.1](#) for definition) in-house, but they outsource a large and growing proportion of services for looked after children including residential and foster care.
- Independent sector providers account for a 66% market share by value of children's home services and 47% by value of foster care.
- Growth of the outsourced market has been driven by council supply constraints and also by price, when the full cost of new in-house provision is compared with the price of existing independent sector services.
- Local authority children's services have not been driven by the same central requirements through legislation or regulation to outsource their services and even where there is a robust market for example in foster care continue to default to in-house provision.
- Incumbent providers within this sector are small to medium scale, with no truly large company.
- There is sufficient independent sector capacity in most parts of the country to respond to any tenders that local authorities may issue for small to medium sized segments of 'Assessment and Care Planning Services' services.
- It is unlikely there would be sufficient capacity to run an effective competitive tender process for a larger scale or 'whole system' tender.
- Balance sheet weakness is a major limiting factor on the ability of most incumbent providers to respond to tenders that might in the future be issued for core Assessment and Care Planning Services where there may be a significant degree of commercial risk. This limitation can be mitigated by forming joint ventures or other partnership arrangement with financially stronger organisations.

4.1 Structure of children's social care services

Statutory powers are devolved to 152 local authorities in England, each of which is responsible for arranging all children's services in its geographical area, accountable to its own electorate as well as to the Secretary of State for Education and Ofsted.

Children's departments typically do not have any aspirations to extend their sphere of activity outside their geographies and it is often difficult to fill gaps left by failing departments without depleting other departments that may lend expertise to turn the failing department round. Such non-geographically based pools of expertise as exist are to be found in the independent sector (not-for-profit or for-profit) organisations with aspirations to operate regionally or nationally. But their focus remains narrowly concentrated on residential and foster care for looked after children in the absence of any willingness of local authority commissioners to engage with them in the co-production of other children's social care services

Table 2

Planned gross revenue spending on children's social care services, England 2011/12 – 2014/15

	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Residential care	920	924	905	893
Foster care	1,284	1,339	1,377	1,442
Adoption services	229	236	269	282
Leaving care support services (planned)	227	227	223	232
Social work (including child protection)	1,726	1,854	1,894	1,878
All other children's social care services	1,871	1,756	1,878	1,957
SUB-TOTAL (narrow definition)	6,258	6,336	6,547	6,684
Young people's services	883	791	713	622
Sure start	n/a	n/a	1,093	985
TOTAL (wide definition)	n/a	n/a	8,353	8,291

Source: Department for Communities and Local Government

Table 3

Value of independent sector provision of certain health and social care services compared with the value of the entire addressable market

SECTOR	Addressable annual market value ¹	Annual value of independent sector provision	Independent sector share %
Acute hospital services	£46 billion (UK, 2013)	£4.0 billion	9%
Mental health secondary services	£11 billion (UK, 2013)	£1.1 billion	10%
Care homes (older people)	£15.1 billion (UK, 2013)	£13.4 billion	83%
Care homes (younger adults)	£3.7 billion (UK, 2013)	£3.1 billion	84%
Domiciliary social care (all adults)	£5.9 billion (UK, 2013)	£5.3 billion	89%
Children's homes (includes council overheads)	£0.9 billion (England, 2014/15)	£0.6 billion	66%
Children's foster care (includes council overheads)	£1.4 billion (England, 2014/5)	£0.7 billion	46%
All children's services other than sure start and young people's services (includes council overheads)	£6.9 billion (England, 2014/15)	£1.8 billion	27%

¹ Publicly and privately paid services combined

Source: LaingBuisson Healthcare Market Review – twenty-sixth edition, updated

4.2 Value of sector

English local authorities have budgeted to spend £6.7bn in 2014/15 on children's social care services (excluding sure start and spending classified under 'young people's services', both of which include a large element of universal as well as targeted services).

If sure start and young people's services were included, the addressable market would be valued at more than £8.3bn as shown in [Table 2](#).

This defines the addressable market size, since private funding of children's social care is negligible².

At about half the scale of the older people's care home sector, and roughly the same scale as the adult home care sector, the children's social care sector is of sufficient scale to attract interest from a fairly wide range of commercial and not-for-profit organisations interested in partnering with the public sector.

The children's social care outsourcing market is less highly developed than in adult social care, though it is more highly developed than in many segments of publicly funded healthcare, [Table 3](#).

4.3 Expenditure trends

Children's social care has been largely protected from budget cuts in recent years.

The spending envelope has expanded slowly in nominal terms since the crunch year for public services of 2011/12, at a compound annual growth rate of 2.2% per annum, equivalent to roughly standstill in real terms ([Table 2 and Figure 1](#))³.

Despite faring better in terms of spending than other local authority departments, children's departments nevertheless perceive strong pressure on resources against a background of rising demand driven by population increase and, possibly, the effect of the recent economic downturn on family stability.

4.4 Outsourcing trends

Outsourcing of children's services to the independent sector is currently largely restricted to placements for looked after children rather than those that can be brought together under the general heading of Assessment and Care Planning⁴.

According to the latest available spending out-turn figures for 2012/13, local authorities outsourced 66% of residential care by value, 47% of foster care and 29% of leaving care support services.

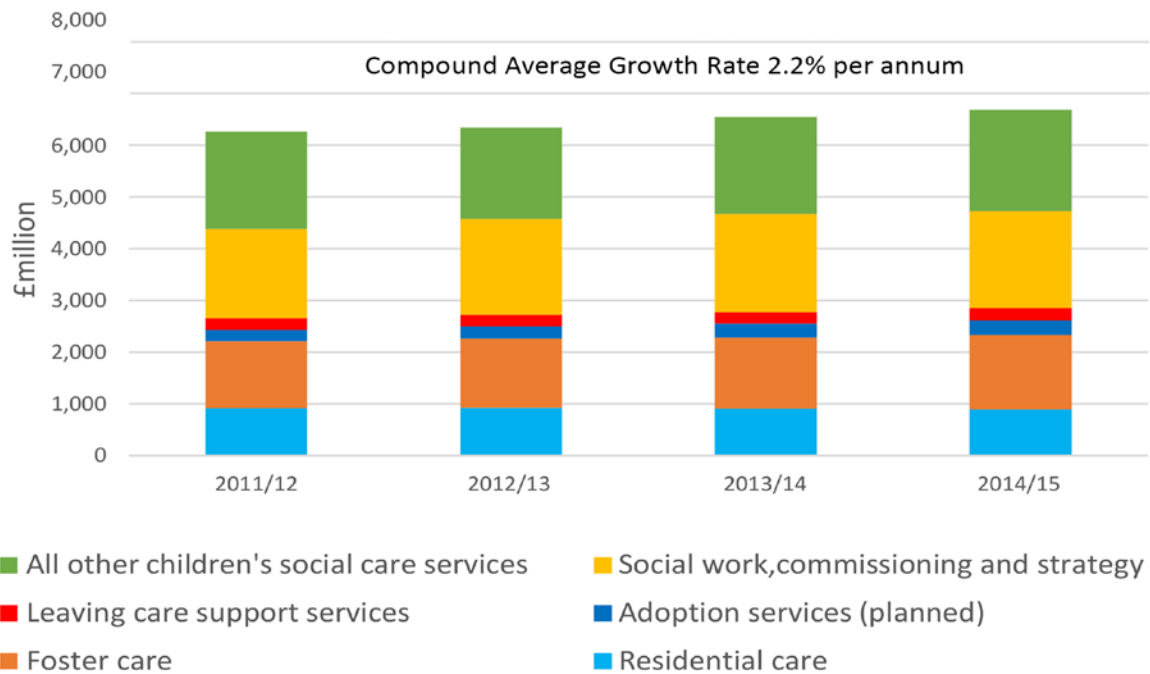
Figure 1

Planned gross revenue expenditure on children's social care services England 2011/12 – 2014/15

² Note that the planned spending series from DCLG is not consistent with the out- turn series from the DfE.

³ The conclusion that children's social care has escaped cuts is based on the narrow definition of children's social care services, excluding young people's services and sure start (both of which include large elements of universal as well as targeted services). If young people's services and sure start were to be included the conclusion would no longer hold.

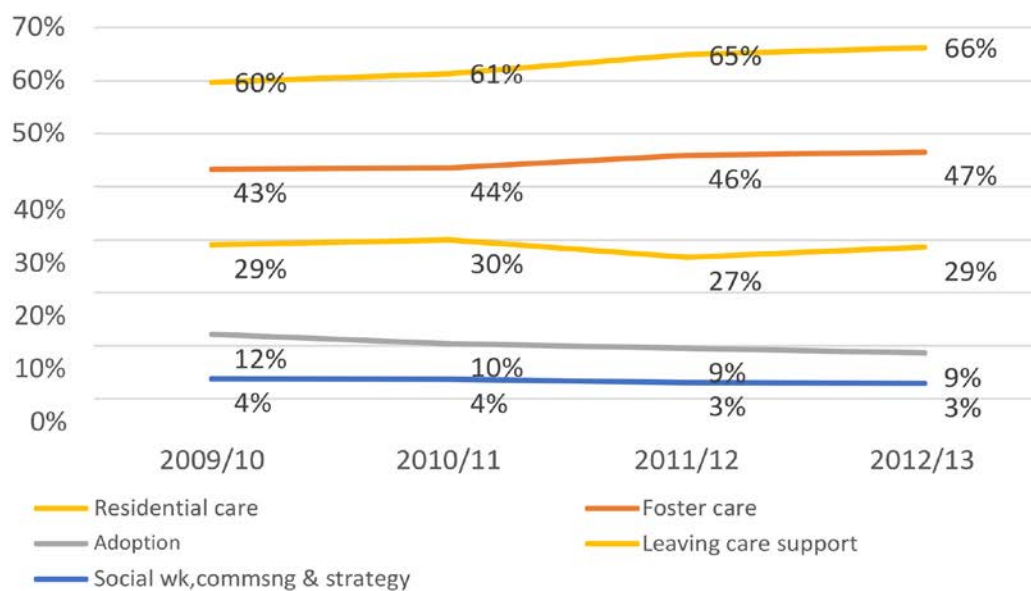
⁴ The corresponding budget head in DfE out- turn statistics is 'Safeguarding and commissioning' and the corresponding budget heads in DCLG planned spending statistics are Social work (including child protection), commissioning and strategy.



Source: Department for Communities and Local Government

Figure 2

Share of children's social care services by value outsourced to independent sector providers by local authorities in England 2009/10 – 2012/13



Source: DfE Out- turn expenditure

All other service heads were below 10% and local authorities outsourced only £59m by value or 3% of the core 'Assessment and Care Planning Services' service heads of 'social work (including child protection), commissioning and strategy' to independent sector providers, Figure 2.

There is also substantial de facto outsourcing of the human resources function in the sense that many local authorities rely heavily on staffing agencies, not only for temporary social work staff to cover holidays and sickness, but also on a frequent basis for core social work staffing. Much of the agency staff use appears to be on an unplanned basis, stemming from widespread social work staff shortages and a pay premium for agency staff which has encouraged social workers to leave their permanent jobs and join agencies in the knowledge they will be rapidly redeployed, sometimes into the authority they have left.

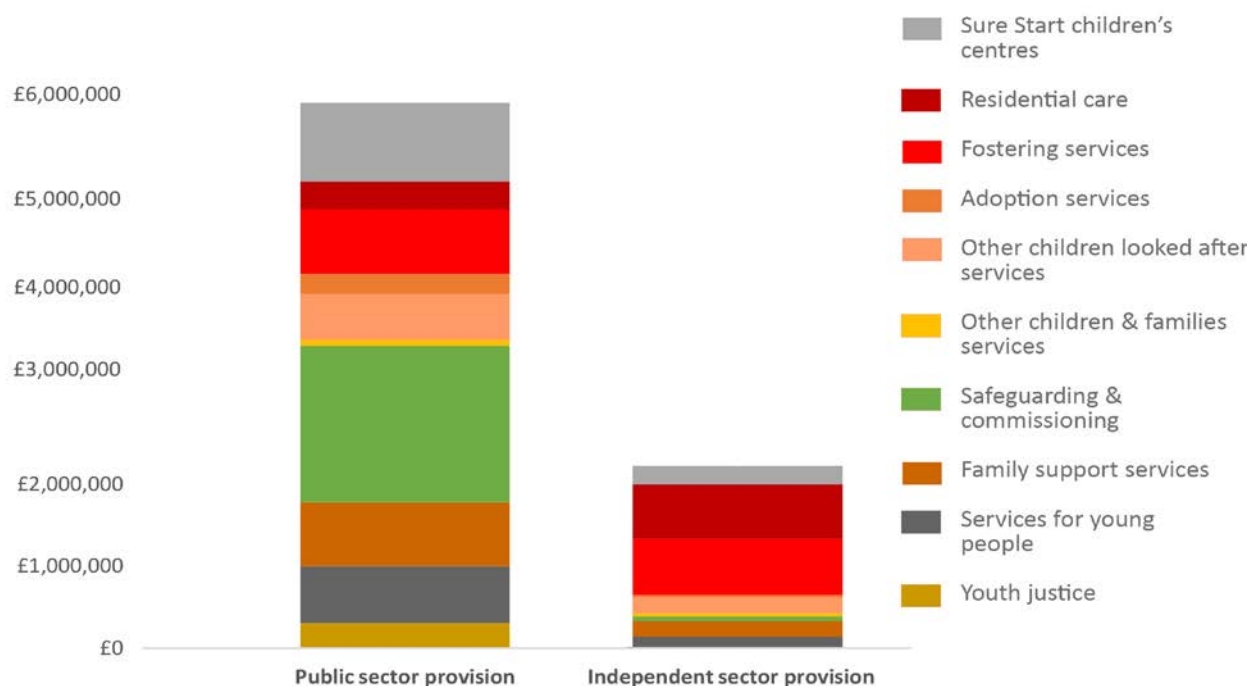
A similarly distorted employment pattern is found among nurses and other staff in many areas in the NHS. The scale of such outsourcing in children's social services is not transparent from DfE expenditure returns since staffing is not a service line on which local authorities report spending by sector. The best information we have is that authorities across England employ 14% of their staff through agencies, [Section 8.3.2.3](#).

Out-turn expenditure statistics from the DfE also identify the amount of money spent by local authorities on the provision of children's social care by other public sector bodies, which can additionally be viewed as a form of externalisation.

However, the share was very small at 2.2% of the total spend of £6.9bn in 2012/13. Nearly all represents local partnerships between neighbouring local authorities or co-terminus health bodies.

Figure 3

Gross revenue expenditure on children's services, England 2012/13



Source: Table 4, below

Table 4

Gross revenue expenditure on children's services by local authorities in England by sector of supply 2012/13

	Public sector	For-profit	Not-for-profit	Independent Sector total	ALL SECTORS
Service areas	£m	£m	£m	£m	£m

Sure start children's centres	962	116	115	231	1,193
Other children looked after services	557	172	28	200	757
Residential care	337	616	44	660	997
Fostering services	790	623	64	687	1,478
Adoption services	241	17	6	23	264
Other children and families services	74	16	20	36	111
Safeguarding and commissioning	1,907	48	11	59	1,966
Family support services	781	107	84	192	973
Services for young people	694	58	64	122	816
Youth justice	306	11	4	15	321
TOTAL	6,650	1,784	441	2,225	8,875

Source: DfE

Outsourcing in the two principal sub-markets of foster care and care homes has been growing, though not at a very rapid pace, in recent years, [Figure 2](#). The drivers are local authority in-house capacity constraints and price (when the full cost of new in-house provision is compared with the price of existing independent sector services). In the case of foster care, the independent sector accounts for nearly all of the growth in placement numbers over the last decade, while in-house foster placement numbers have remained relatively constant. The pattern is fully consistent with an 'in-house first' policy pursued by all local authorities, as evidenced in [Appendix 2, Evidence Review, Section 4.4.2](#). There has been no growth of outsourcing in other segments.

4.5 Main features of the foster care and children's homes markets

The supply side of the market is moderately fragmented at a national level, children's homes more so than foster care:

1. The concentration ratio (the share of the independent sector market controlled by the four largest operators) was 40% for foster care in 2013, the market leader being Core Assets;
2. The corresponding concentration ratio was 20% for children's homes, the market leader being Advanced Childcare, owned by the Cambian Group.

Local markets are more concentrated, but there are sufficient suppliers in most areas of the country to make a competitive market for most placements in foster care or children's homes.

At the high needs end, in contrast, the supplier market can be considered thin, with few choices available for service commissioners, lending monopoly characteristics to this niche area.

Market power typically lies with commissioning local authorities for undifferentiated services, but market power shifts into the hands of providers where a high degree of specialisation is required.

Larger independent sector providers are typically diversified, though nearly always within the broad health and care sector. Most operate a range of children's services, including children's homes, special education and foster care, and some operate other health and care services for adults. But none is significantly diversified outside health and care. There are no general outsourcing or logistics companies with a significant presence in the children's social care sector.

The great majority of independent sector providers that are active in the children's social care space are small to medium sized enterprises (using the European Union definition of up to €50m annual turnover). There are no truly large-scale organisations (i.e. with revenues in excess of £1bn per year).

The largest provider in terms of children's social care revenue is for-profit Core Assets, the UK's market leading foster care provider, with revenues of £166m in 2013. The Cambian Group, owner of Advanced Childcare, has larger overall revenues at around £230m in 2014, but only by virtue of its special education business, which is outside our definition of children's social care.

The largest not-for-profit provider is Action for Children, with revenues from charitable activities of £156m in the year to March 2014, including £82m from supporting families and £25m from services to children in care. But neither Action for Children nor any other not-for-profit provider features as a major national provider of either children's homes or foster care.

The only public service mutual (spin-off from the public sector) with significant revenues (over £2m a year) is Achieving for Children CIC, the social enterprise set up to run children's services formerly operated by the London boroughs of Kingston and Richmond. It has not yet posted its first year's accounts but its annual revenue will be £50m-plus, although this will almost all be as a result of their local authority contracts.

Though the larger independent sector providers of residential and foster care have a geographical footprint that covers most, if not all, regions of England, there is no provider with a presence in most of the 152 authorities with responsibility for children's services.

4.6 Financial strength of leading incumbent providers

The scale of incumbent providers runs from small to medium. There are no truly large-scale organisations (i.e. with revenues in excess of £1bn per year) in the children's social care space. The 20 largest (by revenue) independent sector providers of children's social care services in the UK are listed in [Table 5](#).

Table 5

Leading providers of children's homes, foster care and social work staffing, UK

	Latest Annual Revenue	Tangible Fixed Assets	Total equity & reserves	Ownership
Cambian Group	£231,992,000	£334,332,000	£225,770,000	Listed
Core Assets	£162,969,000	£2,788,000	£57,812,000	Private company
Action for Children	£156,104,000	£33,958,000	£22,376,000	Charity
Acorn Care and Education	£108,153,029	£38,396,129	-£138,250,000	Ontario Teachers
National Fostering Agency	£101,932,000	£4,306,000	-£5,466,000	Graphite Capital
SWIIS (aggregate 3 companies)	£65,373,391	£2,473,368	£5,579,567	Private company
Sanctuary Personnel Ltd	£61,018,021	£227,672	£8,953,824	
Randstad Care Ltd	£38,941,977	£50,608	£3,654,866	Dutch listed
Keys Group	£37,599,321	£18,270,059	£7,701,883	Private company
Partnerships in Children's Services Ltd	c.£30,000,000	n/a	n/a	Sovereign Capital
Northern Care	£25,046,349	£1,991,751	£1,970,296	Private company
Five Rivers Child Care	£24,397,651	£2,015,711	£2,779,326	Private company
Caritas Recruitment Ltd	£22,832,000	£30,000	£632,000	Private company
By the Bridge	£21,238,241	£217,031	£4,037,028	Apposite Capital
ISP (Integrated Services Programme)	£19,747,788	£447,350	£4,134,950	Charity
CastleCare Group Ltd	£19,184,855	£7,198,728	-£3,273,728	Baird Capital
Compass Holdco Ltd	£15,120,634	£298,548	-£2,241,748	August Equity
Sunbeam Fostering Group Ltd	£11,307,631	£430,826	£2,311,688	Private company
Hays Social Care Ltd	£10,848,000	£17,000	£2,318,000	Listed
Educare Adolescent Services Ltd	£10,098,912	£866,921	-£312,506	NGBI Private Equity

Source: Statutory accounts

The top twenty providers include:

- One stock exchange quoted company in the children's social care space, Cambian Group plc, whose activities span children's social care (children's homes and foster care) as well as special education and mental health hospitals;
- One charity, the long-established Action for Children
- No public service mutual, since Achieving for Children is yet to report its first set of accounts
- Seven private equity owned companies in the children's social care space, the largest of which is Acorn Care and Education, owned by the Ontario Teachers' Pension Plan.

There are only a handful of existing providers with balance sheets strong enough to allow them prudently to bid for large-scale tenders where there may be a significant commercial risk. The key indicators are total equity and reserves, and tangible fixed assets (Table 5). Cambian Group plc, owners of Advanced Childcare, has by far the strongest balance sheet with total equity and reserves of £226m at mid-2014, followed by core assets with £58m at December 2013.

The seven private equity backed companies are also capable of bidding for large-scale tenders with significant commercial risk, even though their balance sheets are weak in many cases. An extreme example is Acorn Care and Education, whose total equity and reserves are negative to the tune of an astonishing -£138m, Table 5. However, this represents the long-term debt that Ontario Teachers' Pension Fund has placed on Acorn as part of its financial structuring. It will not have to be repaid until Ontario Teachers disposes of Acorn. This is a pattern typical of private equity backed companies. In practice, it means that the ability of any private equity backed company to take on major new contracts with significant commercial risk will depend on whether the private equity backer is prepared to carry the risk.

Most private equity companies themselves have sufficient equity and reserves easily to take on the likely commercial risks involved in even major children's services contracts, though their willingness to do so will depend on the view they take on whether the additional cash flow they acquire is sustainable – since their business model is to acquire businesses, build them and sell on sustainable cash flows.

4.7 Profitability of incumbent providers

The profitability of major providers is not excessive:

- Companies whose main business is operating foster care agencies, and which post full statutory accounts, have reported average operating profits (EBITDA: Earnings Before Interest, Tax, Depreciation and Amortisation of Goodwill) of 11% of revenue. This is similar to the profitability of other non-asset based sectors such as home care and supported living;
- Companies whose main business is operating children's homes, and which post full statutory accounts, have reported average operating profits (EBITDAR: Earnings Before Interest, Tax, Depreciation, Amortisation of Goodwill and Rental of leased assets) of 12% of revenue. This is significantly lower than the profitability of other asset based sectors such as care homes for adults, which is typically between 20% and 30% and may be explained by in-built operating challenges including small scale of homes and short length of stay. In the minority of homes where full occupancy is achieved over a prolonged period, profitability can be very high, but this is matched by low profitability where occupancy is low;
- Larger providers are typically diversified, though nearly always within the broad health and care sector. Most operate a range of children's services, including children's homes, special education and foster care, and some operate other health and care services for adults. But none is

significantly diversified outside health and care. There are no general outsourcing or logistics companies with a significant presence in the children's social care sector.

4.8 Risk of financial failure among larger incumbent providers

The only major business failure in the last decade was Sedgemoor Group Ltd, a private company. Sedgemoor started trading in the South West in 1988 and grew into a national provider with over 65 residential properties and 14 schools providing care and education services to children with a wide array of behavioural difficulties and complex health needs, as well as fostering services. At its peak it was generating annual revenue of £25m. Having run into financial difficulties, in September 2007 the company went into administration. Commentators at the time identified poor management as the principal cause of failure.

Providers are nevertheless highly conscious of the risks of operating in a high profile and highly regulated area. The demise of Castlebeck Group in 2012 in the adult mental health sector illustrates the existential threat to providers from failure of quality assurance. To place matters in context, however, there have as yet been no such catastrophic, value-destroying corporate failures in the children's social care sector.

We do not have any data on the rate of business failures among smaller providers.

4.9 Role of small providers including Social Work Practices

There are large numbers of smaller providers and family businesses providing residential and foster care for looked after children. But like larger providers, the smaller independent sector providers are virtually absent from delivery of the core Assessment and Care Planning functions. The recent emergence of the Social Work Practice model may foreshadow a change, in which small-scale providers have a more prominent role in supplying these core children's social care services.

4.9.1 Social Work Assessment and Support

Local authorities have only been afforded the opportunity to delegate core elements of their children's social care provision relatively recently. When it first became law, *The Children and Young Person's Act 2008 (Part 1)* granted a limited number of local authorities permission to delegate social care functions relating to looked after children and care leavers to third party providers. Initially, this was run as a pilot but the provisions were extended to all local authorities in November 2013.

Until the innovation of Social Work Practices (SWP), local authorities in England had been largely prevented from outsourcing statutory social work services. There were exceptions. One example was The Camden National Society for the Prevention of Cruelty to Children project, which involved the NSPCC undertaking child protection investigations for the London Borough of Camden from June 1993 to June 1995. In England, Wales and Northern Ireland the NSPCC is unique amongst charities as it has statutory powers to intervene on behalf of children. Under section 31 of the Children Act 1989, only local authorities and the NSPCC can apply to a court for a care, supervision, or child assessment order. This was implemented due to the serious capacity issues in social work services following industrial action. Interviews with those involved in the project concluded some very good assessment work had been undertaken and the arrangement had enabled a critical service to be provided when there were insufficient local authority social workers to carry out child protection work. However, there were difficulties with managing cultural differences between the organisations. Most challenging was maintaining consistency of relationship between children and families due to changes of worker. There was a view that any problems experienced were as a result of cultural differences, the set up and systems

established, not the quality or knowledge of NSPCC workers. Overall the project was seen as a success, enabling the provision of a critical service over a two-year period.

In 2007, the Social Care Practices Working Group explored the feasibility and options of piloting social care practices. The business model favoured by the group was the professional partnership model, which concluded that the partnership would contract with the local authority to provide field social work for looked after children, and to commission services that its own staff could not provide. It would own its assets and pay the partners and any staff that it might employ.

The working group anticipated that existing voluntary or private sector organisations might bid to provide pilots. Some local authorities also favoured particular governance models, which influenced the tendering process significantly.

For example, one local authority wanted to pilot a third sector model with an existing provider and advertised the tender specifically to voluntary sector organisations it already worked with. Another authority aimed to commission a social enterprise model that precluded bids from private or voluntary sector organisations by specifying that it sought an organisational structure with at least 50% ownership by qualified social workers to meet the requirement for the SWP to be social worker led. Only one local authority decided to adopt a completely open procurement process and consequently received interest from 16 organisations, four of which went on to submit bids. Another local authority decided not to enter into the standard procurement process but invited bidders to submit ideas about the approach that they would take to delivering a SWP.

While this approach was considered to stimulate innovation, it also resulted in a lack of clarity and, from the union perspective, a lack of transparency. Where local authorities struggled to identify bidders, DfE-appointed consultants played a role in stimulating interest and bids, using their network of contacts.

The working group anticipated that each practice would hold a budget, provided through the contract with the local authority, and would use it to fund the placement, support and activities that they believed each looked after child should have. It was envisaged that SWPs would have autonomy and control over placement decisions.

Unfortunately none of the SWPs had responsibility for a budget to fund placements for children coming into care. Commissioners working with local authorities and providers at the commissioning stage raised concern over the delegation of budgetary responsibility and the extent of decision making. Only one SWP that worked solely with care leavers had full control of a placement budget. Arguably this was a major flaw of the social work pilot programme.

As none of the SWP practices had budget responsibility for care placements, it was not possible for the evaluation to report on the success or failure of any sub-contracting arrangements. Without SWP having accountability for placement budgets, it was difficult to properly analyse the effectiveness of the pilots.

In 2012, an evaluation concluded: "SWP as a group did not offer children and young people more choice regarding placements than was experienced by those in comparison sites." Arguably this is because SWP had little, if any, control over the mechanisms for sourcing placements.

Despite all these difficulties, it is worth noting some of the achievements of SWP and their potential in delivering innovation in the children's services market. A key finding was that SWP staff were able to spend more time face to face with children and families and had more autonomy to use their professional judgment.

Also, SWP generally produced significantly higher morale, better retention and greater continuity of work with children, families and service users. This empowered some of the SWP staff to work creatively and flexibly to provide a more responsive, cost-effective and tailored-made service.

4.9.2 The Providers of Social Work Services (England) Regulations 2013

The Social Work pilots ended in November 2013 under the terms of a sunset clause in the legislation. New regulations were needed to enable arrangements to continue and to extend to all local authorities the ability to enter into transfers of functions that were previously only available to the named pilot authorities.

Regulations came into force in November 2013. They enable local authorities to enter into arrangements with a provider of social work services to undertake some or all of the authority's social care functions in relation to individual looked after children, and in relation to care leavers.

These provisions currently include a requirement that any provider of social care services for looked after children and care leavers should be separately registered with Ofsted.

There is a clause in the Deregulation Bill currently before Parliament that would remove this requirement. Assuming this secures agreement, it is anticipated that the requirement to register with Ofsted will be removed in spring 2015.

4.9.3 Children's Social Care Innovation Programme

Most recently, the DfE set up the Children's Social Care Innovation Programme in 2014 with a view to providing tailored and substantial support of up to £100 million to a range of organisations including those of smaller scale.

The programme will operate by supporting individual pilots and change programmes which test or spread much more effective ways of supporting vulnerable children, and by developing stronger incentives and mechanisms for and understanding of innovation, experimentation and spreading of successful new approaches.

Pilot programmes and pump-priming is one of the principal approaches that the government has used across the entire health and care sector as a means of stimulating innovation and spreading good practice. Many successes can be cited, but our concern is that pilot programmes alone do not generally lead to a step change in service delivery nationwide.

We do not doubt the value of the Innovation Programme, or similar pilot funding. The option we present here is whether the DfE should adopt this as the sole approach, or whether to pursue other approaches to developing capacity and diversity in parallel.

OPTION 2 FOR DfE CONSIDERATION (see summary of options in Section 1.12)	COMMENTS
<p>Boost grant funding (through the DfE's Innovation Programme, or through similar funding streams) and other support for pilot programmes hosted by local authorities and their partners to develop innovative approaches to children's services, and seek to disseminate learning from those that are successful through existing or new channels:</p> <ul style="list-style-type: none"> a) As the sole approach b) As a supplementary approach 	<p>Past experience is that pilot programmes do not generally lead to a step change in service delivery nationwide.</p> <p>A sole focus on this option is likely to result in slower transformation than with other options.</p> <p>There nevertheless remains an important role for pilot programmes as a supplementary approach to developing diversity and capacity</p>

4.9.4 Children and Young Persons Act 2008 (Relevant Care Functions) (England) Regulations 2014

The Children and Young Persons Act 2008 (Relevant Care Functions) (England) Regulations 2014 (SI 2014/2407) have recently been published and came into force on 10 September 2014. The new regulations enable local authorities to delegate almost all of their social services functions relating to children, as defined in the Local Authority Social Services Act 1970. Authorities can also delegate certain functions as directed under the Children Act 2004 relating to Children's Trust Boards, Children and Young People's Plans, and the duty to cooperate.

These functions can now only be delegated to third party providers that operate on a not-for-profit basis.

The regulations do not extend the not-for-profit restriction to the functions that may already be delegated under the 2008 act, nor do they affect local authorities' existing ability to outsource services to profit-making bodies where they may undertake or deliver services.

The Children and Families Act 2014 (Part 5) extends the potential for the outsourcing of services, clarifying the Secretary of State's powers to intervene if a local authority adoption service is deemed to be underperforming, with reserve powers for the minister to direct external providers in the same way that local authorities are currently subject to government directions.

In all, this legislation has paved the way for the creation of a wider market for children's social care provision, broadening the established looked after children services market which includes fostering, adoption and residential services.

4.10 The role of the voluntary sector

4.10.1 Scale of council outsourcing to the voluntary sector, and leading voluntary sector providers

The voluntary sector (by which we mean all non-statutory not-for-profit organisations - for sector definitions see Section 4.11, Box 1) provided £441m of children's social care services in England in 2012/13, Table 4, accounting for 5% of gross expenditure by councils. The scale of not-for-profit provision under contract to councils is, therefore, a quarter of for-profit provision, which absorbs 20% of councils' gross expenditure. Voluntary organisations are less active in looked after children services, where outsourced services are dominated by for-profit providers. Instead, voluntary sector organisations focus much of their activity on 'family support services' and 'services for young people', where they provided £84m and £64m of services under contract to local authorities in 2012/13, Table 4, accounting for 9% and 8% respectively of gross English council spending across those areas.

In the absence as yet of any significant presence by public service mutuals in this sector, nearly all not-for-profit provision is in the hands of long established charities. The largest charities which are active in the sector are Action for Children and Barnardo's. Action for Children recorded revenues from charitable activities of £156m in the year to March 2014 (including £82m from supporting families and a further £25m from services to children in care). Barnardo's reported earning £158m from fees and grants for service provision for the year ending March 2013, including £85m for family support and placement. With combined income of approaching £200m a year from those activities which match the broad description of children's social care, these two organisations on the face of it appear to be absorbing approaching half of English councils' £441m (2012/13) spending on children's social care supplied by voluntary sector providers.

NSPCC is another high profile charity which speaks on behalf of children. In the year to March 2013 it spent £96.5m on Childline, services for children and families, child protection advice and awareness and child protection consultancy. But NSPCC funds its services principally through donations and, unlike other charities, does not rely on winning outsourced contracts from councils. In the year to March 2013, NSPCC earned only £9m from councils for services such as training and education in child protection for local authorities. NSPCC hardly figures at all, therefore, in the £441m spent by English councils on outsourced children's social care services in 2012/13.

The learning disability charity Mencap also provides some children's social care services, but its principal focus is on adults and its range of activities is much wider than social care, incorporating advocacy, housing, education, leisure and employment, in addition to care and support.

4.10.2 Willingness of voluntary sector providers to engage in creating more capacity and diversity

In the voluntary sector in England, there is recognition of the government's commitment to more open public service markets within which the voluntary sector can thrive, but we were told that there is a widespread view that the way this is playing out both in localities and large national contracts is not currently working.

Voluntary organisations report struggling with capacity to support children and families with many now having to turn people away for the first time. The sector has concerns that the government's approach to securing provision will be driven by the market and that the focus will be on profit and efficiency savings, rather than on delivering outcomes. It forecasts that this will have a detrimental impact on both the quality of services for children as well as employment conditions for staff, leading to an increase in need and a further shortage in skills, knowledge and experience. The current commissioning culture, procurement methodology and the lack of consistent positive partnerships are viewed as a barrier for the voluntary sector to increase its capacity for delivery.

In 2014 the National Coalition for Independent Action published its working paper *Outsourcing and the Voluntary sector*. It states: "There is a lack of reliable, up-to-date statistics on the voluntary sector, partly because cutbacks have reduced what is collected, but also because there is no consistent definition of the sector across the government departments and local authorities who fund or monitor its activities. But more importantly, people and organisations across the sector have widely differing profiles and perspectives on their current and future roles."

The National Coalition argues that the quality of public services at the point of delivery and the working conditions of those who deliver those services continue to fall demonstrably. The paper claims that, a shift from grant funding for voluntary agencies towards large, payment-by-results contracts for all providers, effectively excludes all but the oligopolies, mega-charities and social enterprises. The report states that procurement and commissioning has become an industry in itself. The bulk of outsourced

services, in terms of both monetary value and social impact, are delivered to vulnerable, hard-to-reach people, large organisations regularly underbid to win contracts. They then cherry pick the profitable, quick-win elements, and subcontract the riskier ones, either to the cash-strapped voluntary sector or to the public sector, which nevertheless retains a legal responsibility for those services.

4.11 Conclusions on capacity of incumbent children's social care providers

In addition to our desktop analysis of market structure and the capacity of individual players, we had the benefit of hearing to providers' own views on their appetite for expanding into core 'Assessment and Care Planning Services' areas of children's social care, from the stakeholder event we held in September 2014, and one-to-one telephone interviews with providers ([Section 6](#)).

Our conclusions from this evidence are that:

- There is sufficient independent sector capacity in most parts of the country to respond to any tenders that local authorities may issue for small to medium sized segments of 'Assessment and Care Planning Services' services;
- It is unlikely there would be sufficient capacity to run an effective competitive tender process for a larger scale or whole system tender because of:
 - Current lack of direct experience of delivering core 'Assessment and Care Planning Services'; and
 - Commercial risk in the light of limited balance sheet strength
- Capacity for taking on smaller contracts exists within a wide range of small to medium size enterprises and a handful of larger ones which share the following characteristics:
 - Visibility on how 'Assessment and Care Planning Services' processes work and their impact on 'downstream' placements of looked after children;
 - Employment of personnel with qualifications and experience similar to those of local authority staff, particularly social workers;
- Balance sheet weakness is a major limiting factor on the ability of most incumbent providers to respond to tenders that might in the future be issued for core Assessment and Care Planning Services where there may be a significant degree of commercial risk. This limitation could be mitigated by forming joint ventures or other partnership arrangement with financially stronger organisations which wish to enter the children's social care sector (following examples from the healthcare sector).

Box 1 Definition of statutory and independent sector

In its market analyses, LaingBuisson segments each addressable market into the four quadrants of public and private demand and supply. Since privately funded demand for children's social care is minimal, this allows the analysis to be collapsed into a two-fold segmentation of publicly funded supply between statutory and non-statutory bodies.

The sole statutory providers are local authorities, or in a handful of cases bodies to which statutory local authority functions have been delegated. Non-statutory providers consist of both for-profit providers, which include individuals, partnerships and companies which distribute their profits (if any) to shareholders, while not-for-profit providers include charities and housing associations as well as social enterprises which may be incorporated in a variety of forms (Community Interest Companies, Companies Limited by Guarantee, Industrial and Provident Societies, etc.), the common feature of which is that they do not distribute profit to non-employee shareholders. There are further subdivisions, such as Public Service Mutuals, which are employee owned spin-offs from the statutory

sector. They are not-for-profit entities usually incorporated as Community Interest Companies (CICs), but not all CICs are Public Service Mutuels.

In LaingBuisson's simplified schema, the supply side of the market is divided into two:

- The statutory sector; and
- Independent sector, the latter being divided into:
 - For-profit providers on the one hand; and
 - And not-for-profit providers on the other, including: The 'not-for-profit' segment in this schema more or less corresponds with the term 'voluntary and community sector' as frequently used in official circles.

5. ANALYSIS OF INTERNATIONAL OUTSOURCING OF SOCIAL CARE SERVICES

In this chapter we consider the international experience of outsourcing children's social care services. We also consider significant outsourcing of adult social care services and the initiatives to develop a market in health care.

Our main findings are:

- A number of governments have outsourced significant elements of their children's social care and welfare services. These are predominantly within North America, Canada, Australia and New Zealand.
- Local government bodies have, in the main continued to be major providers of child protection services.
- The experience of outsourcing has not been without difficulty in many of the countries considered in this review. Consistent features were related to poor outcomes and significant budget over spend.
- International experience demonstrated that it takes a significant amount of time to recoup any benefits, either of quality or cost, and is highly dependent on expert commissioning and contract management.

5.1 Summary of evidence review

Our review of international evidence (see [Appendix 2](#)) showed that, where another body other than the state provides social care services, there are a wide variety of models that exist to govern these outsourced arrangements. A key finding was that success or failure depends largely on the quality of partnership working, organisational culture, and the skills and ability of leaders to champion genuine and trusting relationships. Successful outcomes are evident where new models are overseen by expert project management, appropriately resourced and supported with an effective communication and quality assurance strategy. Evaluations of models placed a particular emphasis on the importance of early and wide consultation with all stakeholders, at all levels.

Negative opinion about the success of outsourcing was more prevalent where there had been a lack of consultation with stakeholders, where implementation had been poorly managed, or where evaluations had taken place shortly after a new model had been introduced. There was a common view that any new architecture must acknowledge the length of time required to achieve agreed outcomes and that there must be a focus on the attainment of long-term outcomes as true progress is best measured over several years.

The main types of contractual arrangements found in the research were based on the lead agency and the service-specific Performance Based Contract (PBC) models:

5.1.1 Lead agency model

Under the lead agency model, the public agency contracts with one or a limited number of external agencies to provide specified services for the target population from referral to case closure, or some other point specified in the contract. Some lead agencies provide most if not all services with few or no subcontracts. Others procure most services and a few deliver no services directly. Some lead agencies

are single agencies that typically are non-profit making, with long histories of providing services to public agencies. Others are newly formed corporations that are created by two or more child welfare service agencies who decide to collaborate rather than compete for lead agency tenders. Lead agency contracts may or may not tie payments directly to performance, but public agencies typically look at past performance when they re-tender contracts. Some lead agencies have outcomes-based contracts with their subcontractors as well.

5.1.2 Outcomes-Based Contracts

Instead of using lead agencies, some public agencies enter directly into outcomes-based contracts (OBC) with agencies that offer specified services. It was evident that there is a shift away from contracting for outputs (holding agencies accountable for how things are done) towards contracting for improved outcomes for children and families (holding agencies accountable for results).

It was not possible to identify which contract model works best. Innovative practices and improved results have been noted in all types of models. Conversely, all types of contracts have also experienced failure. Results at improving outcomes are mixed across all types of contracts. Some contracts have exceeded expectations, some were dismantled, and others were modified and expanded. As for the cost of the contracts, some initiatives cost far more than expected, others redirected resources to serve more people for the same cost, and only a few resulted in actual savings.

From the evidence reviewed it was difficult to find many examples where the responsibility of initial child protection investigations had been transferred to a non-government organisation. Largely, where any outsourcing of welfare services had been a success, it should be noted that child protection had remained the responsibility of the authority or state.

5.2 United States

In 2012, the Alliance for Children and Families reported that at least 14 states had some level of privatising their child welfare services, and that a number of other states were considering this. Successes in Illinois, Florida, and other states provide evidence that privatisation can lead to better outcomes for children and families, greater accountability and increased efficiencies. Yet, less successful implementations have marred public opinion. There are many privatisation arrangements in the United States and state legislatures have played a major role. Some states have enacted laws that promote privatisation, while others have enacted laws seeking to regulate and curtail such activity.

In 1996 Kansas became the first state to privatise its child welfare system. The Kansas privatisation effort was implemented very rapidly which resulted in confusion around roles and responsibilities, and a shortage of services during the initial transition. While Kansas initially had a rocky start to their child welfare privatisation initiative, private contractors have exceeded expectations in finding permanent homes for foster children and reportedly provide superior services in all commissioned categories.

In the 1990s, Florida's child welfare system was criticised for being one of the worst in the nation. In 1996 a state statute mandate directed the Florida Department of Children and Families (DCF) to privatise foster care and child welfare services state-wide by 2003. The implementation of privatisation took five years and the final governance structure had 20 lead agencies providing child- welfare services in specific geographic areas.

Florida secured a Federal IV-E Foster Care Waiver⁵ allowing foster care funds to be used for any child welfare purpose rather than being restricted to out-of-home care. As the Florida lead agencies discovered, *“the money follows the child and not the foster care placement”*. In addition to the waiver, Florida participants also identified a cultural shift in Florida towards family-centred practice as being critical to the improvements in foster-care outcomes.

An independent study in 2012 ranked Florida as the fourth best state in the country at protecting children from abuse and neglect. Florida scored high on reducing the overall foster care population, reducing abuse in foster care, rapid response to child abuse inquiries, and finding permanent homes for children. Whilst Florida's privatisation arrangements are being reported as a particular success, it is critical to acknowledge the length of time this has taken to implement.

Success has also been demonstrated in Illinois. In 1997, the child welfare system was regarded as the worst in the nation. Legislative reforms vastly expanded the role of the private sector, introduced and contractually enforced performance measures and emphasised evidence-driven public policy innovations. By as early as 2000, the number of state wards reduced to 15,500, greatly improved child safety, and earned Illinois a reputation as a national model of child welfare service delivery.

However some privatisation efforts have not been successful. In 2009, the state of Nebraska began contracting with private companies and not-for-profits to provide child welfare and juvenile justice services after national indices showed Nebraska removed too many children from their homes.

A *Nebraska Performance Audit Committee Report* in November 2011 found that while the Department of Health and Human Services (DHHS) initially insisted that privatisation would be accomplished within existing resources it had, in fact, paid the contractors \$30.3 million more than originally planned. In Nebraska the private contractors and the state agencies both underestimated the cost of foster care and the private providers misjudged the scope of work to be done. After the huge cost overruns and financial instability among the child welfare contractors, Nebraska mostly abandoned its privatisation effort in 2012. Across the board, legislators, foster parents and child advocates now say Nebraska's privatisation effort failed because it was ill conceived, poorly managed, rushed, and inadequately funded.

5.3 Canada

For more than 100 years in Ontario, Children's Aid Societies (CASs) have played an important role in protecting children – intervening and providing support when children's needs and safety are not met by their family or community. CASs in Ontario are independent organisations empowered by the Ontario government. They have the exclusive mandate under the Child and Family Services Act to protect children who have been, or are at risk of being abused and/or neglected by their caregivers, to provide for their care and supervision where necessary and to place children for adoption. CASs have authority to remove children from homes where they face either a risk of harm, or have experienced harm.

In 2009, there were widespread concerns about the quality and sustainability of child welfare services in Ontario. Funding on child welfare had doubled over a ten-year period and there was insufficient evidence that outcomes were improving. Questions were raised about child welfare management and service delivery. In response the government established the Commission to Promote Sustainable Child Welfare with a mandate to develop and implement solutions to ensure the long-term sustainability of the child welfare system.

⁵ The Child Welfare Waiver Demonstration authority provides states with an opportunity to use federal funds more flexibly in order to test innovative approaches to child welfare service delivery and financing
<http://www.acf.hhs.gov/programs/cb/programs/child-welfare-waivers>

The Commission developed a systems framework through which to critically examine all aspects of the organisation, and delivery of child welfare in Ontario against the definition of sustainability. In short, the Commission observed a system with many strengths capable of delivering much greater value if purposeful changes were made to address its deficits. The Commission's systemic evaluation of child welfare in Ontario concluded that the sustainability strategy required:

- A reconfiguration of child welfare service delivery to ensure that all CASs have the capacity to deliver timely, high quality services and that collectively, the system can optimise the value and outcomes realised from the funds invested.
- A funding approach that results in a more equitable distribution of available funds, provides CASs with the latitude and accountability to determine the most effective response to meeting local needs and fosters agency resiliency.
- A new framework of accountability to bring greater focus, clarity and results-orientation to efforts across the child welfare system.
- Reducing and streamlining administrative burden.
- Approaches that draw on the strengths and traditions of Aboriginal communities.
- Broader integration across all children's services.

The 2012 *Realizing a Sustainable Child Welfare System in Ontario* report concluded that over the course of its mandate, the Commission had worked in partnership with the Ministry, CASs and others to begin to implement the sustainability strategy and that much progress had been made.

5.4 Australia

The Communities for Children Initiative, established in 2004, funds non-government organisations (NGOs) as 'Facilitating Partners' (FPs) across Australia. FPs play a facilitating and strategic role in the local area and sub-contract with other NGOs, called Community Partners (CPs) to deliver programmes in particular areas of expertise. If an appropriate CP is not available in the community, the FP can deliver services but must work with local community organisations to build their capacity to deliver the necessary services in the future. By endeavouring to not provide services directly, there is a clearer separation between commissioning and providing, and conflict of interest can be avoided.

Each local area establishes and maintains a 'Coordinating Committee' of NGOs and other stakeholders who oversee programme development.

Evaluation of the initiative in 2009 showed that there was, on balance, a positive impact. With regards to children in care, Australian states are making increased use of NGOs providing care placements.

All states remain responsible for child protection investigations and are responsible for children who are at significant harm.

5.5 New Zealand

The Children's Action Plan 2012 set out plans for a new Child Protect line that will provide a single point of contact for all New Zealanders to report any concerns they have about children or young people.

The Child Youth and Family Service commissions over 700 organisations on a national and regional basis. Critically, the Child Youth and Family Service maintains a national central website providing up to date information on contractual arrangements across the country. This well-managed web based resource is fundamental in supporting the model.

New Zealand is piloting 'high trust contracting'. This is a new approach towards the way government funds the community social services sector. The aim is to increase capacity and diversity by enabling community organisations to focus more on the families they serve and less on ticking boxes, complex paperwork and reporting.

High trust contracting provides:

1. A short, simple funding agreement
2. Payment of funding up front, in annual instalments
3. Meaningful, outcomes-focused year-end reporting
4. A focus on outcomes – results are agreed on and described
5. Flexible service delivery – enabling providers to better meet the needs of families in their local community
6. Customised approach – recognising the holistic needs of families and ensuring that the contract reflects this.

The essence of high trust contracting is reflected in the principles that guide the funding relationship. These include:

1. Respecting and valuing each other's expertise
2. Acting with integrity and good faith
3. Recognising accountabilities
4. Open, transparent, honest and timely conversations.

To be eligible for a high trust contracting, community organisations need to have a strong and trusted relationship with government.

5.6 Lessons Learned

- a) Organisational culture is at the root of the success or failure of outsourcing efforts.
- b) Effective and wide consultation and communication is vital to the success of outsourcing. This must include all stakeholders at all levels.
- c) Outsourcing should be supported by legislation allowing flexible use of funds to improve outcomes for children and families.
- d) Outsourcing is likely to be more effective when supported by independent advocacy from the offset, to ensure fairness, transparency and equal opportunity to contribute.
- e) It is not necessary to outsource all services and there should be careful consideration of the services that are to be outsourced to ensure that conflicts of interest are avoided. This is particularly important where there are plans to outsource any commissioning responsibilities.
- f) From the start of the outsourcing process through to continued delivery of the service, it is essential to ensure that all stakeholders can easily access information that is free from jargon and to ensure a two-way communication.
- g) Implementation should be meticulously planned ensuring that funding and start-up times are factored in – phased and gradual implementation hailed the best results.
- h) There was a common finding that the resource required for both procurement and contract management had been significantly underestimated. There is a need to undertake a robust exercise to determine the resources that will be required to effectively procure services and ensure ongoing contract management and quality assurance. Contracts need to include some flexibility to adapt as needs change over time.
- i) Some areas struggled to provide validated evidence of success or failure due to a lack of accurate and timely data prior to any transfer of services. Knowing baseline information from which to

measure progress/lack of progress is critical. All parties should have a shared understanding of contract monitoring arrangements prior to any service transfer.

- j) Experience to date has highlighted technology as a priority area for attention. Better results were evident where there had been dedicated effort to ensuring sophisticated computer software programs and applications to support partnership working were in place.
- k) Positive experiences of outsourcing were supported by effective workforce strategies. These recognised that to develop capacity, there should be a focus on (a) supporting individual workers and (b) ensuring lean efficient organisational arrangements. Organisational culture and trust played a substantial role.
- l) The outsourcing of placement services for children in care was a dominant area in the research. International experience showed that these were often the first services considered for outsourcing. Where these services were outsourced, outcomes improved where conflicts of interest were minimised through the separation of commissioner and provider roles.
- m) There was a widely held view that outsourcing needed to focus on outcomes for children and that savings (especially short term savings) must not be a driving factor. In some American states where outsourcing has been successful, they witnessed an increase in expenditure for the first three to six years.
- n) It was not possible to find any examples in the United States, New Zealand or Australia where government departments had chosen to privatise the initial investigative functions of child protective services.

6. ANALYSIS OF OUTSOURCING IN HEALTH AND OTHER CARE SERVICES IN ENGLAND

In this chapter we consider the experience within the UK of significant outsourcing of adult social care services and the initiatives to develop a market in healthcare. We also consider the new delivery models for children's social care that have emerged in England in recent years and consider their merits and contribution to building market capacity.

The key findings show:

- The UK government has throughout the 1990s and early 21st century successfully outsourced a considerable proportion of adult social care services. This has predominantly been driven by explicit policies by government, supported by legislation and regulation. These initiatives have also been accompanied by reductions in expenditure and an introduction of greater choice and flexibility for consumers.
- In the first decade of the 21st century, government has significantly extended the internal market within the NHS to encourage an external market in the delivery of healthcare. This has been particularly pronounced in the delivery of community health services and elective surgery.
- While there is understandable caution for introducing a market in sensitive welfare services particularly involving children, there are examples of ambitious initiatives across government including the Ministry of Justice contracting out of core probation services to community rehabilitation companies. But success is not known yet.
- Public service mutuals are established ways for providing innovation and savings across the social care market.

6.1 NHS

With limited experience from policy initiatives aimed at developing capacity in the children's social care sector, we have looked at the experience of initiatives in other publicly funded health and care sectors. There are several relevant and instructive examples from the NHS.

Development of new capacity and diversity through outsourcing has been a common theme across much of Britain's publicly funded health and care system since around the turn of the century, when the Blair administration shifted from an 'old Labour' to a 'new Labour' stance on the NHS and other public services.

Despite the pushback from opponents of privatisation during the passage of the Health and Social Care Bill during 2011, the greater part of the political spectrum has supported the twin policy objectives of a) contestability and competition in order to generate efficiencies and improved outcomes and b) widening of consumer choice.

In considering the lessons for children's social care services, we have been aware that the concept of consumer choice has limited application, because of the nature of the service users. There is, however, good read-across regarding the competition levers that central government has to develop capacity and diversity.

6.1.1 ISTC programme

The best known example of deliberate creation of independent sector capacity to challenge an incumbent public sector monopoly is the Independent Sector Treatment Centre (ISTC) programme, which injected new, privately operated hospitals into the English NHS elective surgery system in the 2000s. The programme is regarded as having been moderately successful. It created significant new capacity in some areas and, equally important, the threat of competition is believed to have altered behaviour among incumbent NHS providers and encouraged greater efficiency and consumer awareness which in turn helped the Labour government to deliver its promise of a maximum 18-week waiting time between GP referral and first outpatient appointment. The downside was that the procurement was highly expensive in Department of Health manpower resources and it was necessary to offer above-tariff prices and compensation on exit in order to attract investors to back the construction of new ISTC units. A significant proportion of the new capacity was brought back in-house when local NHS bodies took over responsibility for maintaining the contracts, but about half of the capacity originally created continues to operate in for-profit ownership on behalf of the NHS.

We do not believe that a central procurement of this type provides a model for the DfE in its ambition to develop diversity and capacity in children's social care services, if only because ISTCs are asset-heavy while core children's 'Assessment and Care Planning Services' are asset light.. However, the ISTC programme does have relevance to the issue of attracting new entrants into the children's social care market because of the remaining perception that the government failed to support the programme after the second round, fuelling a view that government cannot be trusted to sustain challenging policies over the long term and that investing in centrally procured services in the health and care sector is high risk. The perception is all the more important because there is a significant overlap in senior management personnel between independent sector providers of healthcare and children's social care. There is a single investment community whose interests span acute hospitals and children's social care.

6.1.2 Equitable Access to Primary Care

The Equitable Access to Primary Medical Care programme was the corresponding but smaller central procurement initiative in NHS primary care which was run by the Department of Health up to the end of the Labour administration in 2010. Its aim was to build new health centres to meet the shortage of modern facilities in deprived areas. The tender was opened up to all sectors including for-profit corporate organisations which were offered Alternative Provider Medical Services (APMS) to operate GP services from the new centres, effectively challenging the established model of small-scale, professional GP practices.

The equitable access programme was successful in creating new capacity, and for the first time gave corporate⁷⁶ for-profit providers a foothold in NHS general practice. But costs were high and a significant proportion of the new capacity was brought back in-house when local NHS bodies took over responsibility for maintaining the contracts. As with the ISTC programme, the equitable access programme does not serve as a model for the development of capacity and diversity in children's social care.

6.1.3 Right to Request

Much more relevant for children's social care is experience from the right to request policy implemented during the Transforming Community Services initiative which came to a conclusion in April 2011 when primary care trusts (PCTs) divested themselves of any remaining provider functions. The right to request

⁷⁶ 'Corporate' providers such as Care UK and Nestor Primecare, which are not classed as part of the 'NHS family' for the purposes of eligibility to work under GMS or PMS general practice contracts and eligibility of employed GPs for the NHS pension scheme, in contradistinction to GP-led, for-profit groups of NHS GP practices which are entitled to operate under GMS and PMS contract as well as being eligible for NHS pensions by virtue of being wholly owned by GPs and/or other members of the 'NHS family'

allowed NHS staff to propose the transfer of NHS services en bloc to a new social enterprise controlled by staff. As a result there are now 18 significant (revenue of over £25m a year) public service mutuals offering community health services in their locality. We have considered whether a similar right to request policy would be appropriate for children's social care services and have concluded that it may be an attractive option for ministers to consider, especially in the context of the new architecture we propose for dealing with failing authorities, which would involve a requirement for the successors of failed authorities to outsource all services as soon as practicable.

OPTION 7 FOR DfE CONSIDERATION (see summary of options in Section 1.12)	COMMENTS
<p>Encourage spin-off of public service mutuals (PSMs) from statutory children's services as a means of developing diversity and capacity:</p> <ul style="list-style-type: none"> a) By introducing a 'Right to Request' similar to that adopted in the <i>Transforming Community Services</i> initiative in the NHS b) No specific encouragement in children's services, other than general official sponsorship of the of public service mutual model 	<p>While we do not consider that the creation of large numbers of public service mutuals alone would be sufficient for the rapid development of capacity and diversity in children's social care services, it can play a significant part.</p>

6.1.4 Lead provider framework (commissioning support to CCGs)

The most recent central procurement initiative within the NHS to have resonance for children's social care services is the Lead Provider Framework (LPF), a tendering process being run by NHS England to recruit independent sector organisations to join a framework agreement for provision of commissioning support to clinical commissioning groups (CCGs). It is intended that when the framework becomes operational in January 2015 it will supplement the NHS in-house commissioning support units (CSUs), which emerged from the now abolished PCTs and are currently hosted by NHS England. NHS England projects that between £3bn and £5bn of services will be procured through the LPF. The initiative is potentially relevant to the task of developing capacity and diversity in children's social care, first because it effectively amounts to partial externalisation of aspects of the NHS commissioning function, while CCGs remain accountable for their statutory functions, demonstrating that the entirety of commissioning of public services does not have to be provided in-house. Second, the establishment of an accredited list of specialised commissioning support providers is potentially relevant as an approach to the essential task of strengthening commissioning within the children's social care sector.

6.1.5 Any Qualified Provider (AQP)

Framework agreements have also been used in the NHS to support the Any Qualified Provider (AQP) regime, which is a driver of increasing availability of independent sector hospitals for elective surgery as well as many smaller providers of parts of the healthcare pathway (e.g. diagnostics, physiotherapy, podiatry). The principles of AQP can be brought across to children's services for example:

- The commissioner sets the prices.
- The specifications are set by the commissioner based on service user need.
- AQP provides competition under quality, not price.

AQP to date has seen more than 1,000 providers operate on this framework. This can be managed by setting higher hurdle costs, lower prices on tighter specifications according to commissioner need.

6.1.6 Expansion of the GP out-of-hours market following the 2004 revision of the GP contract

The final example from the NHS relates to the removal of out-of-hours responsibilities from NHS GPs in the 2004 revised GP contract. A consequence was the rapid expansion of independent sector out-of-hours services to fill the vacuum as PCTs outsourced their new responsibility for arranging out-of-hours which they had inherited from GPs. The two major incumbent for-profit out-of-hours providers, Nestor Healthcare and Harmoni (now part of Care UK), had hoped to win most new out-of-hours contracts, but in the event most were won by incumbent or newly formed GP cooperatives. A major incentive for GPs to join or form cooperatives was to control their own pay and conditions while deputising for their local GP colleagues under arrangements which had existed prior to 2004, rather than having to accept the pay and conditions of commercial companies which would otherwise have taken their place. There are 23 GP cooperatives, most formed in the 1990s. Their relevance to the issue of developing capacity and diversity in the children's social carer sector is that, just like public service mutuals in health and social care, most have remained rooted in their own geography, and have therefore not contributed to market capacity more widely. A handful have, however, developed into more commercial organisations with an ambition to expand. The most prominent example is the Vocare Group, which commenced operations in Tyneside and Teesside and has now, starting in April 2014, won the contract to provide services in Bath and North East Somerset following a contested bid against the incumbent GP-led not-for-profit organisation. The experience of GP co-operatives, therefore, helps illustrate how children's social care spin-offs might behave in a new market.

6.2 Adult Social Care

The creation and expansion of new markets – bringing in new providers and extending the range of existing providers to deliver what were previously local authority functions – is by no means unprecedented. Indeed, the formation of markets in public services has been one of the defining shifts in the way government has been run since the 1980s.

Today, over 90% of adult residential and homecare is provided by independent sector providers, much of it funded by the public sector. The independent sector has replaced the statutory sector as dominant supplier of adult social care capacity in the space of just 40 years.

6.2.1 Independent sector's emergence as the dominant supplier of adult social care

The origins of the massive growth of the independent social care sector lie first in a policy vacuum and later in purposeful market management by central government. The policy vacuum phase dates from the late 1970s when local social security offices responded to lobbying from voluntary sector care home providers and started to pay supplementary benefits to people unable to afford their own fees and whom local authorities were unwilling to support. The new funding source was rapidly exploited by private, for-profit providers and fuelled the rapid expansion of capacity which soon led to for-profit providers replacing the statutory sector as the principal source of supply. It was a process in which central government acquiesced, but never declared as policy. On the positive side, very substantial sums were invested in new care home capacity with better physical amenities than previously existed, which the public sector

could not have provided in-house, but at the cost of uncontrolled admissions of people who did not need to be in care homes.

The era of income support funding by default came to an end in 1993 when state funding of long-term care was transferred from the open ended social security account to local authorities with fixed, cash-limited budgets under the *NHS and Community Care Act 1990*. The transition marked a change to more purposeful market management. By 1992, the *Local Government Act* had introduced compulsory competitive tendering which eventually gave way to The Local Government (Best Value) Performance Plans and Reviews Order in 1999 in order to challenge the reasons for, and methods of, provision, improve performance and increase efficiency. Most important, in terms of stimulating the publicly funded adult social care market, the Conservative administration used a condition on central government grant spending to require councils to spend 80% of the new, post-1993 Special Transitional Grant funding on independent sector providers. This ensured that councils outsourced the bulk of home care services and also reinforced outsourcing of residential care.

The adult social care market is now mature, diverse, and includes a number of long established voluntary sector providers as well as more recent social enterprise spin-offs from public services. There has been no shortage of investment in the sector, with residential and domiciliary social care benefiting from both public and private finance. Moreover, the expansion of personal and individual budgets has given individuals with non-residential care and support needs greater choice over the services they receive, and has improved outcomes, increasing the quality of provision and fostering greater levels of innovation.

At the same time, there are serious market failures in the adult social care sector, which graphically illustrate why open supply side competition alone is insufficient to foster a successful market for publicly funded services, without also intelligent, strategic commissioning. The extreme focus of commissioners on driving costs as low as possible (in a very challenging financial environment) has led to the following market failures; publicly paid prices being driven below the level necessary to sustain investment in existing care home facilities and incentivise investment in new capacity; the whole-scale adoption by the public sector of a fundamentally flawed 'task and time' home care model with time units of as little as 15 minutes; and a 'silo' approach to service provision in the absence of outcome- based commissioning of care pathways. These have to be balanced against the market successes; on the supply side, attraction of investment of about £30bn over four decades, and on the commissioning side, assessment of need introduced by English councils in 1993 has largely eradicated unnecessary, publicly funded admissions to care homes. There are now 250,000 fewer older people in residential care settings than there would have been if placements had continued at the same level as in the peak demand year of 1993.

6.2.2 *The Care Act 2014 and new powers for councils to delegate adult social care functions*

The Care Act 2014 established new provisions for any elements of local authority adult social care and support functions to be outsourced, except core safeguarding responsibilities.

Following the end of a national pilot programme, the Department of Health has established this year (2014) the power to delegate adult statutory functions, which is now available to all English local authorities. The adult social care social work practice (SWP) pilots, four of which are identified as public service mutuals, were launched in 2011 to test delegation of certain functions and to establish whether these incentivise innovative ways of working, reduce bureaucracy, increase staff satisfaction, and improve user satisfaction as social workers and the people they work with are brought closer together. The evaluation programme found positive evidence of delegation working well, and evidence of reducing bureaucracy, lowering communication barriers and increasing job satisfaction and empowerment through the SWP sites. As local authorities are now able delegate adult statutory care to other providers outside

of the council, there is an opportunity for new providers, including mutuals, to alleviate the expected increase of adult social care reviews and assessments. This will bolster an already burgeoning market, and further increase competition, enriching and strengthening the versatility of the supplier portfolio.

At a more ambitious level, the scene is now potentially set for capitated, outcome-based 'whole system' contracts in which external lead contractors, or an alliance of external contractors, could for the first time bid to provide the full pathway of social care services for older people or younger adults, including home care and residential care, as well as assessments and other functions now almost exclusively provided in-house. Public service mutuals could take on such contracts, dependent on an appropriate sharing of risks between commissioners and providers, and so too could a wide range of other for-profit or not-for-profit organisations. There are clear parallels with the possible direction of travel for children's social care services as well.

6.3 Ministry of Justice

The Ministry of Justice has taken a number of steps to build a contestable market. The National Offender Management Service (NOMS) has a budget of £4billion for England and Wales (2012/13) and has focused market development in three key areas; electronic monitoring, prisons and probation supervision. The market has, until recent times, been highly concentrated. All contracts were held by just four companies – G4S, Serco and Sodexo with Capita supplying electronic monitoring services.

This position was exacerbated by the well-publicised dispute between G4S and Serco over alleged fraudulent pay claims. As a result G4S and Serco withdrew from the third bidding round for the electronic monitoring contracts, leaving Capita as the only viable bidder.

The Transforming Rehabilitation programme will considerably extend the number of suppliers within the offender management business. These reforms involve replacing the previous 35 individual probation trusts with a single National Probation Service for England and Wales. The National Probation Service will be responsible for court assessments, enforcement and managing an estimated

20% of offenders deemed to be at high risk of harm – around 50,000 people. The remaining low- to medium-risk offenders – 80% – will be managed by 21 community rehabilitation companies (CRCs), drawn from the voluntary, community and social enterprise (VCSE) sector, private sector and mutuals, all of which were allowed to bid for rehabilitation contracts.

The CRCs will also have a new responsibility for supervising short-sentence prisoners (those sentenced to less than 12 months in prison) after release. Thirty organisations and consortia, including those from the private and voluntary sectors, bid for these contracts.

These organisations are known as Tier 1 bidders. Tier 1 organisations will be expected to build supply chains involving smaller organisations, known as Tier 2 and Tier 3 organisations, in order to subcontract some of the services. From April 2015 the work being done by the CRCs will be contracted out by the Ministry of Justice.

This policy direction has created a contestable market of some 20 providers. Later in the report we look at the benefits of segmentation in encouraging market entry and we will come back to both the geographical segmentation and tiered segmentation adopted by NOMS as a possible approach to expanding the children's social care market.

6.4 Review of New Delivery Models

6.4.1 *Doncaster Children's Services Trust*

The Doncaster Children's Services Trust was launched on 30 September 2014. This landmark initiative provided an opportunity for the council to establish a new model for the delivery of children's services in Doncaster and to accelerate improvement and innovation. The trust's aim is to strengthen services to ensure maximum protection for children and young people. Following an unsatisfactory inspection in October 2012, the Secretary of State for Education commissioned a review of children's services in Doncaster. This review was undertaken by Professor Julian Le Grand, Alan Wood and Moira Gibb, and was published in July 2013. On July 15, the Secretary of State for Education wrote to the Mayor of Doncaster, enclosing a draft direction which required the council to transfer its social care services to an independent trust. In the autumn of 2013, following representations from the council, the Secretary of State for Education agreed to the establishment of the Doncaster Children's Services Trust, without the requirement to remove entirely Doncaster's children's services statutory responsibilities. The Secretary of State, through a statutory direction, required the council to contract with Doncaster Children's Services Trust to perform children's social care functions (and related services) on the council's behalf. A commissioner for children's social care was appointed with responsibility for the establishment of the trust and for overseeing existing improvement measures.

The work on establishing the trust was driven by a joint board comprising the council, the DfE and the trust. The trust was set up as a company limited by guarantee and is an autonomous organisation, independent of the council, which has entered into a service contract with the trust to deliver its delegated children's social care functions. The trust is governed by a board which includes a chairman appointed by the Secretary of State for Education, non-executive directors, including council representatives, the local CCG and South Yorkshire Police. The remaining non-executives boast national expertise. The trust is responsible to the council for the delivery of services under this contract and the Director of Children's Services remains accountable for the statutory functions. The council has transferred its children's social care services staff under the Transfer of Undertakings (Protection of Employment) Regulations.

The set-up costs for the trust, including professional due diligence and legal support, are estimated to be approximately £3m. The additional annual costs of delivering children's social care services through the trust model, such as VAT and insurance, are approximately £3.5m. It is, however, anticipated that some of these additional costs will be mitigated over time (and it should be noted that an estimated £1.4m of this £3.5m annual additional cost is made up of VAT). It is too early to evaluate the effectiveness of this new service delivery model and the DfE has commissioned a long-term study into its effectiveness.

In October 2014, the Secretary of State issued a direction to Slough Borough Council requiring the council to contract with a trust to perform children's social care functions and related services on its behalf.

6.4.2 Virgin Care and Devon County Council

Another example of a different initiative is the model for delivering integrated children's services in Devon.

Devon's Integrated Children's Services originally started in 2001 and brought together health and social care assessment and budgets to provide services for children with physical, sensory and learning disabilities, public health nursing services and mental health and wellbeing services. In 2011, the services were put out to tender following the Government's national Transforming Community Services directive, requiring all PCTs to become commissioning-only organisations. This meant that NHS Devon could no longer work alongside Devon County Council (DCC) in providing these integrated services. NHS Devon and the council believed that appointing a single accountable organisation to deliver the services on their behalf would provide the best opportunity to maintain and strengthen the integration of the services.

In September 2012, Virgin Care was awarded the contract to start from April 1, 2013 following an extensive open procurement process and due diligence exercise. However, in January 2013 the DfE's consultation on Social Work Practice pilots raised questions about the proposal to transfer social work services to Virgin Care three months later. Legal advice was that this would not be permissible and a two-stage transfer of ICS Social Care staff would be required. On April 1, all NHS staff and more than half the social care staff transferred to Virgin Care. Remaining social care staff with statutory social work responsibilities remained in DCC with dual management arrangements within Virgin Care.

Only a small proportion of the planned social care budget transferred to Virgin Care, as the social work accountabilities remained with the council. The contract was re-negotiated in light of this.

New regulations came into force in November 2013 that enabled DCC to formally discharge the authority's social services functions in relation to looked after children and care leavers.

As a result, the phase 2 transfer for remaining staff was planned for April 2014 and, in the interim period, protocols governing the social care interface between Virgin Care and mainstream social work services were completed, promoted and tested. These were necessary, as the council remained responsible for child protection and other statutory duties.

However, several factors impacted on the plans for the phase 2 transfer:

- The new provisions included a requirement for Virgin Care to be separately registered with Ofsted. This registration requirement caused some delay due to all parties being new to the process.
- The council received a safeguarding inspection in April 2013 and was found to be inadequate across the board. An improvement plan was agreed in September 2013.
- The inspection resulted in a further period of interim management with a different format and there was consequently a dip in social care staff morale.

With these developments, there was much deliberation about the planned phase 2 transfer and a decision was made to postpone the transfer of the remaining social work staff until April 2015.

6.4.3 Public Service Mutuals

While research for this report has covered a range of mutual forms, we have primarily focused on public service mutuals (PSMs), working from the *Public Service Mutuals: Next Steps* definition of PSMs as independent organisations which have left local authority control but continue to deliver public services, and in which 'employee control continues to play a significant role in their organisation'.⁷

As part of the government's long-term plan to transform the way public services are delivered, the Cabinet Office has allocated a £10m fund to support more public servants to form mutuals via the Mutuals Support Programme. This programme has provided support and training to help mutuals grow and, in turn, cut waste and save taxpayers' money. There were 101 PSMs in operation towards the end of 2014, up from nine in 2010. They provide services across 14 sectors and range in size from a handful of staff to over 2,000. Collectively they employ over 35,000 staff and deliver services valued at well over £1.5bn.

PSMs have been identified nationally as a means of securing the quality of public sector services and of supporting public sector staff into the future, particularly in an age of economic austerity and against a backdrop of wider reductions in direct centralised government control. Indeed, a number of studies have shown that PSMs may be well equipped to do this, as they are capable of providing more effective services than their local government counterparts, increasing productivity and innovation whilst improving staff

⁷ *Public Service Mutuals: The Next Steps*. Julian Le Grand, Mutuals Taskforce Cabinet Office, 2012

wellbeing and job satisfaction.⁸ The Cabinet Office has also identified adult and children's social care and social work as exhibiting the greatest potential for the mutual model approach.⁹ It would, therefore, seem mutuals could provide us with one of the good foundations on which to build a new market for children's social care provision.

Enthusiasm about the PSM model, however, must, we believe, be tempered with realism on the extent of the contribution it can make to increasing capacity and diversity in a medium term timescale. The early indications have certainly been positive. A review by the Boston Consulting Group argued that, 'in order to remain commercially viable, mutuals should be capable of withstanding shocks, both financially and operationally, and must take on additional responsibilities [to do this] far beyond those they had when part of their parent organisation.'¹⁰ If they do not diversify they remain vulnerable since their initial contracts may be subject to re-tendering at any time after the initial contract period. The figures cited by the Boston Consulting Group in the 2013 Big Society Capital-commissioned study *Soft Finance, Hard Choices* support the claim that PSMs do have an appetite for expansion, asserting that the PSMs they studied which had spun out of the public sector had increased the number of contracts they delivered by 29% - and their turnover by 15% - in the three years to the end of 2012. This diversification suggests a willingness on the part of existing PSMs to take on additional challenges and wider delivery areas.¹¹ Indeed, this was echoed in the interviews we have conducted with PSMs as part of this study, in which a number of organisations expressed interest in expanding into a range of different children's services, including, potentially, child protection services.

Further analysis, however, which we conducted based on such statutory accounts as were available at October 2014, indicates a less rapid rate of growth in health and social care PSMs' revenue base overall and limited expansion outside the original geographic base. The 18 health and social care PSMs which posted full statutory accounts recorded weighted average revenue growth of 3.5% per year over a period from 2011 to 2014. While most of them won other small contracts within or close by their home base, all except one remained effectively rooted in their original geography. The only health and care PSM to have demonstrated a significant appetite for growth has been CSH Surrey, which was the first community health services social enterprise to be established by public sector employees in October 2006. In July 2013, the organisation rebranded itself as CSH Surrey specifically to enable future growth and diversification of services. CSH expanded its operations outside Surrey in September 2014 when Bupa CSH Ltd, a partnership between CSH Surrey and Bupa, was named by Coastal West Sussex CCG as the preferred prime provider to run a new musculo-skeletal service for local NHS patients.

We have also analysed the statutory accounts of other, non-PSM spin-offs from the public sector, including arms-length local authority trading organisations (LATCOs) operating in the social care space as well as GP cooperatives. They exhibit a similar pattern to PSMs, that is, most stay rooted in their original

⁸ The Cabinet Office has listed a number of ways in which mutuals can offer parent bodies and commissioners flexible and dynamic solutions to diverse strategic challenges, forming a compelling business case.' The benefits of mutuals include the delivery of 'more for less' i.e. greater efficiency, increasing competition, increasing innovation and supporting local growth. To add to this, the Cass Business School survey of UK companies, 2012, found that companies which are 'substantially or wholly owned by the people who work for them' with fewer than 75 employees performed better in terms of profitability compared with non-employee owned companies.

⁹ Mutual Information Service, the Cabinet Office.

¹⁰ Boston Consulting Group, 2013.

¹¹ *Soft Finance, Hard Choices: A Review of the Finance Market for Public Service Mutuals*. Adrian Brown & Loius Watt, Boston Consulting Group, 2013. Jason De Bono, Cabinet Office, has further highlighted that PSMs are proving successful at generating new business, expanding into more areas and winning additional contracts, acting as engines for small business growth in their local communities.

geographies and only a handful of them have adopted a fully commercial approach and have sought major diversification of their services elsewhere.

A further factor which constrains expansion for PSMs is their weak balance sheets. Without access to significant reserves. It would be imprudent to take on major contracts with significant commercial risk. They may mitigate this by seeking medium to long term funding on the security of cash flow rather than assets (e.g. social bonds, just as many larger for-profit health and care groups have funded expansion by issuing high yield bonds in recent years). They may also mitigate weak balance sheets by partnering with other organisations with access to substantial capital. There are at least two examples of this approach being taken by community health service PSMs, Bromley Healthcare CIC which has partnered with Serco, and CSH Surrey (the trading name for Central Surrey Health Ltd) which has recently partnered with Bupa to win the major musculo-skeletal contract in West Sussex.

Despite these mitigations, newly formed PSMs with a small asset base are as a whole likely to be constrained in the pace at which they seek to implement any ambitions for major diversification outside their home geographies. It is for this reason, and other reasons noted above, that we would not expect any new PSMs in the children's social care sector to make a substantial contribution to capacity and diversity, in the sense of making such capacity and diversity available outside their own geographies, for either DfE interventions or ordinary local authority partnership arrangements, at least in the short to medium term.

If PSMs are to be in a position to take on a greater segment of market provision, we need to consider how to enable existing mutuals to broaden what they deliver. We also need to consider how to encourage new entrants into the market. The ability to raise finance to fund development and expansion is central to this. A number of established schemes, such as Bridges Ventures Social Entrepreneurs Fund and Big Issue Invest's Social Enterprise Investment Fund LP, already provide growth capital to social enterprises, which have scalable business models and can show evidence of social impact. However, there is potential to expand this provision to ensure funds are accessible to an even greater number of mutuals. The proposed transposition of the new EU procurement directives, which reserve government contracts for organisations which promote social value, may also help in this regard by giving mutuals more access to local authority commissioned service provision. The ongoing support of the Cabinet Office Mutuals Support Programme and local government is also integral to providing assistance and advice to new and emerging (as well as established) PSMs. Existing PSMs have also told us they would be more encouraged to take on higher risk ventures if the division and level of accountability and responsibility was clearly set out in contracting provisions. This was especially important in order to ensure PSMs have appropriate arrangements in place relating to their public indemnity insurance cover.

We believe PSMs could be successfully used as one of the vehicles to develop a diverse and expansive market for children's social care provision. And whilst it is acknowledged it may take some time to entice a greater volume of PSMs to enter the market, and that it may take some years for these bodies to evidence their longer-term outcomes, a number of existing PSMs may be encouraged to broaden out their provision to encompass children's social care and social work in the near future.

6.4.4 Achieving for Children

The Royal Borough of Kingston and London Borough of Richmond-upon-Thames have recently amalgamated their children's services into a single shared organisation called Achieving for Children (AfC). AfC is a social enterprise company that was created in order to support and strengthen service delivery, as well as to bring about greater economies of scale in the neighbouring councils' commissioning of services. Aims also included increasing their power to negotiate high-quality contracts, reducing management overheads and reducing administration costs by maximising the use of resources.

AfC launched on 1 April 2014, with the intention of providing children's social care and education support services both to their own councils, as well as other local authorities, schools and partners in the education, health, social care and criminal justice sectors. AfC sees its new model of delivery as creating an environment in which services can be developed more effectively and creatively 'outside of the rigid local government bureaucracy'. It is working in partnership with other local organisations delivering services for children and young people, such as health providers, voluntary organisations, local businesses, schools and colleges in order to achieve its aims of delivering better quality, value for money services.

As this enterprise has only been running for seven months, it is not yet possible to evidence any financial gains or achievement of improved outcomes. However, Kingston and Richmond state that whilst the transitional cost of delivering AfC has been £1.5m, they project savings in the order of £6m over three years from the initial merging of services. They also predict wider efficiency benefits once different opportunities and ways of working have been fully developed and utilised by the new organisation.

The fact that AfC plans to both improve and streamline the services that the authorities delivered to children, young people and their families in Kingston and Richmond, and to expand their provision to other suppliers, means this initiative offers a significant contribution to the development of a new market in the children's social care sector. However, it is likely that any expanded provision would be limited to locally-situated authorities, most likely those sharing boundaries with AfC's host councils. As such, unless other local authorities can be encouraged to adopt this model, the approach may have limited ability to transform services outside London.

7. DEVELOPING THE MARKET WITH CHILDREN'S SOCIAL CARE TRUSTS

In this chapter we consider the contribution that Children's Social Care Trusts could make to developing capacity and diversity within the market. This solution has recently been developed in areas of sustained failure through intervention by the Secretaries of State for Education and Communities and Local Government. As we have seen in the previous chapter it has also voluntarily been developed in Kingston and Richmond.

Our main findings are:

- The current trust model which requires the local authority to delegate its social care functions to an autonomous organisation has significant merits:
 - Central focus on a social care
 - Opportunity to innovate and remodel support services and systems
 - Possible overlay of social enterprise or mutual governance
- We also see some limitations within this model as a catalyst for developing significant diversity:
 - The design does not require the delegated functions to be subjected to any market testing or procurement competition prior to contract award, and the trust may continue to remain in market terms, a single monopolistic provider with a guaranteed income stream free from any external competition.
 - We also found among the suppliers we interviewed very limited appetite to enter the market as a Children's Trust provider
- We propose that this model is developed further through the formation of what we have called a Children's Commissioning Trust (CCT). A key characteristic of this model will be the requirement, within a defined period either before or after, transfer, for all services, where possible, to be tendered on the open market and outsourced. These services will be segmented to be attractive to the market. The advantages of this model are that it
 - Encourages market entry from a range of suppliers
 - Introduces competition across all services and develops market diversification
 - Has the potential to develop innovative outcome-based commissioning
 - Can be developed into a joint venture company between a range of key public service funders with a major financial and performance stake in common issues impacting on the welfare of children and young people
 - Creates a suitable vehicle for attracting private sector venture capital through social impact bonds.
- There are nonetheless some residual disadvantages of the CCT Model and these include;
 - Destabilisation of in-house services during the period of preparation and transfer
 - The significant increase in commissioning and contracting capacity
 - Managing the journey of the child and the co-ordination of the supplier chain.

7.1 Children's social care trust delivery models

In [Section 6.4](#), we considered the emerging models of delivering children's social care outside of the local authority envelope. A new model of delivery has recently become operational in Doncaster, where the trust operates external and autonomous to the local authority. A similar model has recently been proposed by the Secretary of State for Slough Borough Council October 2014. We believe these arrangements offer one opportunity to deliver additional capacity alongside innovative solutions.

The Trust model develops market capacity through local authorities delegating their functions to a third party – a trust – which would be set up as an autonomous organisation.

The Trust would assume responsibility for the staff employed in the services transferred and deliver the delegated functions on behalf of the local authority. Government should continue to use this as a response to service failure through a direction by the Secretary of State but this option could also be made available to all authorities on a voluntary basis.

The local authority would ordinarily retain a thin commissioning and contracting function alongside all statutory responsibilities, with the functions being delegated to the trust.

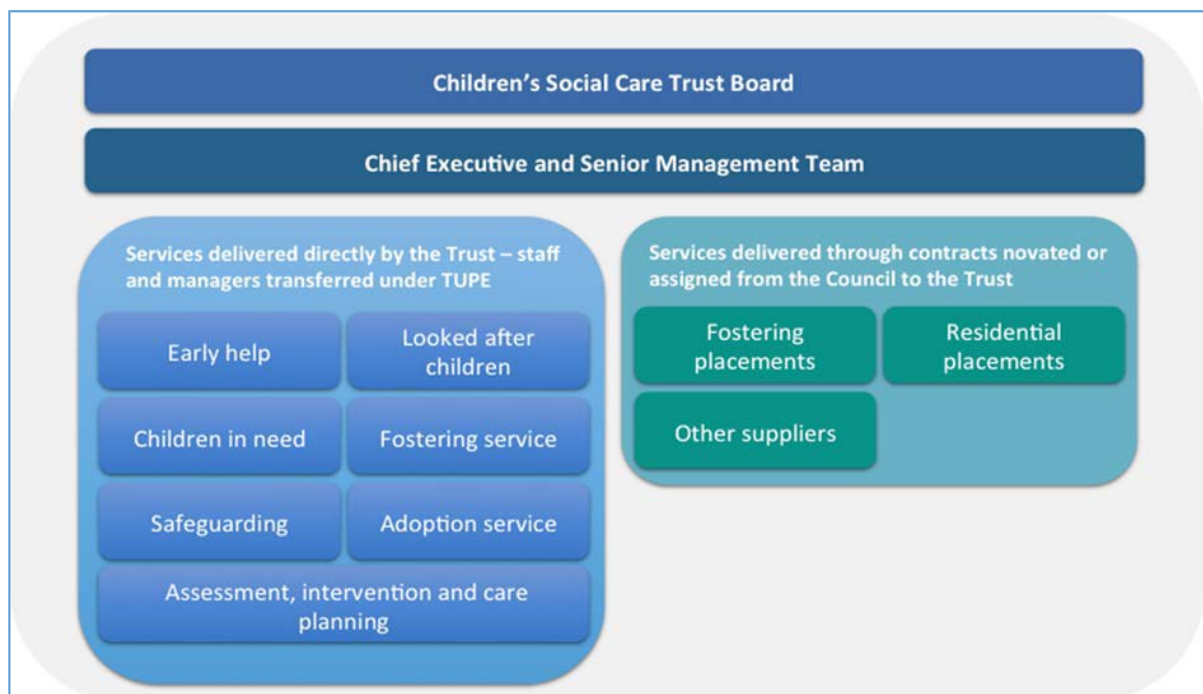
However, the Secretary of State could still reserve the right to remove the statutory responsibilities from the local authority and make the trust accountable to the Secretary of State.

There are a number of choices around the governance of the trust.

- A company limited by guarantee, with a board consisting of a chair, chief executive, other executive and non-executive directors.
- The trust could also be set up as a community interest company (CIC). A CIC is an organisation with primarily social objectives whose surpluses are re-invested in the company or in the local community, to encourage staff engagement.
- The trust could be set up as a PSM, an organisation partly or wholly owned by staff. As we described in chapter five, such mutual organisations have begun to report a record of delivering innovation, high levels of user satisfaction, lower staff absenteeism and sickness rates and greater ease of recruitment and retention.

Figure 4

Children's Social Care Trust



7.1.1 Advantages of the Trust Model

Although this model is in its early stages of operation, we would expect these new organisations to be able to provide a more specific focus on their social care functions. There would also be the opportunity to remodel systems and support services and specifically tailor them to the needs of social care. Alternative governance arrangements would also offer further advantages. As a CIC, partners and third sector providers could be co-opted into the arrangements providing a strong element of partnership and localism. As a PSM there is also the potential to develop a strong employee voice, better staff retention and engagement.

The Ofsted *Annual Social Care Report (October 2013)* reported that 20 local authorities were rated as inadequate and for many of these councils the trust model could offer a real opportunity to introduce new capacity and energy into the service. We also believe, as the new delivery models demonstrate their success, other authorities ambitious for innovation and improvement will begin to either replicate the model or contract with existing trusts.

7.1.2 Disadvantages of the Trust Model

While we expect the trust model will become an effective mechanism for introducing greater diversity of provision into the market, we think there are limitations to its likely impact on developing capacity beyond what we have already stated. The majority of the independent sector providers we spoke to did not demonstrate a great enthusiasm for becoming a children's trust, citing capacity, expertise and risk as the main disincentives. Furthermore, while it is technically possible for the Secretary of State to delegate the functions under a direction to a for-profit company we would expect this to be unlikely given the government's response to the 2014 consultation on delegating social care functions. This would, therefore, limit the providers to not-for-profit companies and we are not confident that there will be sufficient incentives within the trust structure to encourage new suppliers to enter the market. We explore possible solutions to these issues in [Section 7](#).

Furthermore, given our knowledge of social care markets, both internationally and within the UK, we believe there are some fundamental impediments intrinsic to the current trust model for it to be a significant lever for generating new capacity within the market.

- The trusts so far created have not been subjected to any market testing or procurement competition prior to contract award.
- They are, in market terms, single monopolistic providers within a given geographical area with a guaranteed income stream and are free from any external competition.
- There is no requirement for them to market test or commission the services they provide and they continue, as do local authorities, to be conflicted in their roles of both provider and commissioner.

For these reasons, while we are optimistic that the trust model has the opportunity to provide a more social work focused model, we do not see it as a significant lever engaging the independent sector or leading to a growth in the market. A further disadvantage of the model is the cost and delay.

Experience to date in Doncaster is that it takes in excess of 18 months from inception to inauguration. The set-up costs in Doncaster exceeded £2m with annual additional costs of around £3.5m. In chapter eight we look at ways of strengthening the system's architecture to both reduce the cost and time to set up the trust.

7.2. Developing Children's Commissioning Trusts

To mitigate these issues, our preferred option is to further develop the concept of the children's trust and redefine it not as a provider of services but as a primarily commissioning organisation. We call this model a Children's Commissioning Trust (CCT). The CCT would be set up as an autonomous not-for-profit commissioning organisation and the local authority would delegate its social care functions to the Trust. The CCT board would comprise representatives from key local agencies, such as health, police and local government. A key characteristic of this model will be the requirement, within a defined period either before or after transfer, for all services to be tendered on the open market and outsourced. These services will be segmented to be attractive to the market. We explore the advantages of procurement segmentation later on in this chapter. The local authority would retain a thin commissioning and contracting function and statutory responsibilities although the Secretary of State might *in extremis* reserve the right to remove these and make the CCT accountable to her.

We can also see significant advantages in time of developing this model further into a joint venture company, between a range of key public service funders with a major financial and performance stake in common issues and impacting on the welfare of children and young people. Possible joint investors in this could include the clinical commissioning groups, police and crime commissioner, JobCentre Plus and probation. Company membership could also be extended to include local community groups and voluntary organisations and front-line employees. This model could also create a suitable vehicle for attracting private sector venture capital through social impact bonds.

7.2.1 Advantages of the Children's Commissioning Trust Model

We believe that the commissioning trust model will offer a very significant opportunity to develop capacity within the market. We are confident that the requirement to market test all services and to only be a provider of last resort will encourage market entry from a range of suppliers. It will introduce competition across all services, develop market diversification and has the potential to develop innovative outcome-based commissioning.

The commissioning trust will also bring the service closer to communities and service users and provides accountability to local people. It presents the opportunity to drive local solutions led by local agencies, pool budgets and deliver outcome-based commissioning based on the needs of children and families rather than services.

7.2.2 Disadvantages of the Children's Commissioning Trust Model

We do see some disadvantages with the model although these are primarily associated with any major service transformation programme. These include destabilisation of in-house services during the period of preparation and transfer, and the significant increase in commissioning and contracting capacity required of the new organisation.

Managing the journey of the child and the co-ordination of the supplier chain through these more segmented contracting arrangements will require new skills from local authority commissioners and contract managers. As we have seen with the trust model in Doncaster, time and cost are also a key consideration. Chapter seven outlines ways to mitigate these issues.

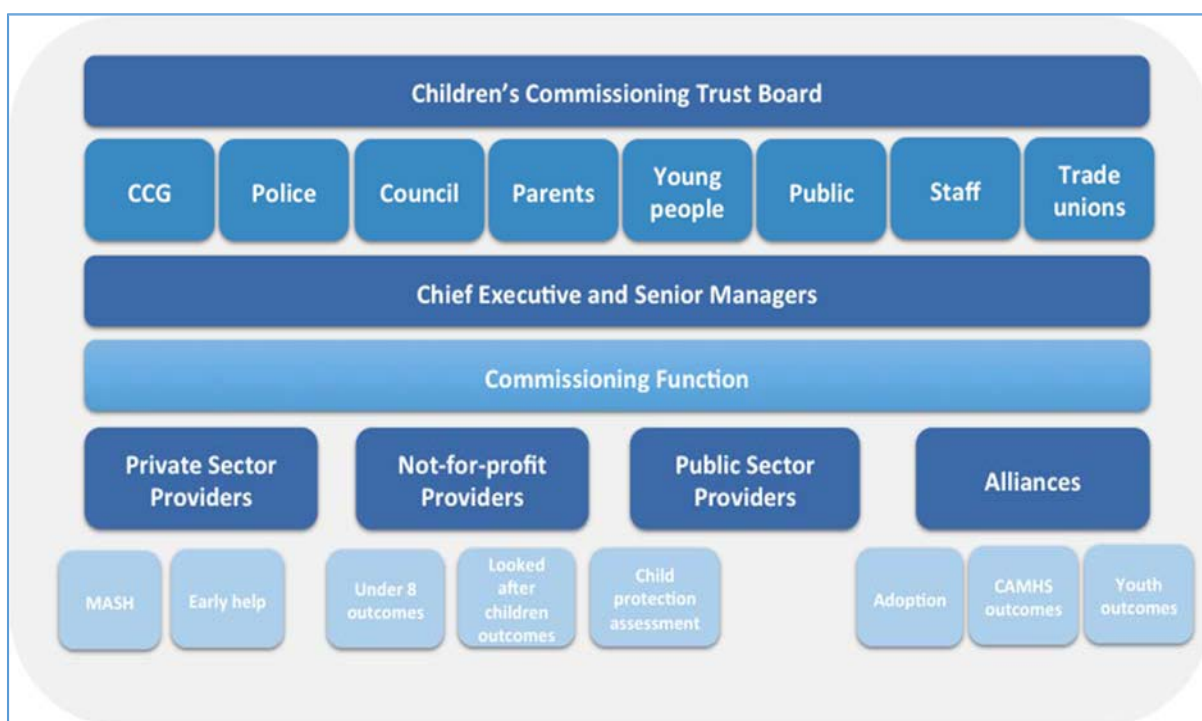
The legal arrangements of the Children's Commissioning Trust will need careful consideration. While regulation 4 of the 2014 regulations establish that a local authority's functions under Part 1 of the Act are to be treated as not being relevant care functions for the purposes of section 1 of the Act, the functions under part 1 are the local authority's powers to delegate, so a provider that takes on the

functions could not delegate further. However, we believe as long as the Children's Commissioning Trust is clear that within its contracting arrangements it retains the statutory function, the regulations will not create an insuperable difficulty.

The Children's Commissioning Trust, as delegee, could still commission and sub-contract the provision of services. For example, the Commissioning Trust could sub-contract out support assessments for children, retain the decision-making function (as it must) as to what support to provide to a child, and then engage a third party support provider to actually deliver the service.

Nonetheless, it does point to the need for the Children's Commissioning Trust to retain significant expertise on the control of its statutory functions. If the children's trust was to be created under a direction by the Secretaries of State there would be no such restriction to prevent onward delegation but we would anticipate nonetheless similar arrangements by the trust on retained expertise.

Figure 5
Children's Commissioning Trust



7.2.3 Merits of a single template for future interventions

We consider there may be merit in developing a single template for future interventions involving transfer of local authority functions to a new body, or a base template allowing a degree of variation alongside a small team with the relevant legal, procurement and project management expertise. The advantages would include set-up time and cost. In Doncaster's case these were 18 months and £2m respectively. Refinement of a single or base template could foreshorten many of the legal and other processes for future interventions.

<p>OPTION 1 FOR DfE CONSIDERATION</p> <p>(see summary of options in Section 1.12)</p>	<p>COMMENTS</p>
<p>Develop a single template to be used in all future interventions which result from serious and persistent failure alongside a small team with the relevant legal, procurement and project management expertise. The template to involve the transfer of local authority functions to a new body, including the option of adopting and refining the proposed 'Children's Social Care Trust' (Section 7.1) and 'Children's Commissioning Trust' (Section 7.2) models.</p> <p>Or seek individual solutions based on local factors</p>	<p>The alternative is 'one off' local solutions. Benefits of a single template are cost (less need for professional advice, legal fees, etc.) and speed of implementation</p>

8. DEVELOPING THE MARKET BEYOND TRUSTS AND MUTUALS

In this chapter we consider how the market may be developed beyond the Trust model. Although the current policy direction by ministers is not to generate a whole-scale marketisation of children's social care, in our investigation we came to the conclusion that it is hard to envisage how additional capacity and diversity could be created without more services being exposed to market forces. We have, therefore, considered a number of additional strategies beyond the development of trusts or mutual organisations that might be considered by future governments to encourage new market entrants and further diversify the market.

Our main findings, informed by interviews with service suppliers and others, are:

- Local authorities have made limited inroads into externalising core children's services.
- The lack of diversity and capacity has primarily been caused by a reluctance by local authorities to engage the market and a lack of incentives for them to purchase services externally.
- There is a frustration by many providers that they are primarily seen as a supplier of last resort when the local authority has exhausted its internal resources.
- Suppliers consider that current commissioning practices by children's social care services are not conducive to market development with an over-emphasis on cumbersome procurement processes and input-focused contracts that hinder innovation and focus on outcomes.
- The short-term approach by local authorities to fixing problems within their core services does not make best use of the skills and capacity within the market.
- There is a clear appetite from a number of significant providers to enter new areas of the market including assessment and safeguarding as long as it is underpinned by a clear policy direction from national government services and a sensible approach to costs and risk sharing.

The options to encourage market entry are summarised as follows:

- Procurement segmentation. We believe that the key to encouraging market entry, contestability and innovation is segmentation. This will allow a range of smaller providers to enter at points at which they feel confident, and to stimulate this we believe the new delivery model has to be primarily a commissioning organisation. We describe three key aspects of segmentation – service, tiers of need and function – which we believe will develop capacity in the market.
- Increasing the requirement for local authorities to market test their in-house services where there is a contestable market. This could be successfully delivered by either statutory guidance or regulation, and we illustrate the options open to government from compulsory outsourcing to a range of incentives.
- Intervening in local authorities that are failing to deliver effective services and requiring all or part of those services to be delivered externally following competitive dialogue. We believe that this alone will substantially stimulate the market, particularly if linked to our approach to procurement segmentation.
- Finally, to deliver an effective market, we believe that all the evidence suggests that commissioning needs to undergo a radical shift towards developing capitated outcomes-based incentivised contracts and government should put in place the capacity and infrastructure to develop this.

8.1 Increasing Market Demand

In considering our remit we are clear that the policy direction of the current government is not to generate a whole-scale marketisation of children's social care but to facilitate new entrants to the market, thereby encouraging diversity, capacity and innovation. As Edward Timpson, Parliamentary Under Secretary of State for Children and Families, said in May 2014:

At the moment local authorities are accountable for statutory children's social work and I want to be clear that the government has absolutely no plans to change this, but we are asking whether a wider range of organisations could deliver high quality services.

Nonetheless, in our investigation we came to the conclusion that it is hard to envisage how significant additional capacity and diversity could be created without more services being exposed to market forces. Despite 15 years of encouragement and exhortation, local authorities have made only limited inroads into externalising children's services, particularly in the core functions of assessment, intervention and care planning services. While it is of course possible to stimulate some additional capacity and diversity within the statutory sector, we found it difficult to see how a step change could be achieved without eventually opening more children's social care services to a contestable and competitive market through an extension of outsourcing. We have drawn a broadly similar conclusion in relation to placement services for looked after children, such as fostering and children's homes where, although a substantial and growing market already exists, there is strong evidence of endemic 'in-house first' policies being pursued by most local authorities, to the likely detriment of service users (see [Appendix 2, Evidence Review, Section 4.4.2](#)).

We have, therefore, looked at what both for-profit and not-for-profit organisations could offer, whether in cases of intervention by the DfE or in partnership with the great majority of authorities that are not subject to intervention. Greater capacity and diversity for one purpose will be equally available for the other. However, it is hard to envisage how additional capacity and diversity could be created if limited to the small number of councils in intervention, as this would not generate sufficient demand to support a fully functioning market. We have, therefore, later in this chapter, looked at a number of additional strategies that might be considered to diversify the market.

8.2. Supplier interviews

Throughout September and October 2014, we conducted interviews with a range of different companies in order to ascertain whether there was an appetite to expand and diversify the market for children's social care provision in the future. We spoke to a range of companies, from the very large to the small, including charities, current providers in the private and public sectors, as well as to potential providers that would be new to this market. We also spoke to a variety of companies that do (or would) support suppliers to provide social care services, and to grow and develop their organisations i.e. grant giving bodies, membership/affiliate companies and consultancies which provide commissioning and evaluation services.

We tested out the appetite for market entry through the stakeholder event and by targeted interviews with senior management of for-profit and not-for-profit organisations we considered may be prospective entrants into a new market for 'Assessment and Care Planning Services' in children's social care in future.

Our key findings are:

- There is strong interest by incumbents active in existing markets for looked after children (foster care, children's homes and social work staffing agencies) to expand their range of business into Assessment and Care Planning Services processes where they consider they have strong insights;
- None of the incumbents would currently be capable of bidding for large scale, whole system contracts of the type that could emerge as an option for failing authorities;
- But several would be capable of, and enthusiastic about, bidding for any small to medium sized tenders that were to be issued;
- Incumbents are open to partnering with other organisations (possibly new entrants) which strengthen their financial and operational capacity to bid for tenders;
- New entrants may come from a variety of backgrounds, including other segments of the broad health and social care sector where there are several well capitalised operators, as well as public service mutuals with an appetite for exploiting new opportunities for expansion and diversification;
- The principal perceived barrier to market entry is risk, according to senior managers interviewed:
 - Reputational risk
 - Commercial risk, especially where reconfiguration of services is involved
 - Risk that government policy might change, reducing the value of investments they have made in building and mobilising capacity;
- Availability of capital to invest in assets is not a major barrier for potential new entrants, since Assessment and Care Planning Services are 'asset light';
- The only other significant barrier mentioned by interviewees is the perceived unwillingness of commissioners to engage with providers in 'co-production' and reconfiguring of services;
- There is a recognition that commercial risk can best be mitigated by sensible risk sharing in contracts;
- Reputational risk is more difficult to deal with. One private equity investor we spoke to described this as a 'Marmite test' – some organisations will be highly averse to the risk of front-page scandals if something goes wrong. Others are more phlegmatic;
- The large, broad-based outsourcing companies we spoke with said they were highly averse to reputational risk and would be unlikely to be early entrants to this market.

In all, a number of key themes emerged from our discussions which have been summarised as follows:

8.2.1 The Current Situation: Outsourcing and Commissioning

Interviewees told us that the current situation, whereby local authorities both commission and provide social care services, is a source of contention. As one interviewee put it: *"There is currently no clarity in the division between commissioner and provider functions."* As a means of addressing this, the potential outsourcing of all or any area of children's social care services was viewed very positively, and there was a definite appetite for the widening of provision. It was felt that companies outside of local authority control have the skills and expertise to become much more involved in doing this - though suppliers were clear that outsourcing should not simply be used as the default option in all cases.

The other significant barrier mentioned by interviewees is the perceived unwillingness of commissioners to engage with providers in co-production and reconfiguring of services. We also found a consensus that the way commissioning is currently undertaken by local authorities is often flawed i.e. that local authority commissioning lacks consistent strategic thinking, and decisions are being made on the basis of short-term cost savings. This approach puts smaller organisations in a particularly detrimental position whereby they are often squeezed out of the market. To tackle this, it was felt commissioners needed to focus on

the outcomes they want to achieve in order to obtain the right high quality services, rather than on making savings.

8.2.2 Procurement and Market Segmentation

It was felt that the high costs associated with procurement, tendering and contracting process presented a barrier to market entry for smaller companies and the voluntary sector, and needed to be made more 'lean' (though it is worth noting that the larger organisations we spoke to did not find the competitive process an inhibitive barrier).

Furthermore, segmentation of provision was considered to be a helpful mechanism to develop the market, both in terms of areas of specialism and levels of risk. Importantly, suppliers told us that external provision cannot be reserved for local authorities in difficulty – that to get the best outcomes for children and young people, outsourcing opportunities had to be made available to, and developed alongside, all local authorities from those rated outstanding by Ofsted to those rated inadequate. As one supplier told us; '[this] must be a collaborative process, and develop[ed] over time for a sustainable future growth.'

8.2.3 Market Entry and Partnership Working

Another deterrent to small and voluntary sector companies entering the children's social care market was high set-up costs. Consideration would need to be given to helping small companies set up new structures, and to cover property and development costs if the wider market is to be developed – though this could be addressed by smaller companies partnering with other organisations in order to tender for contracts. The need for genuine partnership between local authorities and external suppliers across the market was mentioned by the majority of interviewees as essential to the creation of a wider market.

A number of suppliers mentioned examples of successful partnership working between voluntary and private sector companies, and how these could be further improved. Interviewees also felt that partnership working and interlocution need to be recognised skills, to be supported with expert input in order to develop the market.

8.2.4 Risk Appetite

Whether in relation to entering the market or broadening existing provider services, our interviewees were clear that their delivery offer would be dependent on the degree of responsibility and accountability their companies would be expected to take on in order to provide children's social care services.

As one interviewee told us: "It's all about risk, and the degree to which this is transferred." Suppliers told us they recognised that taking on provision would mean taking on high levels of risk, particularly in relation to reputational risk (though this was not such a concern for the larger companies we corresponded with). The large, broad-based outsourcing companies we spoke with said they were highly averse to reputational risk and would be unlikely to be early entrants to this market. In order to address this, government would need to be clear about the levels of responsibility, liability and accountability they would require from companies taking on the delivery of children's services.

The degree to which risk would be transferred from the host authority to the provider (both in terms of staff and service delivery) has a direct bearing on the type of services external suppliers would be willing to supply. If these splits were clear, a number of providers told us they would be interested in supplying a broader range of services, including potentially, child protection services.

8.2.5 Human Resources

Some suppliers expressed concern about whether there was enough capacity and capability in the children's social care workforce to accommodate external service provision, particularly in relation to core social care services. However, two large providers were confident that there were enough good quality social workers available across England to deliver social care services via external companies.

Moreover, these suppliers felt confident they could provide a fully staffed, motivated workforce by incentivising their staff and reducing the administrative burden they placed on their social workers.

In addition to these key themes, the suppliers we interviewed, almost without exception, felt that, whilst it was possible to create a landscape of broader provision, such a venture would only be successful if it was accompanied by formal, consistent legislation and policy making designed to support market development. This would be fundamental to necessitate the scale of cultural change that would be required within local authorities, and for providers to feel secure enough to invest in an expanded market.

Though the suppliers recognised that this shift may take time to be realised, providers were willing to play the long game if consistent government support and requisite provisions were in place.

8.3 Other options for developing capacity and diversity

In our discussions with suppliers we were struck by their clear appetite to enter more widely into the children's social care market. While local authority commissioners often told us that there was a resistance in the market to taking on the more high-risk areas of service, we found this reluctance overstated.

Instead, we found a generalised frustration by suppliers at the quality of local authority commissioning, the cumbersome nature of the procurement process and a reluctance by local authorities to see beyond inputs, all of which created significant barriers to market entry and innovation.

Similarly, given the relative immaturity of this market, there is a lack of expertise among commissioners in relation to contract management. This creates an environment in which there is too great a focus on monitoring inputs, and where providers are over-managed rather than enabled to innovate on behalf of their service users.

The current commissioning process is resource intensive, both in terms of cost and staff time necessary, in preparing specifications and tenders that tick all of the procurement boxes, rather than developing meaningful service delivery. Commissioners are too preoccupied with designing processes rather than enabling the outcomes they wish to see achieved.

We therefore propose the options below for stimulating more effective commissioning of children's social care.

8.3.1 Outsourcing specific services through either regulation or direction

As described in chapter four, most overseas governments intent on outsourcing have developed market capacity by issuing a regulation requiring certain specific services to be outsourced to a third party outside of state government. This has been achieved successfully in parts of the USA, New Zealand and Australia and has also been applied in both the NHS and adult social care in England and most recently in the National Offender Management Service.

This mechanism could be rolled out in children's services in England along similar lines. If this option was to be considered we would recommend introducing it on a phased and timetabled basis to ensure the contestability of the market and the secure transfer of services.

This could commence with the outsourcing of those services where there is already an established market, such as fostering placements, residential placements and adoption services, extending into other areas of provision.

A requirement to outsource a proportion of the service could also be stipulated along the lines of the 1993 single transitional community care grant where 85% of expenditure was ring-fenced to the independent sector.

In this model the local authority retains a strong commissioning and contracting function and all the statutory responsibilities. In time, this option could be extended to issue a regulation requiring all social care services to be outsourced to a third party outside of local government.

It is worth noting, however, that we have found no evidence internationally of this having occurred, as all countries we have looked at who have recently embarked on a process of externalisation, retained child protection services within the state envelope.

An alternative approach would be to only use the requirement to outsource specific services at the point of significant service failure. This might be triggered for example by an Ofsted inspection or by the failure of the local authority to consistently achieve government targets, for example, in respect of adoption.

Irrespective of whether this was a strategy employed at times of service failure or more generally, consideration needs to be given as to whether the outsourcing should be to a newly created delivery model such as a trust or foundation or to existing and emerging suppliers.

We present the 'regulation' approach to developing capacity and diversity as a series of options for consideration by DfE:

	OPTIONS 3 & 4 FOR DfE CONSIDERATION (see summary of options in Section 1.12)	COMMENTS
3	Seek to develop diversity and capacity through national rules (regulation) on how central government grants are spent	Experience in other parts of the publicly funded health and care system suggest that regulation which promotes externalisation is the most effective lever central government has to stimulate diversity and capacity rapidly
4	If regulation were to be adopted at the main approach to stimulating diversity and capacity, there is a whole range of options on how it might be implemented. These include:	

4a	<ul style="list-style-type: none"> i) Use conditions on grant funding ii) Use some other rule 	A condition on grant funding represents the simplest approach. It was used successfully in adult social care after the 1993 community care reforms to ensure that councils spent 80% of their Special Transitional Grant (STG) funding on independent sector providers
4b	<ul style="list-style-type: none"> i) Frame the regulation such as to encourage a particular form of market segmentation in tender specifications ii) Leave market segmentation to the discretion of local authorities 	<p>We were particularly attracted to the model of 'tiered' segmentation applied in the recent national procurement of probation services, where independent sector providers across England have won contracts to run 21 Community Rehabilitation companies to provide support services, leaving the highest level functions only for public sector in-house supply (Section 5.4)</p> <p>By analogy, a similar segmentation could be applied in children's social care services, 'Tiered' elements might be delivered by 'Early Help' companies which would contract with local authorities to provide preventive services, family support, targeted youth services, substance misuse and under-fives provision (as described in Section 7.2.3).</p>

8.3.2 Procurement Segmentation

Suppliers informed us that they would be most inclined to enter the market in areas where they already had the skills, expertise and experience. Very few suppliers have the capacity to provide the entire social care package and we are not optimistic that such a proposal would either deliver a contestable market or encourage new entrants. However, we learned that there was significant appetite for certain segments of the market and we recommend this as a key mechanism to build the capacity.

The segmentations we think worthy of consideration are as follows:

8.3.2.1 Segmentation by service area

This is currently the only avenue by which the independent sector is entering the market but it has been limited predominantly to fostering and residential placements and mainly on a spot purchase basis. We would recommend instead that alternative service provision segments were put out for tender. For example, an adoption service, family support service or adolescent support service.

There are already examples of these types of service segments being successfully delivered and a proactive approach would deliver considerably more capacity in the market. These providers could then grow the capacity and skills to provide the underpinning social work services for looked after children and care leavers.

8.3.2.2 Segmentation by Tiers

This approach requires commissioners to segment services into tiers based on levels of intensity and risk. Children's social care has four recognisable tiers outlined in the box below. An option we propose is that councils be required to procure all or a proportion of their tier two and tier three services.

Children's Social Care Tiers of Intervention

Level 1 – Universal

Children and young people at this level are achieving expected outcomes. There are no unmet needs or need is low level.

Level 2 – Additional

Children and young people at this level are in need of coordinated early help and support from services. The need cannot be met by a universal service/setting alone but can be met by a single service or one group of single services.

Level 3 – Multiple/Complex

Children and Young People at this level have diverse and complex needs and targeted, multi- agency support services are required and are supported by a clear co-ordinated action plan.

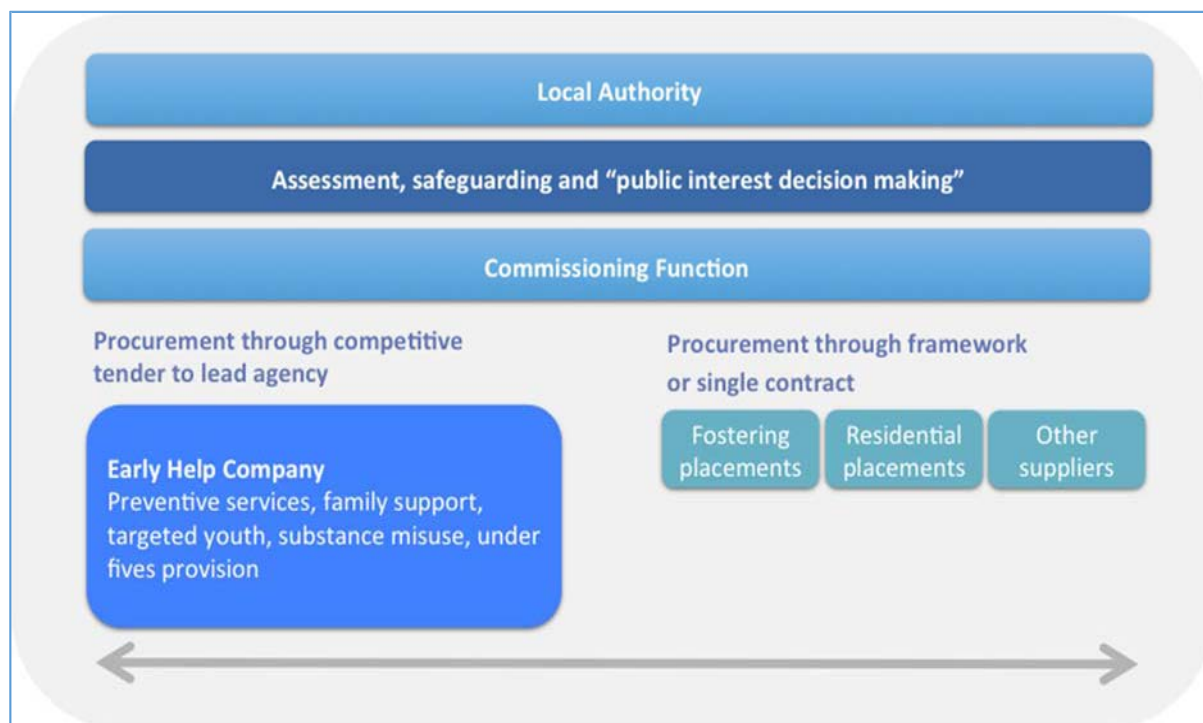
Level 4 – Acute /Specialist

Children and young people at this level require intensive help and are in need of specialist support, following a statutory assessment. This could be due to safeguarding issues or where there is no risk of actual or likely significant harm, but needs are acute and multi-agency plans are not effective.

The resistance to outsourcing within children's social care has predominantly centred on those aspects of the service that determine whether a child is in need of protection or whether the state should intervene in family life. We believe segmenting by tiers of provision overcomes this hurdle. As we have shown earlier in this report ([Section 6.3](#)), this has been introduced by the Ministry of Justice through its Transforming Rehabilitation Programme, with the majority of probation's rehabilitation and supervision workload being delivered by 21 privately managed CRCs. We believe this would offer a significant opportunity for market entry within children's social care. This could be achieved through either a regulation that requires councils to externalise their tier two and three service offer, or alternatively to put in place a centrally managed process similar to that employed by NOMS whereby these services are procured through new delivery models such as an Early Help Company illustrated in [Figure 6](#). The Council would retain the assessment and commissioning function, and the statutory responsibilities for all of the "public interest" decision making such as decisions to initiate care proceedings.

Figure 6

Creating lead agencies – Early Help Companies



8.3.2.3 Segmentation by Function

We have been struck in our conversations with most commissioners by an inherent resistance to outsourcing assessment and child protection activity. Nonetheless, there is a flourishing market in the provision of agency social workers. In September 2013, (SFR08/2014) there were 23,000 full time equivalent social workers and these were supplemented by another 3,400 social workers employed by agencies. This figure excludes management posts also covered by staff employed by agencies. On average, authorities across England employ 14% of their staff through agencies and in some authorities this can exceed 30%. The sector is therefore utilising for-profit companies in areas of most sensitivity but this is done as a last resort and almost always in an ad hoc fashion. Furthermore, there is a growing industry in companies supplying teams of social workers, sometimes with their own integral management, to support authorities in some difficulty. This is a more managed process with the supplier being commissioned to either provide extra capacity in the form of a discrete team of social workers or alternatively paid to undertake a set number of assessments within a given period. This is effectively segmenting by function and we were impressed by the new working practices that these suppliers had introduced to increase their productivity and efficiency. For example, one supplier we met explained that they were able to undertake 1,000 assessments for the same cost it took the local authority to do 650, and at the same time the supplier reported that the customer felt the quality of the assessments was superior to that undertaken by their own staff.

There are a number of innovations the suppliers are introducing to achieve this drive for both efficiency and quality. Primarily the task, for example a single assessment, is segmented into that which requires professional input and that which can be undertaken by administrative staff. Each social worker is supported by up to two business support staff that undertake the planning and organisation of visits and meetings and the inputting into the ICS system. Assessments undergo a two-fold quality assurance process firstly of an administrative nature and then by an experienced service manager. The ICT

arrangements are in place to enable this to be done remotely and social workers are remunerated according to quality and the number of assessments completed to a set timescale. The supplier reports improving satisfaction by the social workers who are predominantly undertaking work with children and families and utilising their professional skills rather than undertaking computer-based administrative functions.

8.3.2.4 Segmentation by geography

The Le Grand report *Ways Forward for Children's Social Care Services in Birmingham* identified the inherent difficulty the scale of services would present to either a partnering local authority or independent sector supplier. An alternative approach would be to segment the services to be outsourced into more manageable geographical lots based on natural communities. This would allow suppliers to bid for as many lots as they had the capacity to take on and would introduce a degree of competition into the process.

This has been a successful approach previously used by local authorities tendering domiciliary care services and also children's centre services. In our view, it also points to a smaller scale of unit than might be immediately considered with smaller suppliers bidding for single units and larger suppliers covering larger areas. Earlier in this report we considered some of the beneficial approaches introduced by the social work pilots and this geographical segmentation could be a significant stimulus to social work pilots being able to actively engage with this market.

Local authority commissioners we spoke to, expressed a concern that suppliers would limit their interests to the more easy to deliver or profitable service areas leaving the local authority with the more complex and difficult services. While we appreciate the concern, this fear was not supported by the evidence as to how the market has developed to date or the appetite expressed within our supplier interviews. We found a number of examples of suppliers demonstrating a keen interest in entering into complex and difficult child protection markets provided that accountability and responsibility was clearly articulated and risk appropriately shared.

As we have covered elsewhere, despite these hesitations, local authorities have on many occasions reverted to the independent sector as a provider of last resort for child protection assessment services and the market has always been forthcoming in these circumstances.

It should also be noted that experience in other health and social care segments does not support the view that independent sector suppliers limit their interests to easy to deliver services. While that can happen, for example in elective surgery under 'choose and book', which is set up in such a way to allow independent sector providers to offer only the slots they wish to, there are other areas where the entire history of independent sector provision has been to supply specialised services for patients who are difficult to place. The most prominent example is mental health hospital provision.

8.4 Strengthening Commissioning in Local Authorities

8.4.1 Capitated Outcomes-Based Incentivised Commissioning (COBIC)

As explained previously, suppliers are frustrated by what they see as an under-developed commissioning function within children's services departments. We believe that Capitated outcomes- based incentivised commissioning (COBIC) provides a fast and readily available solution to radically improve the services provided to children. This is now becoming well-established within NHS commissioning and we can see the opportunities for children's foundation trusts to develop their commissioning along similar lines.

There are a number of advantages inherent to the mechanism, which would improve outcomes for children.

8.4.1.1 Capitation

The contract is not a block payment, nor volume-related, but a multi-year contract calculated on the predicted levels of population and service demand. As a consequence commissioners and providers are able to focus on improving processes and activities to achieve outcomes, with additional rewards for achieving the desired outcomes, rather than expending organisational energy on monitoring activity, managing demand and revising budgets throughout the lifetime of the contract.

The multi-year nature of the contract creates strong incentives for prevention activity and up-front investment in services whose impact will be felt in the later years of the contract.

Service providers can focus on activities that will help reduce future demand over the lifetime of the contract, for example moving to early intervention and prevention work rather than delivery of expensive interventions at crisis point. Health providers using COBIC-style contracts have, for example, looked to health prevention activity as an investment to help reduce future levels of treatment/clinical/social support activity.

Establishing the capitation amount also provides the opportunity to review and re-base the budget for the service. This could include, for example, a zero budget approach to remove the effects of incrementalism, a review of benchmark data or the application of any commissioning intentions.

This inbuilt review mechanism encourages providers to look for better ways of delivering services and also enables the delivery of savings over the lifetime of the contract. These savings could be shared with the commissioning bodies or local authorities. Risk and gain share arrangements can be built into the contract.

8.4.1.2 Outcomes-based

This is a key advantage to this type of contracting arrangement.

The mechanism provides a framework to 'do better things' as well as 'doing things better'. Using this framework replaces the tendering of existing services to existing specifications with a contract of co-determined outcomes. Instead of contracts being based on activity levels and descriptions of services, contracts are designed to focus on outcomes. For example, children receive a successful placement rather than a contract, which states so many fostering placements are made in a time period.

The process of setting outcomes also enables the commissioning of improved outcomes. The thinking does not have to be constrained by the service offer that is currently made, but should enable a review of what could be achieved and what is required to meet local needs and to improve the quality of life for children.

Critically, the co-determination is achieved not just through commissioner and provider dialogue, which in itself is novel replacing provider responses to a service specification written by commissioners, but the outcomes are designed through active dialogue with citizens. This is an important and key distinction in this type of contract. Commissioning bodies no longer have to second-guess what matters, or to respond to accepted wisdom. A dialogue with service users and the communities enables accurate focus on what matters to citizens.

The outcomes are then reflected in a range of indicators, which are also developed through a dialogue with services users, commissioners and service providers.

The use of outcomes also facilitates easier co-commissioning of services to children across a range of organisations. Budgets for a range of services from local authorities and health for example can be pooled. Services can then be revised to focus on delivering outcomes rather than activities and services provided by a range of organisations, enabling better re-design and ending distinctions which service users see as artificial and bureaucratic. Again this can be achieved without the need to develop new organisational and stand-alone governance structures.

This approach could also be used to facilitate contracting both for differing service organisations serving the same locality as well as similar organisations serving differing localities, or a mix of both.

8.4.1.3 Incentivise

As well as the gain shares that arise from capitation, the contract can also be built to develop indicators that reflect the co-determined outcomes. These indicators can be linked to payments, which form part of the overall contract. The number and range of indicators which are incentivised (have a payment linked to them) can be changed over the lifetime of the contract to reflect service improvement activity and also to act as a focus for improvement activity.

This approach frees up commissioners/local authorities from the requirement to review and revise service specifications to reflect service changes over the lifetime of the contract; instead improvement activity becomes the driver to payment of incentives.

The amount of incentive payment can be linked to the level of performance achieved over the lifetime of the contract as reflected in the delivery of the indicators.

The amounts for both capitated and performance-related payments can be adjusted to reflect the level of risk in both service demand and population growth and the degree of complexity in the changes to the service needed to delivery to the outcomes.

8.4.1.4 Contracting

The use of COBICs does not require any legislative change nor change in organisational or governance structure. Existing commissioners/local authorities would be free to contract with a range of providers. This process would be fast to implement as a consequence.

There is another advantage to COBIC contracting.

By developing outcomes-based contracts it is unlikely that one single provider would be able to respond effectively to the entire contract.

Within the health sector we have seen contract responses, which have been made by a combination of primary and community services, as well as multiple providers or through single accountable provider and subcontractor arrangements.

The breadth of the provider response required also enables those responding to contracts to work with other providers and specialist providers. This has enabled other non-traditional service providers to enter into new and emerging markets with reduced levels of risk to themselves and commissioning organisations.

This would be particularly helpful within children's services where we have found a high level of interest from potential providers looking for a market entry point.

In healthcare, the contract process itself does not always require full competitive tendering where value for money and service user benefit can be demonstrated, although when competition is used, the competitive dialogue process has been beneficial. Competitive dialogue allows for the development of service specifications with providers, which encourages innovation, and allows the novel ideas of both existing and new providers to be cultivated.¹²

As an alternative to competitive tendering within the health sector, we have seen the development – with support from the regulator, Monitor – of most capable provider mechanisms to robustly test the ability of a provider, and their new partner providers, to respond to the needs of the contract.

A similar process could be developed for children's services to enable more rapid and focused deployment of contracts and deliver reduced procurement costs, whilst still providing a robust mechanism to ensure the delivery of value for money. This mechanism can also be used to test the ability of current service providers to respond to new contracts and enable an informed judgement as to whether or not alternative procurement routes might be necessary.

8.4.2 Learning implementation lessons from the NHS

There are some aspects to the implementation of outcomes-based contracts that should be considered.

Access to robust activity and costing data in order to establish the 'true' base budget of the service, is preferable to ensure that capitation and incentives are not overstated, thus providing a disincentive to seek improvements.

However, commissioners rarely have access to a true provider cost basis, consequently commissioners often have to make a judgement about the value they expect providers to deliver for any given population. One approach to this issue might be to ask what improvements in outcomes do commissioners require as a minimum from their investment, and what are they prepared to pay for better outcomes?

Similarly providers have to understand the costs of their delivery chains, and also have strong motivation for better understanding of links between cost, activity and outcomes and then acting upon that understanding.

Access to robust information about best practice and potential for improvement to ensure that expectations of what could or should be possible is built into the contract and used in contract negotiations. The absence of this information does not stop a COBIC from being developed, but it makes it more difficult to accurately predict the gain share and risk levels.

¹² Although EU procurement Regulations encourage the competitive tendering of services over procurement threshold limits healthcare (and other similar public services unlikely to be of interest to bidders in other member states) are considered 'part B' services. The Regulations currently divide services into so-called "Part A" (or "priority") services and "Part B" (or "residual") services. Only Part A services are fully caught by the Regulations. Part B services are caught by a lesser regime, with only a few of the detailed rules of the Regulations applying. The Regulations themselves do not require any form of prior advertising or competitive tendering of Part B services. However, they are still caught by the general obligations of transparency, equal treatment, non-discrimination and proportionality – with the commissioner of the services being responsible for assuring themselves of meeting these obligations.

COBIC compared to payment by results (PBR)

COBIC is different from the existing payment regime for many services in the NHS, namely, Payment By Results because it rewards providers of healthcare on the outcomes they deliver for patients rather than purely on the basis of activity.

Because PBR rewards providers on the basis of a set fee (tariff) for services multiplied by activity, it incentivises providers to focus on the activity rather than benefit – whereas focusing providers on the outcomes patients are seeking from the services encourages them to work together on integrating healthcare services and ensuring service users get what they need from the service rather than the service providing what the tariff descriptor suggests.

In addition, COBIC contracts tend to be for 5-7 years and because the funding is pooled across the population, providers are encouraged to work together and are able to make investment decisions that can have a pay-back over time, which an annual, tariff-specific activity focused contract (PBR) does not encourage.

A cultural shift is required to move the mind-set of participants from contracting on activity or block payment, to one that focuses on the delivery of outcomes and looks for innovation in service delivery that achieve those outcomes.

Given the change in the nature of contracting skills in the development of COBIC contracts, different sets of skills and activities are needed from both those commissioning and those providing services. These include development of relevant outcomes and engagement skills with service users to develop outcomes and indicators.

Table 6
Benefits of COBIC, and challenges for implementation

BENEFITS OF COBIC	CHALLENGES FOR IMPLEMENTING COBICS
Payments made on the basis of population and demand, not block nor volume	Providers need to understand their costing and activity and their relations to outcome, to manage their risks.
Establishing the capitation amount enables review of budget and reflection on commissioner and citizen priorities	Commissioners and providers don't always have ready access or knowledge of best practice and information about what might be achievable
Capitation provides an incentive for service redesign which focus on prevention/early intervention	Cultural shift in mind set from measuring services by activity to focusing on outcomes, which can sometimes be difficult to achieve

Provides an opportunity to gain/risk share with providers	New Commissioning skills around developing outcomes and developing these with service users are necessary
Provides a mechanism to 'do better things' by co-determination of outcomes and indicators with commissioners, providers and crucially service providers	Narrow focus on scope of services in the contract risks losing the advantages of co-commission and joined-up working
Facilitates co-commissioning and pooling of budgets with range of other organisations which provide services to children, ending the barriers that others see as artificial and bureaucratic	Outcomes based contract requires re-alignment of provision along pathways, or the negotiation of new relationships between providers whose inputs contribute to relevant outcomes. Partnering and alliances with other providers, private sector might be necessary.
Part of the payment to providers is based upon delivery of improved outcomes measures by incentivised indicators pick by service users	
Focus on outcomes reduces the requirement to monitor activity levels and focus on service improvements	
Incentive levels can be easily changed over the lifetime of the contract to reflect service improvements	
The split between capitated and incentive payments can be set to reflect the level of risk within the contract	
Commissioners no longer have review and revise service specifications during the course to the contract, as these are no longer the primary contract documentation.	
The use of COBICs do not require legislation or the creation of new organisations	
Leads to the development of alliances and partnership in service delivery	
Provides an easy market entry point for other sectors and providers into the market	
Does not require full competitive tendering a 'most capable provider' could be developed as an alternative route to ensure value for money delivery from robust providers	

Using Any Qualified Provider principles to expand the market in children's services

Any Qualified Provider was used successfully in the NHS to grow the market for healthcare services, introducing new entrants, raising the game of incumbents and ultimately, offering patients choice of provider for their treatment. Over 40 individual services were commissioned this way, All 152 CCGs offered AQP for at least one and usually three different services, enabling over 1000 individual providers to offer their services to over 1 million patients annually.

A similar process could be applied to children's services, which would enable more, and smaller scale organisations to apply for contracts across the country.

Before AQP in the NHS, each provider applied to deliver services against commissioner-set specifications. All providers were assessed against a consistent set of quality and legal/financial hurdles to demonstrate their credentials to deliver care for patients. All providers were paid the same rate for the service to which they applied to provider. This meant that they competed on quality and outcomes, rather than price.

The NHS AQP Process:

- Providers must pass a standard qualification process to ensure they meet the appropriate quality standards.
 - o *CQC/Monitor registration where required*
 - o *Staff registration with professional regulatory bodies*
 - o *NHS Contract terms and conditions are mandatory*
 - o *Service specific requirements*
- There was nationally consistent assessment criteria and process to qualify but the providers were accountable to the local commissioner
- Once a provider has qualified they are reviewed locally through routine contract management as well as an overall annual assessment performed centrally
- Once a provider has successfully completed the questionnaire and has been qualified to provide a service for the first time, their details will be recorded in a national directory of qualified providers.
- Qualified providers were listed on a central directory, and were accessible to patients locally through Choose & Book, a national system that allowed patients to see providers available to them and to work with their GP to choose the best provider for their own individual circumstances.

Benefits of AQP

Benefits to commissioning process:

- Compared to competitive tendering, AQP reduces the bureaucracy of pre-qualification questionnaires – once a provider qualifies in one area, they can use the same application to apply elsewhere, simply changing the elements that are locally specific to the new commissioner.
- The process is simpler for all providers and as such should be more accessible for smaller providers.
- The directory allows the nationwide sharing of qualification information, and lets commissioners and the public see where AQP contracts exist.

Benefits to Patients and the NHS:

- A central database and online inter-active map of services allowed Patients and GPs to see the location and service offer of each organisation
- The database allowed the GP to continue to operate their 'gatekeeper' role, ensuring only relevant conditions were offered choice (to mitigate consumer led demand)
- **AQP is NOT privatisation** – services remained free at the point of use, based on clinical need, keeping true to the principles and values enshrined in the NHS Constitution
- **AQP is compatible with integration** – providers are obliged to locally cooperate and comply with the local service specification and local care pathways/protocols

9. STRENGTHENING THE SYSTEM ARCHITECTURE TO SUPPORT MARKET DIVERSITY

In this chapter we consider the current system's architecture and how this could be strengthened.

These are summarised as follows:

- Creating a new national body, the National Children's Social Care Commissioning Board.
- Supporting effective commissioning by developing a strategic view of the market, setting out national framework agreements, modelling outcome-based contracts and setting out the associated ground rules.
- Providing a national approach to undertake specialist commissioning on behalf of councils and/or trusts.
- Developing Nationally Approved Leaders.
- Strengthening the role of commissioners of children's social care.

We believe there needs to be a significant re-shaping of the national system architecture to support and facilitate these proposals. Local authorities need to be supported to commission more effectively and national government needs additional capacity to put in place transformational solutions. We propose three new elements to the current system.

9.1 National Children's Social Care Commissioning Board (NCSCCB)

We believe a new national body reporting to the Secretary of State for Education could be created to act as a national driver for effective commissioning of children's services and the delivery of radical solutions at the point of service failure. We would see this body undertaking some of the similar functions currently undertaken by NHS England within the NHS.

Supporting effective commissioning and market developments by local authorities

The NCSCCB would take the lead in developing a national approach to commissioning effective children's social care. It would build on the work initiated by the government's Commissioning Academy¹³. It would develop national tools and resources to develop local authorities' approaches to commissioning and streamline local authority procurement processes to reduce duplication and cost for both commissioner and provider. It would take the lead in developing COBIC contracts to be utilised by children's foundation trusts and local authorities.

Commissioning specialist services on a national basis

We believe high-cost, low-volume services could be more effectively commissioned at a national level and managed centrally by the NCSCCB, which would acquire the skills and expertise to undertake this on behalf of local authorities. This would apply to placements for children with high level and complex needs.

¹³ The commissioning academy is a development programme for senior leaders from all parts of the public sector to deal with the challenges facing public services, take up new opportunities and commission the right outcomes for their communities. The academy is supported by the Local Government Association, the Department for Communities and Local Government, the Ministry of Justice and the National Offender Management Service, the Department for Education, the Department of Health, the Department for Work and Pensions and the Home Office.

Providing expertise and capacity to put in place new delivery models

As we have seen from the experience in Doncaster and also in Richmond and Kingston, the setting-up of new delivery models requires significant capacity and specialist skill sets in respect of company and contract law, project management, and procurement. This has previously been supplied by a combination of staff from councils, government officials, private law firms and consultants. It is our view that it would be far more cost effective to provide this capacity through a specialist team of people with the relevant skills and knowledge. This team could be called upon to provide the additional capacity to support local authorities in the development of the new delivery models, and would in time build up a repository of key documentation, including tender and procurement documentation and template service contracts.

Developing a strategic framework for the effectiveness of the new delivery models

While we anticipate that in the majority of cases children's foundation trusts will be delivering services under contract on behalf of a local authority, we do see the need for the NCSCCB to provide a strategic overview and assurance for the effectiveness of the trusts and provide overall leadership for their improvement.

We present these options open to the DfE in pursuing the important goal of promoting commissioning excellence:

OPTION 5 FOR DfE CONSIDERATION (see summary of options in Section 1.12)	COMMENTS
Establish a National Children's Social Care Commissioning Board reporting to the Secretary of State to develop and support local commissioning capacity Adopt some other means of promoting commissioning excellence	We have argued (Section 7.3) that transformation of delivery through tendering will not be achieved without a parallel transformation in commissioning. We believe there is a strong case for locating support with the Department for Education and for the NCSCCB to be well funded.

9.2 Nationally Approved Leaders Programme

Following their investigation into Birmingham, Le Grand and Wood considered the lack of capacity available within the system to support local authorities in difficulty to bring forward options to improve their children's safeguarding services. They identified a lack of capacity problem in the three key areas of leadership, skills and infrastructure. Their suggestion is to create nationally approved leaders, or NALs, in children's social care. We would see the NCSCCB commissioning and co-ordinating the NALs and utilising the capacity to support the development of children's foundation trusts.

The Le Grand-Wood proposal suggests the possibility of local authorities working in partnership with a commercial provider to create an independent not-for-profit trust.

We have not, as part of our work, would not rule it out as a possible form of governance. What is more critical in our view is the form of organisation that the services are transferred to and we are clear that if the intent is to grow diversity and capacity the successor organisation should be predominantly a commissioning organisation along the lines of the children's foundation trust we have mapped out above.

Nationally Approved Leaders

An NAL would be a partnership body - a consortium of a local authority allied with a commercial provider and, where appropriate, with national voluntary organisations. These partnerships will apply to the Department for Education to become registered as an NAL to (1) undertake intervention on behalf of the Secretary of State (ranging from part of an authority's service to the full service), and (2) build long-term capacity for continuous improvement in a local authority area. Approval will be awarded following a stringent accreditation procedure.

One model of intervention in the identified failing authority would be for the NAL to create an independent, not-for-profit trust (in the form of a CIC, preferably with a mutual structure) to run children's social care services for a period of ten years in the first instance. Where an intervention is designed to deal with a part or parts of a failing service, this could take a different form, such as that of a social work practice, currently being piloted by the Department for Education in children's social care and by DH in adult social care. Funding for the interventions would come from the Department for Education and the passing over of budgets from the local authority under contract to the trust, the social work practice or the other new institutions.

In all cases of intervention the process would be:

- An Ofsted finding of inadequate
- Inadequate capacity within the Local Authority to improve
- Appointment by the Department for Education of a Commissioner
- The appointment of an NAL to deliver the creation of a trust or of alternative ways of delivering the service
- A statutory direction to the local authority issued by the Secretary of State

We present the National Approved Leaders option as follows:

OPTION 6 FOR DfE CONSIDERATION (see summary of options in Section 1.12)	COMMENTS
Implement the Nationally Approved Leaders proposal Develop some other route to developing leadership capacity to respond to calls for alternative service suppliers	We make the case for this proposal in the paragraph above

9.3 Strengthening the Role of Commissioners for Children's Social Care

The Secretary of State for Education has the power under section 497A (4b) of the Education Act to appoint a commissioner for children's social care if she is satisfied that a local authority is failing to perform its functions to an adequate standard. This power has been exercised in Doncaster and Birmingham and more recently in Rotherham and Slough. We see the opportunity of enhancing this role under the auspices of the NCSCCB and would identify the following key functions.

- Supporting the NAL in delivering the intervention to improve services as quickly as possible

- Providing the link with the NCSCCB to ensure the expertise and capacity is available to set up the children's foundation trust and put in the appropriate governance and systems
- Overseeing the segmentation and market testing of services and the secure transfer of functions to the new organisation.

APPENDIX 1: KEY PROJECT PERSONNEL

Advisory Panel Members

Professor Julian Le Grand, Professor of Economics, **London School Economics**

Alan Wood, **President of the Association of Directors of Children's Services**

Isabelle Trowler, **Chief Social Worker for Children and Families in England**

LaingBuisson Project Team

William Laing, CEO, **LaingBuisson**

Malcolm Newsam, **Cobic** Consultant Advisor

Elaine Redding, **Cobic** Consultant Advisor

Andrew Smith, Director of Finance, **Cobic**

Dr. Nicholas Hicks, Chief Executive, **Cobic**

Marie Tucker, **Cicada Services**

APPENDIX 2: EVIDENCE REVIEW

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1. INTRODUCTION

This evidence review was prepared as part of the overall report *Developing the Capacity and Diversity of Children's Social Care Services in England*. It provides an overview and examples of outsourcing children's social work services within England, and in other English speaking countries across the world. It provides a summary of key lessons learnt from the range of these experiences. It should not be used for any other purpose.

In England, local authorities have long been commissioning certain child welfare services from the private and voluntary sectors. Over the last twenty years, there has been a rapid development of private and voluntary providers of children's social care services. There has been considerable change in residential childcare, where the private sector is now by far the largest provider. In foster care the private and voluntary sector have a substantial and growing market share alongside the provision of local authorities. In addition to these services for children in care, the private sector and voluntary organisations provide a valuable range of support and advice services to families in need.

Local authorities in England have continued to deliver core statutory social care functions. These functions have not been delegated to voluntary, not-for-profit and for-profit organisations because of legislative, moral and political constraints.

The Providers of Social Work Services (England) Regulations 2013 came into effect in November 2013 and enables local authorities to discharge to an independent provider some or all of the local authority's social services functions in relation to looked after children and care leavers. The government has since published the *Children and Young Persons Act 2008 (Relevant Care Functions) (England) Regulations 2014* that allows local authorities to delegate almost all of their social services functions relating to children, as defined in the *Local Authority Social Services Act 1970*.

The regulations allow authorities to delegate certain functions under the *Children Act 2004* relating to Children's Trust Boards, Children and Young People's Plans, and the duty to cooperate. These functions can now be delegated to third party providers that operate on a not-for-profit basis.

These changes in legislation will now enable voluntary and independent providers to legally provide these core social work services. However, early in 2014, a report into children's social care services in Birmingham¹⁴ highlighted the absence of statutory, voluntary or independent sector capacity to offer an alternative to continued delivery by a failing council.

¹⁴ *Report to the Secretary of State for Education and the Minister for Children and Families on Ways Forward for Children's Social Care Services in Birmingham*. Julian Le Grand 2014

2. METHODOLOGY

A review was undertaken of recent and relevant literature on the theme of outsourcing children's social work services within England, in other English speaking countries across the world, and are summarised in this document. In the conclusion, recommendations are made on the themes or elements that may be considered as possible options for further consideration in the main report. The evidence review does not make recommendations but it provides an overview of lessons learnt from the sources of evidence reviewed.

The primary challenge in undertaking this evidence review was the breadth of the topic. The subject generated a considerable amount of data, and to some extent the sheer volume of evidence meant that an extensive academic review was not appropriate.

2.1 Search strategy for review of outsourcing examples in England

Given that local authorities in England have been largely prevented from outsourcing statutory social work services, there was limited information to consider, specific to the outsourcing of social work services. There was however, a plethora of information concerning the impact of outsourcing placement services for children in care. Due to the volume of information, it was decided to capture key messages in a dedicated section in this evidence review.

A comprehensive search was made of Internet resources in England, to provide context for analysing the evidence and to provide access to reports published by the private and voluntary sectors. The primary sites used were:

- Welcome to Gov.UK <https://www.gov.uk/>
- Social Care Institute for Excellence <http://www.scie.org.uk/>
- University of York, Social Policy and Social Work <http://www.york.ac.uk/>
- Research in Practice <https://www.rip.org.uk/>
- Children and Young People Now <http://www.cypnow.co.uk/>

2.2 Search strategy for review of outsourcing internationally

A review was made of material and information from a number of sources:

- Wider sources through literature and web-based searches, including international experience
- Recommendations from the Department for Education, the Advisory Panel and project team
- Wider Internet searches were helpful in researching international experience, especially for accessing reports published by the private and voluntary sector, and helped to provide a context for analysing the evidence.

The approach focused on experiences of outsourcing in the following countries:

- United States
- Canada
- Australia
- New Zealand

3. SUMMARY OF KEY INSIGHTS

The evidence review highlighted the below key insights, which are drawn from a large number of research reports and articles. Insights are drawn from a finite range of research papers on a broad topic, and whilst the majority of these were based on common findings across reports, some of the conclusions drawn are based on subjective opinion.

1. Organisational culture is at the root of the success or failure of outsourcing efforts. This was a dominant feature in the review of evidence and cannot be overemphasised.
2. Effective and wide consultation and communication is vital to the success of outsourcing of services. This should include all stakeholders at all levels from the offset.
3. Outsourcing should be supported by legislation allowing flexible use of funds to improve outcomes for children and families.
4. Outsourcing is likely to be more effective when supported by independent advocacy from the offset, to ensure fairness, transparency and equal opportunity to contribute.
5. It is not necessary to outsource all children's services and there should be careful consideration of the services that are to be outsourced to ensure that conflicts of interest are avoided. This is particularly important where there are plans to outsource any commissioning responsibilities.
6. From the start of the outsourcing process through to continued delivery of the service, it is essential to ensure that all stakeholders can easily access information that is jargon-free and that there is two-way communication.
7. Implementation should be meticulously planned ensuring that funding and start-up time are factored in - phased and gradual implementation brought the best results.
8. There was a common finding that the resource required for contracting had been significantly underestimated. There is a need to undertake a robust exercise to determine the resources that will be required to effectively procure services and ensure contract management and ongoing quality assurance. Contracts need to include some flexibility to adapt as needs change over time.
9. Some areas struggled to provide validated evidence of success or failure due to a lack of accurate and timely data prior to any transfer of services. Knowing baseline information from which to measure progress/lack of progress is critical. All parties must have a shared understanding of data and of contract monitoring arrangements prior to any service transfer.
10. Experience to date has highlighted technology as a priority area for attention. Better results were evident where there had been dedicated effort to ensuring sophisticated computer software programs and applications to support partnership working.
11. Positive experiences of outsourcing were supported by effective workforce strategies. These recognised that to develop capacity there must be a focus on (a) supporting individual workers and (b) ensuring lean efficient organisational arrangements. Organisational culture and trust also played a substantial role.
12. The outsourcing of placement services for children in care was a dominant area in the research. International experience showed that these were often the first services considered for outsourcing.
13. There is a view that where a government body is both a commissioner and provider of services for children, this introduces a conflict of interest due to the pressure on the body to maximise the capacity within its own services, despite the fact these may not deliver the most suitable service for the individual child.
14. There was a widely held view that outsourcing needed to focus on outcomes for children and that savings (especially short term savings) must not be a driving factor. In some American states where outsourcing has been successful, they witnessed an increase in expenditure for the first three to six years.

15. It was not possible to find any examples in the United States, New Zealand or Australia where government departments had chosen to privatise Child Protective Services' initial investigation functions.

4. ENGLAND

Given that local authorities in England have been largely prevented from outsourcing statutory social work services, there was limited information to consider specific to their outsourcing of social work services. There was however, a plethora of information concerning the impact of outsourcing placement services for children in care.

4.1 The role of the voluntary sector

The voluntary sector describes those organisations that focus on wider public benefit as opposed to statutory service delivery or profit. They are also known as Third Sector or not-for-profit organisations. Broadly speaking there are two types of organisations within the voluntary sector: registered charities and non-charitable voluntary bodies. Registered charities are probably the largest single category, and include some of the best-known voluntary organisations in the UK but the sector also includes small informal community groups.

Non-charitable voluntary bodies usually use volunteers for some of their activities and the organisations are not for personal profit – i.e. they do not pay share holders, but do pay their way and reinvest any profit back into the organisation or the community. Public Sector Mutuals and Social Enterprises would fit into this category.

Children England, a leading membership organisation for children, young people and families voluntary sector, state that “there is recognition of the government’s commitment to more open public service markets within which the voluntary sector can thrive, but a view that the way this is playing out both in localities and large national contracts isn’t currently working.”

Voluntary organisations report struggling with capacity to support children and families with many now having to turn people away for the first time. The sector has concerns that the government’s approach to securing provision will be driven by the market and that the focus will be on profit and efficiency savings, rather than on delivering outcomes. They forecast that this would have a detrimental impact on both the quality of services for children and employment conditions for staff, leading to an increase in need and a further shortage in skills, knowledge and experience. Current commissioning culture, procurement methodology and the lack of consistent positive partnerships are viewed as a barrier for the voluntary sector to increase its capacity for delivery¹⁵.

In July 2014, Children England and the Trade Union Congress (TUC) published the *Declaration of Interdependence in Children’s Services*¹⁶. In this they call for a focus on collaborative and supportive relationships between the statutory and voluntary sector. The declaration states that improvements are needed in commissioning and procurement and that this must be driven by social values, and be underpinned with funding that is fair and sustainable.

In 2014 the National Coalition for Independent action published its working paper ‘*Outsourcing and the Voluntary Sector*’¹⁷. It states “there is a lack of reliable, up-to-date statistics on the voluntary sector, partly because cutbacks have reduced what is collected, but also because there is no consistent definition of the sector across the government departments and local authorities who fund or monitor its

¹⁵ *Perfect Storms*, Children England 2012

¹⁶ *Declaration of Interdependence in Children’s Services*. Children England & Trades Unions Congress – 2014

¹⁷ *Outsourcing and the Voluntary sector*. National Coalition for Independent Action, 2014

activities. But more importantly, people and organisations across the sector have widely differing profiles and perspectives on their current and future roles”.

The Coalition argues that the quality of public services at the point of delivery and the working conditions of those who deliver those services continue to fall demonstrably. The report claims that, for voluntary agencies a shift from grant funding, and for all providers, the shift to large, payment-by-results contracts effectively excludes all but the oligopolies, mega-charities and social enterprises. This report also states that procurement and commissioning has become an industry in itself and as the bulk of outsourced services – in terms of both monetary value and social impact – are delivered to vulnerable, hard-to-reach people, large organisations regularly underbid to win contracts. They then cherry pick the profitable, quick-win elements, and subcontract the riskier ones to the cash-strapped voluntary sector – or back, indeed, to the public sector, which nevertheless retains a legal responsibility for those services.

4.2 Outsourcing statutory social work services

Local authorities in England have been largely prevented from outsourcing statutory social work services. There are rare exceptions to this: The Camden National Society for the Prevention of Cruelty to Children (NSPCC) project involved the NSPCC undertaking child protection investigations for the London Borough of Camden from June 1993 to June 1995. This was implemented due to the serious capacity issues in social work services following industrial action.

Interviews with those involved in the project concluded that some very good assessment work had been undertaken and the arrangement had enabled a critical service to be provided when there were insufficient local authority social workers to carry out child protection work. However, there were difficulties with managing cultural differences between the organisations. Most challenging was maintaining consistency of relationship between children and families due to changes of worker. There was a view that any problems experienced were as a result of cultural differences, the set up and systems established, and not the quality or knowledge of NSPCC workers. Overall the project was seen as a success, enabling the provision of a critical service over a two-year period¹⁸.

In November 2013 new legislation¹⁹ enabled local authorities to discharge some or all social services functions in relation to individual children who are looked after by the local authority and care leavers. As this is a recent change in legislation, it is too early for an evaluation of the impact of this legislation to take place.

In 2007, the Social Care Practices Working Group explored the feasibility and options of piloting Social Work Practices (SWPs). The business model favoured by the Social Care Practices Working Group was the professional partnership model. The vision being that the partnership would contract with the local authority to provide field social work for looked after children, and to commission services that its own staff could not provide. It would own its assets and pay the partners and any staff that it might employ²⁰.

Between 2010 and 2011, the Department for Education commissioned an evaluation of the SWPs⁸ that looked at the process by which SWPs were established. The report details how the Social Care Practices Working Group anticipated that existing voluntary or private sector organisations might bid to provide pilots. Some local authorities also favoured particular governance models, which influenced the tendering

¹⁸ Taken from confidential provider interviews conducted during this project, 2014. Individual interviewed had first-hand experience of the Camden project.

¹⁹ *The Providers of Social Work Services (England) Regulations 2013*

²⁰ *Consistent Care Matters: Exploring the Potential of Social Work Practices*. Julian Le Grand, 2007

process significantly. For example, the local authority that wanted to pilot a third sector model with an existing provider advertised the tender specifically to voluntary sector organisations it had already worked with. Another that aimed to commission a social enterprise model precluded bids from private or voluntary sector organisations by specifying that it sought an organisational structure with at least 50% ownership by qualified social workers to meet the requirement for the SWP to be social worker led. Only one local authority decided to adopt a completely open procurement process and consequently received interest from 16 organisations, four of which went on to submit bids. Another local authority decided not to enter into the standard procurement process but invited bidders to submit ideas about the approach that they would take to delivering a SWP. While this approach was considered to stimulate innovation, it also resulted in a lack of clarity and, from the British Association of Social Workers (BASW) perspective, a lack of transparency. Where local authorities struggled to identify bidders, Department for Children Schools and Families appointed-consultants played a role in stimulating interest and bids, using their networks of contacts.

The Social Care Practices Working Group anticipated that each practice would hold a budget, provided through the contract with the authority, and would use it to fund the placement, support and activities that they believed each looked after child should have. It was envisaged that SWPs would have autonomy and control over placement decisions.

Unfortunately not one of the SWPs had responsibility for a budget to fund placements for children coming into care. Commissioners working with local authorities and providers at the commissioning stage raised concern over the delegation of budgetary responsibility and the extent of decision making. Only one SWP that worked solely with care leavers had full control of a placement budget. Arguably this was a major flaw of the social work pilot programme. As none of the SWP practices had budget responsibility for care placements, it was not possible for the evaluation to report on the success or failure of any sub-contracting arrangements. This lack of evidence is a significant limitation, as without SWPs having accountability for placement budgets, it is difficult to properly analyse the effectiveness of the pilots.

The national evaluation concluded, *“SWPs as a group did not offer children and young people more choice regarding placements than was experienced by those in comparison sites.”* Arguably this is because SWPs had little, if any, control over the mechanisms for sourcing placements.

4.3 Looked after children

The evidence review highlighted particular concerns with the way placements for looked after children are commissioned in England. Focused attention is required on this cohort, due to the wider impact on capacity and diversity in the sector, and the increasing numbers of children in care.

Research shows that there is an increasing awareness of the importance of ensuring positive outcomes for looked after children. Adults who were taken into care when they were children are more likely to be involved in child protection investigations as adults and are 66 times more likely than their peers to have their own children taken in to care²¹. Improving outcomes for care leavers now would reduce the levels of social work support required in the future and bring about the much-needed capacity in child protection work.

Research on international outsourcing arrangements showed that where outsourcing had taken place, government departments had usually prioritised the outsourcing of placement services for looked after children and in the majority of cases, these were the first social care services to be outsourced to

²¹ *Research and Priorities - Children in Care*. DfE March, 2014 <https://www.gov.uk/government/publications/children-in-care-research-priorities-and-questions>

independent organisations. This decision had largely been made as there was an existing market for these services, but also with an objective that this would release capacity in the public authority to focus on child protection, family support and care management responsibilities.

Where outsourcing in other countries had been a success, there was a common view that this was largely due to the creation of a provider/commissioner split, and clear mutually agreed contracts. There was general consensus that there is an inherent conflict of interest in organisations acting as both a funder and provider of services.

In England, there has long been a particular concern over the conflict of interest that exists due to local authorities both commissioning and providing placements for children in care^{22 23 24 25 26 27 28}.

Where care planning responsibilities are transferred to a statutory, voluntary or private organisation, there is a need to have a clear understanding of sub-contracting arrangements. Where the organisation also directly provides services to children, there should be consideration of the impact of transferring any existing conflict of interest to the new party. It may be necessary to ensure that those undertaking care management responsibilities do not provide and procure the same type of care services. An alternative approach would be to ensure that, within the organisation, the commissioner role is separated from the provider role and that there is independent evaluation of the decision making process. The SWP pilots were not modelled in a way that enabled testing of sub-contracting arrangements and as such, this area requires further consideration.

4.4 Children's homes market

- There is a lack of new entrants into the market and the risk of demand starting to outstrip supply. A prediction that the sector will see an ever-shrinking supply of providers resulting in a severe lack of choice. Or that the market will become dominated by one or two large providers who may capitalise on their market domination by pushing prices very high²⁹.
- Providers report that an increase in the number of children requiring specialist provision is making the process of matching supply with demand more challenging than ever before (DCSF, 2007b). Nevertheless, some experts within the field insist that there are many examples of high quality specialist residential resources within the UK that are capable of meeting even the most complex needs (NCERCC n.d). The problem with supply and demand, it has been argued, stems from the fact that commissioners are not aware of the full range of available provision; there is a lack of a national picture about the quality, specialism and geography of residential children's homes (Children's Commissioner, 2012). Outdated costing, sequential decision-making, rigid contracting mechanisms and burdensome tendering processes are all said to mitigate against a commissioner's ability to adequately assess the market (DfE, 2012a)³⁰.
- Causes of current fragile state of the market have been linked to frequently changing legislation, inappropriate commissioning policies, price driven procurement, local authorities not adhering to

²² *Pooling our Resources to Serve Children Well*. NCERCC, 2014

²³ *Fostering Aspirations - Reforming the Foster Care System in England and Wales*. Policy Exchange, 2010

²⁴ *Foster-Care Commissioning in an Age of Austerity*. Clive Sellick, 2013

²⁵ *Overarching Report on Children's Services Markets*. Price Waterhouse Coopers, 2006

²⁶ *Children's Homes and Fostering*. Price Waterhouse Coopers, 2005

²⁷ *Determining the Optimum Supply of Children's Residential Care*. Deloitte MCS Limited, 2007

²⁸ *Care Matters*. Placements Working Group Report, Lord Laming 2007

²⁹ *Residential Childcare: The 21st Century Challenge - Correcting a History of Market Failure*. Children England, 2014

³⁰ Action research into the more effective strategic commissioning of children's residential care homes, OPM – July 2013

statutory duties, Ofsted's inspection methodology, the unrecognised workforce, and a lack of commitment and support to develop positive commissioner and provider relationships³¹.

- Significant gaps exist in the understanding of the impact of the creation of larger providers through takeovers and mergers (sometimes backed by significant private finance) on outcomes, market competition and innovation in service³².
- Conversations with local authority commissioners showed that some have concerns that some independent organisations enter the residential care sector without the necessary skills, knowledge and experience to provide services for this vulnerable cohort of children.

4.4.1 Foster care market

- From 2000/01 to 2012/13, there has been a more than three-fold increase (up 342%) in the number of foster care days purchased from independent providers³³.
- The proportion of outsourced placements to agencies has steadily increased for more than a decade and there are now over 300 registered branches of agencies contracting with local authorities to provide foster care.
- 75% of all foster placements, commissioned externally, are provided by an oligopoly of a few, large Independent Fostering Providers³⁴.
- There is no agreed consensus on capacity in the market. The Fostering Network has reported a shortage of approximately 9,000 foster carers, yet 44% of places in the independent sector and 28% of places in the local authority sector are vacant. Emerging thinking that there is not a lack of choice, but possibly a lack of access to choice through ineffective procurement policies implemented at the front line³⁵.
- Market development is hindered by poor needs analysis *"local authorities tend not to have a good understanding of the needs of their looked after children, and the capacity of the local foster carer workforce (both local authority and independent) to meet these, which is an obstacle to effective recruitment, retention and commissioning strategies."*³⁶

4.4.2 Commissioning for looked after children placements

There is a widely held view that there is a fragmented market place and that current commissioning practice is having a negative impact.^{37 38 39 40}

Providers in the independent sector argue that, when commissioning care placements, local authorities fail to pay sufficient attention to the importance of outcomes and instead focus on providers' ability to

³¹ *Home Truths, the State of Independent Residential Childcare 2014*. Independent Children's Homes Association, 2014 http://icha.org.uk/uploads/files/icha_report_final_v3_1.pdf

³² *Research and Priorities - Children in Care*. DfE March, 2014 <https://www.gov.uk/government/publications/children-in-care-research-priorities-and-questions>

³³ <http://www.audit-commission.gov.uk/wp-content/uploads/2014/08/Childrens-services-vfm-briefing-18-Aug-2014-FINAL.pdf>

³⁴ *Foster-Care Commissioning in an Age of Austerity*. Clive Sellick, 2013

³⁵ *Research and Priorities - Children in Care*. DfE, March 2014 <https://www.gov.uk/government/publications/children-in-care-research-priorities-and-questions>

³⁶ *Foster-Care Commissioning in an Age of Austerity*. Clive Sellick, 2013

³⁷ *An Overview of Residential Special Schools, Children's Homes and Fostering Organisations*. Revolution Consulting, 2012

³⁸ Action research into the more effective strategic commissioning of children's residential care homes. LGA 2013

³⁹ *Foster-Care Commissioning in an Age of Austerity*. Clive Sellick, 2013

⁴⁰ *Death by Paperwork*. A joint report by the National Association of Special Schools, the Nationwide Association of Fostering Providers and the Independent Children's Homes Association, 2012

provide cost-effective services. From our research it was difficult to identify any procurement arrangements that had an effective mechanism for evaluating a providers ability to deliver effective outcomes for children.

The DfE paper *Research and Priorities – Children in Care*⁴¹ concludes that: “We need a better understanding of how the foster carer market is operating, including commissioning strategies and their impact on children’s outcomes, more detailed information about the reasons for placement vacancies, and better evidence about the unit costs of foster care in the independent, relative to the local authority, sector.”

Most recently a report by Impower⁴² has caused considerable debate in the sector. The report states that local authorities could save £150m by placing more fostered children with their own carers. Independent providers have challenged these claims, as they believe Impower’s analysis of the costs and benefits is flawed. The debate is contributing to a growing view that, as cost is an important factor in the commissioning process, there is a need for commissioners to have an accurate understanding of the true and comparable cost of placement services provided by local authorities and the independent sector.

In the sector, there is widespread acceptance that increased placement choice is vital to improve the matching of children to care placements and the subsequent outcomes and efficiencies that are delivered (The 2010 Sufficiency Guidance⁴³ was developed to maximise placement choice). Despite the repeated recommendation that local authorities introduce level playing field commissioning arrangements to maximise choice^{44 45 46 47 48 49 50}, it has not been possible to identify any one local authority in England with this model in operation. In 2013 a Freedom of Information request, made by CICADA services to all local authorities enquired about the procedures for sourcing placements for looked after children. The enquiry sought to find out if local authorities enabled access to choice, by allowing those looking for a placement to simultaneously consider available options in both local authority and independent provision. The research found that local authorities did not enable access to a choice of placements but restricted initial placement searches to the council’s own provision. The result of this practice is that those responsible for placement decisions will not be aware of all available options, some of which may be better placed to meet a child’s individual needs.

When in-house options are exhausted and the search moves to the independent sector, many local authorities have sequential procedures that restrict searches to providers on particular tiers. There is a further concern that cost plays too large a role in determining where providers are placed on these tiers, making it less likely that children, particularly those with highly complex needs, will be placed in the right placement to meet their needs.

⁴¹ *Research and Priorities – Children in Care*. DfE, March 2014 <https://www.gov.uk/government/publications/children-in-care-research-priorities-and-questions>

⁴² *Fostering Futures*. Impower, Oct 2014

⁴³ <https://www.gov.uk/government/publications/securing-sufficient-accommodation-for-looked-after-children>

⁴⁴ *Choice Protects*. 2003.

<http://webarchive.nationalarchives.gov.uk/20040117082828/http://doh.gov.uk/choiceprotects/partnership.htm>

⁴⁵ *Scoping the Market*. Price Waterhouse Coopers, 2004

⁴⁶ *Children’s Homes and Fostering*. DfES Children’s Services, 2005

⁴⁷ *Overarching Report on Children’s Services Markets*. Price Waterhouse Coopers, 2006

⁴⁸ Lord Laming Placements Working Group, 2006

⁴⁹ *Fostering Aspirations*. Policy Exchange, 2010

⁵⁰ *Outcomes and Efficiency*. Commissioning Support Programme, 2010

5. INTERNATIONAL EVIDENCE

5.1 United States

In 2012 it was reported that at least 14 states had some level of privatising their child welfare services, and that a number of other states were considering this⁵¹.

Successes in Illinois, Florida, and other states provide evidence that privatisation can lead to better outcomes for children and families, greater accountability and increased efficiencies. Yet less successful outsourcing of children's services has marred public opinion.

There are many privatisation arrangements in the United States and state legislatures that have played a major role.

Some states have enacted laws that promote privatisation, while others have enacted laws seeking to regulate and curtail such activity. At times, privatisation policies have changed dramatically from one year to the next within a state as a result of political or economic shifts, public response, or actual or perceived experience with privatisation.

5.1.1 Illinois

In 2011 the Childcare Association of Illinois published *Illinois Child Welfare: From National Disgrace to National Leader*⁵². The report describes how, in 1997, the Illinois child welfare system was regarded as the worst in America. The Illinois Department of Children and Family Services (DCFS) caseload had increased to more than 51,000 children and Illinois removed more children from their homes than any other jurisdiction in the country.

With worker caseloads approaching 50 to 60 children each, the situation eventually prompted massive ongoing reform by the Illinois General Assembly. By as early as 2000, the reforms had already won widespread recognition, reducing the number of state wards to 15,500, greatly improved child safety, and earned Illinois a reputation as a national model of child welfare service delivery.

The legislative reforms vastly expanded the role of the private sector, introduced and contractually enforced performance measures and emphasised evidence-driven public policy innovations designed to promote safety and permanence for Illinois children.

Specific measures included:

- Increased use of the private sector to provide foster care case management and treatment.
- Increased case management authority for the private sector agencies.
- Performance based contracting.
- Private sector initiatives that helped appropriately return children from out-of-state residential placements.
- Expansion of family preservation efforts to minimise the number of children who enter care.

⁵¹ *Privatization of Child Welfare*. Alliance for Children and Families, 2011

⁵² *Illinois Child Welfare: From National Disgrace to National Leader*. Margaret Berglind, President Child Care Association of Illinois, Spring 2011

5.1.2 Florida

In 2012 the Platt Institute undertook research on the privatisation efforts in Florida⁵³. It describes how in the 1990s, Florida's child welfare system was criticised for being one of the worst in America. Florida lost up to 500 children who disappeared from the state's foster care system and state officials were unable to account for their whereabouts. The report details how, by 2012, Florida had some of the best child welfare outcomes in the country for reducing out-of-home care, adoptions and safety in and out of the foster care system.

This report also details how, in 1996 a state statute mandate directed the Florida Department of Children and Families (DCF) to privatise foster care and child welfare services state-wide by 2003. The lead agencies involved managed foster care and child welfare case management while Florida's DCF or the county sheriff's office continued to handle child protection investigations. The original legislation called for DCF to establish five pilot programmes to privatise case management functions in five regions. The pilot projects were given significant freedom and autonomy in deciding the scope and focus of their work. The individual projects were diverse, each addressing privatisation from a unique perspective. The evaluations found that four of the five initial pilots were not successful. The fifth programme was successful, however, and considered to be the model for replication. Four of the five pilots failed for a variety of reasons including issues around federal funding, complexities over agreeing risk share, ineffective data systems and changes in specification. An independent evaluator reported that the loss of a key individual in one pilot programme had a lasting and damaging impact. He also noted that *"Comparisons of the individual projects to each other are limited due to project differences"*. Specifically, the projects serve different populations and each has a different scope. Such differences include serving only children entering care for the first time versus serving first time placements and existing cases; a difference in terms of scope is including adoptions versus not including adoptions. The project-specific characteristics limit comparability across projects."⁵⁴ Based on the one successful pilot, the state of Florida decided to move forward with the statewide privatisation of child welfare. The privatisation implementation took five years, with one region at a time privatised. By March 2005, the statewide transition to privatisation was complete. The final governance structure had 20 lead agencies providing child welfare services in specific geographic areas in the state's 67 counties, managing 500 sub-contractors, and providing service to approximately 20,000 children.

In 2006 Florida was the only state to take advantage of an IV-E Foster Care Waiver. The waiver allows a state's Department of Social and Health Services to be more flexible in the ways it uses federal child welfare funding. Federal child welfare funding is usually determined by how many children are in state care and the funding structure gives states a financial incentive to keep children in foster care. The DCF requested a flat funding fee, like a block grant, that it could spend on front-end services such as counselling and other interventions, instead of just foster care. The DCF assumed the financial risk because if the foster care population increased, the state would not receive any more federal funding.

In the 2010 Casey report⁵⁵ there was consensus among child welfare stakeholders that the IV-E Waiver had been one of the most crucial components of the success of privatisation. The waiver allows federal foster care funds to be used for any child welfare purpose rather than being restricted to out-of-home care. As the Florida lead agencies discovered, *"the money follows the child and not the foster care"*

⁵³ *Next Steps for Child Welfare Reform in Nebraska*. Lisa Snell, Platt Institute, 2012

⁵⁴ *Interim Evaluation of Florida's Child Welfare Privatization Projects*. Brian Peacock, March 1998

⁵⁵ *An Analysis of the Kansas and Florida Privatization Initiatives*. Casey Family Programs, April 2010

placement.” In addition to the waiver, Florida participants also identified a cultural shift in Florida towards family-centred practice as being critical to the improvements in foster care outcomes.

In 2010, Casey Family Programs published *‘The Need to Reauthorize and Expand Title IV-E Waivers’*⁵⁶. It concludes that *“the reauthorization and expansion of Title IV-E waivers is a critical stepping stone on the path to comprehensive child welfare finance reform. A much-improved balance among family support services, services to extended family caregivers and foster care services can be financed from IV-E dollars in states experiencing large declines in their foster care populations. Title IV-E waivers provide an opportunity to rigorously evaluate new reform strategies and approaches to comprehensive finance reform.”*

An independent study in 2012⁵⁷ ranked Florida as the fourth best in the country at protecting children from abuse and neglect. Florida scored high on reducing the overall foster care population, reducing abuse in foster care, rapid response to child abuse inquiries, and finding permanent homes for children.

Whilst Florida’s privatisation arrangements are being reported as a particular success, it is critical to acknowledge the length of time this has taken.

The April 2010 Casey report, found *“the most consistent message echoed among the Florida lead agency directors was that the first few years of the Florida transition to privatization was extremely challenging, with some informants stating that it was the most trying period of their career.”* However, the lead agencies stated that, *“Once the transition issues were addressed, the system as a whole stabilized and both quality of services and outcomes for children and families improved.”* In fact, all of those interviewed in the Casey report acknowledged that even with the challenges in the early years, *“the child welfare system has dramatically improved since the transition to privatization.”*

It is worth noting that some of the states in which outsourcing is reported as successful, such as Illinois and Florida are described as previously having child welfare services that were ‘some of the worst in America’ which indicates they may have been starting from a low baseline.

5.1.3 Kansas

The research undertaken by the Platt Institute⁵⁸ also considered privatisation efforts in Kansas. In 1996 Kansas became the first state to privatise its child welfare system. The Kansas privatisation effort was implemented very rapidly which resulted in confusion around roles and responsibilities, and a shortage of services during the initial transition. In addition, with a lack of baseline data about the cost of serving each child in care, the state and the contractors severely underestimated the cost in the first round of child welfare cost management. As a result some agencies declared bankruptcy or went out of business.

However, while Kansas initially had a rocky start to their child welfare privatisation initiative, today they have better data, cost-information, and more accountability than most child welfare systems in the nation.

Kansas has privatised three major components of child welfare: family preservation services, foster care, and adoption. Private contractors have exceeded expectations in finding permanent homes for foster children and reportedly provided superior services in all three categories. In the first year, Kansas saw a

⁵⁶ *The Need to Reauthorize and Expand Title IV-E Waivers*. Casey Family Programs, May 2010

⁵⁷ Foundation for Government Accountability, 2012 Right for Kids Ranking, <http://rightforkids.org/> (accessed January 29, 2012.)

⁵⁸ *Next Steps for Child Welfare Reform in Nebraska*. Lisa Snell, Platt Institute, 2012

44% increase in the number of finalised adoptions. Inquiries from families wanting to be adoptive parents have tripled since privatisation.

Kansas has seen the number of children in residential placement decrease from 1,064 to 421 since 1997 and the number of adoptions has more than doubled in the same time period. In addition, the average length of stay in care has decreased from 23 months to 16 months.

In January 2013 the Kansas Department for Children and Families announced that due to the success experienced, it had signed eight new contracts for reintegration, foster care, adoption services, and for family preservation services. There are no plans to outsource child protection services⁵⁹.

5.1.4 Nebraska

In 2009, the state of Nebraska began contracting with private companies and non-profits to provide child welfare and juvenile justice services after national indices showed Nebraska removed too many children from their homes⁶⁰.

Moreover, Nebraska received low marks from the Federal Child and Family Services Review that evaluates how well states provide safety, permanency, and wellbeing for children. A comparison of federal data for 2009 showed the rate of Nebraska children removed from their homes was 12% – more than double the national average of 5.6%. Data demonstrated that Nebraska has rated either first or second highest in this category for at least 10 years.

In January 2011, the Department of Health and Human Services (DHHS) took child welfare privatisation further and turned over case management to the two lead agencies in the Eastern and Southeastern child welfare regions.

Since this time, Nebraska legislators have been investigating the state's implementation of child welfare privatisation. Three of five lead agencies selected in July 2009 to manage services to children and families had withdrawn from the privatisation effort by November 2010. In addition, a November 2011 Nebraska Performance Audit Committee report⁶¹ found that while DHHS initially insisted that *"privatisation would be accomplished within existing resources, by August 2011 it had, in fact, paid the contractors \$30.3 million more than originally planned."* In Nebraska the private contractors and the state agencies underestimated the cost of foster care and the private providers misjudged the scope of work to be done. A 2011 report by the Legislative Fiscal Office⁶² noted that the cost information and other projections provided to the contractors were inaccurate from the beginning of the privatisation efforts. The lead contractors signed the contracts based on information that severely underestimated the level of care and number of children that would be referred to the agencies.

After the huge cost overruns and financial instability among the child welfare contractors, Nebraska mostly abandoned its privatisation effort in 2012. Across the board, legislators, foster parents and child

⁵⁹ <http://reason.org/news/printer/apr-2013-child-welfare-privatization>

⁶⁰ *Next Steps for Child Welfare Reform in Nebraska*. Lisa Snell, Platt Institute, 2012

⁶¹ *DHHS Privatization of Child Welfare and Juvenile Services*. Performance Audit Committee Nebraska Legislature, Committee Report, Vol. 17, No. 1, November 2011, <http://nebraskalegislature.gov/pdf/reports/audit/privatization2011.pdf>

⁶² *Fiscal Overview of Child Welfare Privatization in Nebraska*. Nebraska Legislative Fiscal Office, 18 October 2011 http://nebraskalegislature.gov/pdf/reports/committee/health/lr37_ch6.pdf

advocates now say Nebraska's privatisation effort failed because it was ill conceived, rushed, and inadequately funded⁶³.

5.1.5 Missouri

In 2005, Missouri began a process of transferring the states foster carers over to private agencies implementing performance-based contracts in the process. The process was very inclusive from the beginning, with private providers and state officials working collaboratively in the best interests of children. Providers helped plan what the system would look like and together, parties identified the right performance measures. Under privatisation, lead agencies receive a flat monthly case rate based on an average caseload. They can subcontract with other providers as needed, and performance goals are tied to financial incentives.

In 2013, the *Missouri Child and Family Plan*⁶⁴ reported that outcomes for children in care had improved, particularly since 2010. This reinforces the learning from other areas where it is reported that outcomes are best realised several years after privatisation has been implemented.

5.1.6 Pennsylvania

In 2012, the Casey Family Programs published *Improving Outcomes for Children in Philadelphia: One Family, One Plan, One Case Manager*⁶⁵. This sets out The Department of Human Services (DHS) strategy for reforming child welfare services in the state. The DHS calls its package of reforms Improving Outcomes for Children. It outsourced the state's foster care services and has commissioned community umbrella agencies (CUA) to provide case managers for the 4,095 children in foster care and the 949 families receiving at-home help.

The state of Pennsylvania has placed particular importance on culture change and does not use the term privatisation, instead choosing to focus language on improved outcomes for children.

Each CUA has a community advisory board selected by the community that develops and implements a community engagement plan. The expectation is that the community, not the government, should inform what the service delivery continuum looks like.

There are plans for the DHS to remain legally responsible for children in its system and for investigating abuse and neglect reports.

In January 2012 the city's annual report claimed that there had been a significant improvement in outcomes. "*We've taken a common sense approach to addressing problems that includes: working hard to keep children in their own homes; thinking expansively about the definition of family; reducing dependence on congregate care; collaborating with cross-system partners, such as the school district and mental health system, to develop creative alternatives to placement; and involving families and the community in developing appropriate and culturally competent solutions. This year, we've also delivered on promises that have been talked about for decades.*"⁶⁶

⁶³ *Privatization Fails: Nebraska Tries Again to Reform Child Welfare*. Kevin Hanlon, 2012

⁶⁴ *Title IVB, Child and Family Services Plan*. Missouri Department of Social Services, Children's Division, June 2013

⁶⁵ *Improving Outcomes for Children in Philadelphia: One Family, One Plan, One Case Manager*. Casey Foundation, 2012

⁶⁶ *Improving Outcomes for Children*. City of Philadelphia Annual Report 2012

5.1.7 Oklahoma

Legislators passed five bills in 2012 that changed the organisation, leadership, operation and transparency of the Oklahoma Department of Human Services (DHS). The legislation required the DHS to privatise all types of community- based out-of-home placement, including traditional foster care, kinship care, emergency foster care, contract foster care, and therapeutic foster care, on or before 1 July 2013⁶⁷.

As this is a recent development, it has not yet been possible to identify any validated outcomes.

5.2 Canada

In 2012, The Commission for Child Welfare published its report *Realizing a Sustainable Child Welfare System in Ontario*⁶⁸. The report describes how, for more than 100 years in Ontario, Children's Aid Societies (CASs) have played an important role in protecting children – intervening and providing support when children's needs and safety are not met by their family or community. CASs in Ontario are independent organisations empowered by the Ontario government. They have the exclusive mandate under the Child and Family Services Act to protect children who have been, or are at risk of being abused and/or neglected by their caregivers, to provide for their care and supervision where necessary and to place children for adoption. CASs have authority to remove children from homes where they face either a risk of harm, or have experienced harm.

In 2009, there were widespread concerns about the quality and sustainability of child welfare services in Ontario. Funding on child welfare had doubled over a ten-year period and there was insufficient evidence that outcomes were improving. Questions were raised about child welfare management and service delivery. In response the government established the Commission to Promote Sustainable Child Welfare with a mandate through to September 2012 to develop and implement solutions to ensure the long-term sustainability of the child welfare system. The Commission was created as an independent, arms-length body to bring expertise and an objective perspective to examine the system and to set it on a path to long-term sustainability.

In 2012, the Minister of Children specifically designated 46 CASs and Youth Services to investigate child abuse and neglect, and take the necessary steps to care for children and youth in need of protection. CASs are regarded as non- government organisations which allows a large degree of autonomy from interference or direction in the day-to-day running of CAS by the Ministry. The Child and Family Services Review Board exists to investigate complaints against CASs and maintains authority to act against the societies. The societies receive funding from, and are under the supervision of the Ontario Ministry of Children and Youth Services. The Government of Ontario and the Government of Canada have a cost-sharing agreement for funding certain social services to First Nations children and families living on reserves.

The Commission developed a systems framework through which to critically examine all aspects of the organisation and delivery of child welfare in Ontario against the definition of sustainability. In short, the Commission observed a system with many strengths capable of delivering much greater value if purposeful changes were made to address its deficits. The Commission's systemic evaluation child welfare in Ontario concluded that the sustainability strategy required:

⁶⁷ *Oklahoma Pinnacle Plan*. Oklahoma Department of Human Services, 2013

⁶⁸ *Realizing a Sustainable Child Welfare System in Ontario*. Commission to Promote Sustainable Child Welfare, September 2012

- A reconfiguration of child welfare service delivery to ensure that all CASs have the capacity to deliver timely, high quality services and that collectively, the system can optimise the value and outcomes realised from the funds invested.
- A funding approach that results in a more equitable distribution of available funds provides CASs with the latitude and accountability to determine the most effective response to meeting local needs and fosters agency resiliency.
- A new framework of accountability to bring greater focus, clarity and results-orientation to efforts across the child welfare system.
- Reducing and streamlining administrative burden.
- Approaches that draw on the strengths and traditions of Aboriginal communities.
- Broader integration across all children's services.

The 2012 *Realizing a Sustainable Child Welfare System in Ontario* report⁶⁹ stated “Over the course of its mandate the Commission has worked in partnership with the Ministry, CASs and others to begin to implement the sustainability strategy. Much progress has been made.”

5.3 Australia

Under the Government's 2011 *Building Australia's Future Workforce* package, the Australian government is investing significantly in the Communities for Children programme⁷⁰.

The Communities for Children programme established in 2004, funds NGOs (Non-Governmental Organisations) as 'Facilitating Partners' around Australia to develop and implement a whole-of-community approach to enhancing early childhood development.

Facilitating Partners play a facilitating and strategic role in the local area, and sub-contract with other local NGOs ('Community Partners') to deliver programmes in their areas of expertise. If an appropriate Community Partner is not available, the Facilitating Partner can deliver services but must work with local community organisations to build their capacity to deliver the necessary services in the future⁷¹. By endeavouring to not provide services directly, there is a clearer separation between commissioning and providing, and conflict of interest can be avoided.

Each site establishes and maintains a 'Coordinating Committee' of NGOs and other stakeholders who oversee programme development. Examples of activities implemented under Communities for Children include: home visiting; early learning and literacy programs; parenting skills training; and child nutrition programmes.

Evaluation of the initiative in 2009 showed that there was, on balance, a positive impact. The government made the decision to invest further resources and a second evaluation is currently underway⁷². 60 More recently the Committee for Community Services in New South Wales evaluated the work on the facilitating

⁶⁹ *Realizing a Sustainable Child Welfare System in Ontario*. Commission to Promote Sustainable Child Welfare, September 2012

⁷⁰ <https://www.dss.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program/family-and-children-s-services>

⁷¹ *Communities for Children Facilitating Partner Operational Guidelines*. Australian Government, May 2014

⁷² *Stronger Families in Australia Study: the impact of Communities for Children*. National Evaluation Consortium, <http://www.aifs.gov.au/institute/pubs/fm2010/fm84/fm84d.html>

partners in the area and concluded they were effective. In 2013 there was a recommendation to expand the provision^{73,61}

With regards to children in care, Australian states are making increased use of NGOs providing care placements. In New South Wales the increasing demand for placement services, and the related impact on capacity and service delivery across wider social care services led to the outsourcing of all placement services to NGOs in 2011. The state, not the facilitating partner, contracts directly with these NGOs⁷⁴.

All states remain responsible for child protection investigations and are responsible for children who are at significant harm.

5.4 New Zealand

In developing the 2012 *White Paper for Vulnerable Children, the Child, Youth and Family Service in New Zealand* consulted with key experts in health, justice, education and social services. The consultation indicated that members of the public may be unsure about reporting any concerns they may have, and may not feel comfortable notifying the department. The *Children's Action Plan 2012*⁷⁵ sets out plans for a new Child Protect line that will provide a single point of contact for members of the public to report any concerns they have about children or young people. There are plans for this to be operational by the end of 2014 and for it to be run by a non-statutory agency.

The Child Protect line will be managed by trained professionals who will still refer the most urgent cases to the Child, Youth and Family Service, which will be responsible for undertaking initial investigations.

These urgent referrals will be dealt with by multi agency children's teams, early family support or universal services, depending on the presenting issues and needs of the children, young people and/or their families.

The Child Youth and Family Service commissions over 700 organisations on a national and regional basis. Critically, they also maintain a national central website providing up to date information on contractual arrangements across the country. This well-managed web based resource is fundamental in supporting the model.

New Zealand is piloting 'high trust contracting'⁷⁶. This is a new approach towards the way government funds the community social services sector. The aim is to increase capacity and diversity by enabling community organisations to focus more on the families they serve and less on ticking boxes, complex paperwork and reporting.

High trust contracting provides:

- A short, simple funding agreement
- Payment of funding up front, in annual instalments
- Meaningful, outcomes-focused, year-end reporting
- A focus on outcomes – results are agreed on and described
- Flexible service delivery – enabling providers to better meet the needs of families in their local community

⁷³ *Outsourcing Community Service Delivery*. Legislative Assembly of New South Wales, 2013

⁷⁴ *Outsourcing Community Service Delivery*. Legislative Assembly of New South Wales, 2013

⁷⁵ <http://www.childrensactionplan.govt.nz/action-plan/white-paper/reporting-child-abuse/>

⁷⁶ <http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/high-trust-contracting/>

- A customised approach – recognising the holistic needs of families and ensuring that the contract reflects this.

The essence of high trust contracting is reflected in the principles that guide the funding relationship. These include:

- Respecting and valuing each other's expertise
- Acting with integrity and good faith
- Recognising accountabilities
- Having open, transparent, honest and timely conversations.

To be eligible for a high trust contract, community organisations need to have a strong and trusted relationship with government.

6. KEY INSIGHTS FROM EVIDENCE

6.1 Types of contract models

6.1.1 Lead agency model

Under the lead agency model, the public agency contracts with one or a limited number of agencies to provide specified services for the target population from referral to case closure, or some other point specified in the contract. Some lead agencies provide most if not all services with few or no subcontracts. Others procure most services and a few deliver no services directly. Some lead agencies are single agencies that typically are non-profit with long histories of providing services to public agencies. Others are newly formed corporations that are created by two or more child welfare service agencies who decide to collaborate rather than compete on a lead agency procurement. Lead agency contracts may or may not tie payments directly to performance, but public agencies typically look at past performance when they re-tender contracts. Some lead agencies have outcomes-based contracts with their subcontractors as well.

6.1.2 Outcomes-Based Contract model

Instead of using lead agencies, some public agencies enter directly into outcomes-based contracts (OBC) with agencies that offer specified services. It was evident that there is a shift away from contracting for outputs (holding agencies accountable for how things are done) towards contracting for improved outcomes for children and families (holding agencies accountable for results).

It was not possible to identify which contract model works best. Innovative practices and improved results have been noted in all types of models. Conversely, all types of contracts have also experienced failure. Results at improving outcomes are mixed across all types of contracts. Some contracts have exceeded expectations, some were dismantled, and others still were modified and expanded. As for the cost of the contracts, some initiatives cost far more than expected, others redirected resources to serve more people for the same cost, and only a few resulted in actual savings.

6.2 Consultation and partnership working

A strong message harvested from the evidence review was that effective and wide consultation is vital to the success of outsourcing of children's services and that success is far more likely when all parties are engaged in building a shared vision. A strong partnership between public, independent and voluntary organisations and a high level of trust was deemed essential.

The National Quality Improvement Centre conducted an in-depth study of arrangements in Florida, Illinois and Missouri⁷⁷. It concluded, *"Given the complex relationship between public and private partnerships within a performance-based contracting system, the collaborative planning process was identified as one of the most important factors in the success or failure of their efforts. Although the structure of the decision making process was different across sites, it was evident that the sites took an inclusive approach when negotiating performance-based contracts and designing quality assurance and quality improvement systems."*

⁷⁷ *Performance Based Contracts and Quality Assurance Systems*. National Quality Improvement Centre on the Privatization of Child Welfare Services, 2011

The nature of the public-private partnerships in each site shows that the groups had a collaborative communication structure, process, purpose, goal, environment, and partners. While some variations existed, the results generally demonstrate that the public-private partnerships were collaborative in their initial planning process and maintained that over time.

There was some recommendation that partnership development and culture change was best facilitated by an independent and impartial party^{78 79}.

6.3 Implementation

The way in which outsourcing is undertaken is critical to its success. General consensus was that Nebraska's privatisation effort failed because it was ill-conceived, rushed, and inadequately funded. That caseworkers hired by the private companies had caseloads that were too heavy and in many cases did not have enough training to deal with the complexities of the welfare system. Evaluation concluded that implementing privatisation state-wide rather than in stages or pilots was a mistake, and that lead contractors may have underestimated challenges and costs⁸⁰.

The Reason Foundation found that costs were significantly higher than predicted, at least in the first few years. It also stressed the importance of implementing such change slowly, in phases. The 2011 Reason Foundations annual report⁸¹ gives the following examples:

"Florida, for example, began with five pilot projects, four of which failed and had to be abandoned. When it finally did go to a state-wide system, it did so gradually over a period of several years."

"When Kansas tried to transition its entire system in just two years, it overwhelmed both the state and its non-profit partners, leading to serious problems. Those interviewed in Kansas reported that the state implemented their initiative very rapidly, which resulted in confusion around roles and responsibilities, and a shortage of services during the initial transition. There is common consensus that for privatization to be a success, implementation should be meticulously planned ensuring that funding and start-up time are factored in. Studies showed that outsourcing should be phased with effective project management in place."

6.4 Contracting and quality assurance

The Casey Family Programs (2010) found that the trend in recent years has been to move away from traditional models of contracting toward performance-based contracting with a focus on improved outcomes for children⁸². Rather than simply contracting for a subset of specific child welfare services, the trend has also favoured transferring case management to the private providers, thus giving them primary decision-making authority over day-to-day case decisions. A number of publications reviewed made reference to the advantage of creating competition between the public and private sector suggesting that healthy competition between public and private providers can be positive. *"The Illinois model permitted the most competition among private and public providers and achieved the best results in increasing adoptions and eliminating inefficient providers"*⁸³.

⁷⁸ *Outsourcing Community Service Delivery*. Legislative Assembly of New South Wales, 2013

⁷⁹ *Privatization of Child Welfare Services: A Guide for State Advocates*. McCullough & Freundlich, 2012

⁸⁰ *Privatization Fails: Nebraska Tries Again to Reform Child Welfare*. Kevin Hanlon, 2012

⁸¹ *Annual Privatization Report 2010: State Government Privatization*. Reason Foundation, February 2011

⁸² *An Analysis of the Kansas and Florida Privatization Initiatives*. Casey Family Programme. April 2010

⁸³ *Privatizing Adoption and Foster Care*. E. A Blackstone, A. J Buck & S Hakim, 2004

The National Quality Improvement Centre identified critical factors that any site needs to consider when designing such a system⁸⁴:

- The importance of selecting the appropriate contract performance measures and aligning those outcomes with shared goals across public-private partnerships.
- The importance of setting appropriate benchmarks for performance in contracts and collaboratively monitoring performance.
- The importance of having and using reliable data to assess performance and improve quality (QA/QI).
- The importance of sharing risk in a contractual relationship between public and private agencies.

One criticism of outsourcing is the increased capacity required to effectively procure services and ensure quality contract management and service monitoring. It is not possible for one single provider to provide services for all users and, as such, a degree of subcontracting is inevitable. This, in effect, means that an additional administrative layer is introduced between the responsible authority and the organisation delivering services directly to the user.

A good example is that of Florida where lead agencies provide the majority of delegated services but are allowed, with some exceptions, to enter into subcontracts for child welfare services with other organisations. They can do this without obtaining prior approval from the state and are given the responsibility for monitoring and quality assurance of these subcontracts. This poses an inherent risk to the Department of Children and Families (DCF), because it must rely on the lead agency to provide assurance that the DCF is in compliance with its legal and fiduciary responsibilities for the care, safety and protection of children.

To ensure this, it was necessary to invest significant resources into developing contract monitoring and quality assurance systems. Each lead agency was responsible for quality assuring their own in-house services and subcontracted services using common methodology. The state's contract management units approved lead agency plans and validated quality assurance reviews. To enable lead agencies to carry out their quality assurance responsibilities, the DCF eliminated roughly half of its quality assurance staff statewide and transferred these funds to lead agencies⁸⁵. It is interesting to note that some lead agencies challenged the competence of the DCF to manage and monitor contracts. This led to independent bodies undertaking contract monitoring for a period of time.

Much of the evidence reviewed raised significant concerns about capacity, experience, skills and competence in relation to procurement and contracting. There was recognition that the social care sector is unique and requires a culture of contracting that focuses on social value and the delivery of child-centred outcomes.^{86 87 88}

In England there are a variety of local, sub-regional and regional arrangements in place for commissioning placements for looked after children. There is no centrally maintained database providing an overview of these arrangements, resulting in wide scale duplicated effort in organisations allocating resource to keep

⁸⁴ *Performance Based Contracts and Quality Assurance Systems*. National Quality Improvement Centre on the Privatization of Child Welfare Services, 2011

⁸⁵ *Outsourcing of Child Welfare Services – Has effective oversight been established?* Office of Inspector General Internal Audit

⁸⁶ *Privatization fails: Nebraska tries again to reform child welfare* - Kevin Hanlon 2012

⁸⁷ *Outsourcing Community Service Delivery* - Legislative Assembly of New South Wales. 2013

⁸⁸ *Privatization of Child Welfare Services: A Guide for State Advocates v McCullough & Freundlich* 2012

informed of activity across the sector. It is believed that there are in the region of 20 different regional and sub-regional frameworks for commissioning foster care, with an additional 30 frameworks managed by individual local authorities. In addition to this, there are four different databases on which fostering providers may need to register.

A similar picture exists for the children's homes sector. The resource required to respond to each tender/database is considerable and, as most providers offer services across several local authorities, the duplication required to submit applications is significant.

The national contracts for foster care and children's homes are not used by all local authorities, with many choosing to 'tweak' these for regional or local variation. Where terms and conditions differ, this creates complex problems for providers who then are required to develop a number of different policies and procedures to satisfy each of the local authorities they contract with.

The independent sector reports that contracting practice is diverting significant resources from front line services and having a negative impact on service capacity and potentially the viability of some independent organisations.^{89 90}

6.5 Technology

There was wide reference to technology and this was clearly seen to be a critical area for attention. In Kansas, the first few years were reported as being extremely challenging. Agencies received no state funding for start-up costs, which were significant. Contracting agencies had to develop sophisticated internal management tools, such as comprehensive information technology systems, to quickly capture and measure outcomes.

This was one of greatest investments, but proved one of the most significant factors in the organisation's success under the privatised system.

In New South Wales, Australia, the lack of appropriate technology was seen as a particular risk. A common view was that the future evolution of outsourcing would depend on access to sophisticated computer software programs and applications. A recommendation was made for centralised development of interactive technology systems⁹¹.

Success in Florida is partly attributed to collaboration between private providers and the state to develop a new computer system to better track the children in foster care and the actions taken by caseworkers on any child's case. One innovation that has grown out of the Miami privatisation effort is that Florida is now known for the most modern and accurate child-tracking system in the nation.

In 2007, through a partnership with AT&T, the Miami partnership launched OK Connect, a project that puts readily available technology and business solutions – such as digitally imaged case files, rugged laptops, Internet connectivity, smart phones equipped with cameras and GPS – into the hands of 270 case workers and staff that work directly with children and families. Compliance with mandatory 30-day home visits has grown to almost 100% in Miami since the project began. Case managers say that the new tools have made them feel like they could get their job done for the first time⁹².

⁸⁹ An overview of residential special schools, children's homes and fostering organisations – Revolution consulting'

⁹⁰ Death by Paperwork – A joint report by the National Association of Special Schools, the Nationwide Association of Fostering Providers and the Independent Children's Homes Association 2012

⁹¹ Outsourcing Community Service Delivery - Legislative Assembly of New South Wales. 2013

⁹² Next Steps for Child Welfare Reform in Nebraska. Lisa Snell. Platt Institute 2012

6.6 Data

The need for baseline data is paramount to enable the comparison of results before and after implementing significant reform. The absence of such makes it very difficult to determine if outsourcing has succeeded.

Most initiatives faced tremendous data challenges that created high risk for all parties. There is a need for accurate and timely sharing of data. Knowing baseline information from which to measure success or failure is critical⁹³.

6.7 Communication

Experience showed that there was greater 'buy in' from all parties when there was an effective communication policy in place. *"An effective and ongoing communication policy is vital to ensure that all stakeholders are kept well informed of developments."*⁹⁴

6.8 Outcomes

Where privatisation had taken place with effective planning and partnership working, there were reports of positive impact and improved outcomes for children. A summary of positive outcomes for Illinois, Kansas and Florida can be seen in the table below.

However, privatisation has not always been successful. In Nebraska privatisation was implemented without clear benchmarks or indicators of performance for the state or lead agencies.

The lack of clear benchmarks or performance indicators eventually resulted in three of the five private agencies selected in July 2009 to oversee services withdrawing from the effort by November 2010. In addition, private contractors and state agencies underestimated the cost and scope of the work, so by August 2011 DHHS had paid the contractors \$30.3 million more than originally planned.

The Legislative Fiscal Office later noted that the cost information and other projections provided to the contractors were inaccurate from the beginning of privatisation efforts⁹⁵.

Examples of privatisation of outsourcing in the United States

ILLINOIS	KANSAS
Fewer children in care: Illinois has reduced its caseload from nearly 51,000 (in 1997) to 15,500 (in 2010) children in care – a 69% reduction in the foster care caseload compared to the national reduction of 24%.	During the four years of privatisation in Kansas only 2% of all children were returned to state custody compared with 12% for the nation as a whole.
More children placed in permanent homes: More than 40,000 children moved out of foster care to adoption and guardianship over the last decade.	Since 2003, Kansas has met national safety standards for assuring children are safe from recurrent abuse (94.6% of children are rated safe from recurrent abuse).
Fewer children entering care: Better screening and expanded use of family preservation efforts has helped reduce the number of children entering care to one of the lowest in the nation.	For the last ten years the state of Kansas has met the national benchmark for safety in foster care placement with 99.68% of children safe from maltreatment while in foster care. In 2010, 98% of new Child in Need of Care (CINC) reports, which are initiated when children first

⁹³ Privatization of Child Welfare Services: A Guide for State Advocates v McCullough & Freundlich 2012

⁹⁴ Privatization of Child Welfare Services: A Guide for State Advocates. McCullough & Freundlich, 2012

⁹⁵ Next Steps for Child Welfare Reform in Nebraska. Lisa Snell, Platt Institute, 2012

	have contact with the Kansas child welfare system, are reviewed timely by a social worker (within one half work day) to determine if further action is needed by the agency.
Children in least restrictive placements: Illinois has reduced the number of out-of-state residential placements by building private agency capacity to manage severely compromised children locally.	The rate of repeat maltreatment in Kansas has fallen below both the national standard and the national average.
Child permanency: The permanency rate for children has more than doubled since 1997, to 30.6% today.	The federal government's national benchmark for child welfare outcomes, the Children and Family Services Review (CFSR) 2010, found that of 36 states considered: Kansas ranked in the top 5 performers for four of seven national CFSR outcomes.
Child Stability: 90% of children who exit care to reunification with parents, adoption or guardianship are still stable after 2 years, and 85% are still stable after 5 years.	

FLORIDA
By 2011, adoptions in Florida increased by 46%, the number of children placed in 'institutions' dropped by 65%.
The number of children safely reunited with their families increased by 13% and the adoption rate among children with disabilities increased by 92%.
Florida's foster care numbers dropped from about 29,000 in 2006 to under 20,000 for the 2011 fiscal year. It is critical to acknowledge that it took six years for these outcomes to be realised.

6.9 Delivering financial efficiencies

It was difficult to determine whether or not outsourcing in other countries had resulted in cost savings. There were varied opinions and there was clearly difficulty in determining the best methodology by which to calculate any savings.

Although many states in the United States assumed that privatisation would lead to cost savings, this was not the case in Kansas or in Florida. In fact, both states increased their funding upon implementation, more than doubling their child welfare budgets in the first ten years. However, it was reported that costs levelled off eventually and additional resources were reinvested in other services such as prevention. In Florida, the average expenditures increased for the first four years, but during the last three years the expenditures were lower for the private providers, and far fewer dollars were spent on out-of-home care⁹⁶.

The state of Kansas had to invest more money in its child welfare system, but the quality of services went up exponentially. *"Although there were a lot of critics at first, audits and independent reviews show the same thing: Kansas and its children are now in much better shape."*⁹⁷

⁹⁶ *An Analysis of the Kansas and Florida Privatization Initiatives*. Casey Family Programs, April 2010

⁹⁷ *Privatization of Child Welfare*. Alliance for Children and Families, 2011

In England, although the evaluation of SWPs did not include a full cost-benefit analysis, local authority commissioners did not consider that the pilots had reduced costs and, in some cases, costs were considered to be higher than those of the equivalent in-house service⁹⁸.

The Alliance for Children and Families concludes *“although privatisation often is touted as a cost-saving measure, most evidence doesn’t support this, at least not in the short term. Instead, efficiency and quality must be the true aspirations.”*⁹⁹

⁹⁸ Social Work Practices: Report of the National Evaluation, Department for Education 2012

⁹⁹ <http://alliance1.org/magazine/issue3-11/privatization-child-welfare>

7. CONCLUSION

A review of international literature showed that, where another body other than the state provides social care services, there are a wide variety of models that exist to govern these arrangements. A key finding was that success or failure depends largely on the quality of partnership working, organisational culture, and the skills and ability of leaders to champion genuine and trusting relationships.

Successful outcomes were evident where new models are overseen by expert project management, were appropriately resourced and supported with an effective communication and quality assurance strategy. Evaluations of models placed a particular emphasis on the importance of early and wide consultation with all stakeholders, at all levels.

Negative opinion about the effectiveness of outsourcing was more prevalent where there had been a lack of consultation, where implementation had been poorly managed or where evaluations had taken place shortly after a new model had been introduced. There was a common view that any new architecture must acknowledge the length of time required to achieve agreed outcomes and that there must be a focus on the attainment of long term outcomes as true progress is best measured over several years.

The positive impact of privatisation has been observed – namely in the United States – in Illinois, Kansas and Florida. However, elsewhere, the same positive outcomes were not apparent, and were likely linked to a lack of focus on partnership working as well as unclear benchmarks and indicators, and a poor understanding of cost-base and scope of work at the outset of implementation.

From the evidence reviewed it was difficult to find many examples where the responsibility of initial child protection investigations had been transferred to a non-government organisation (NGO). Largely, where any outsourcing of welfare services had been a success, it should be noted that child protection had remained the responsibility of the authority or state.

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