Quality requirements in youth care tenders

M. Wiegman
S1505319
Master health sciences

Examination committee:
Prof. Dr. J. Telgen
Prof. Dr. A. Need

External committee:
Msc. M. Driedonks
Msc. M. Wietmarschen

August 23, 2018

SUMMARY

This research provides an overview of the quality requirements in tenders for youth care in the Netherlands. Quality requirements were obtained from a total of 988 contracts. Chi-square tests on starting dates of the contracts and the number of collaborations between municipality per contract confirmed. The random sample is therefore representative for all tenders in the Netherlands.

A total of 459 distinct quality requirements were found in the study with a mean of 28 quality requirements per tender. Four different ways were used to divide the quality requirements:

1. According to quality indicators found in literature;
2. In the different specifications of services or products;
3. Considering the amount of administrative burden in requirements;
4. In which section of the tenders the quality requirements were mentioned.

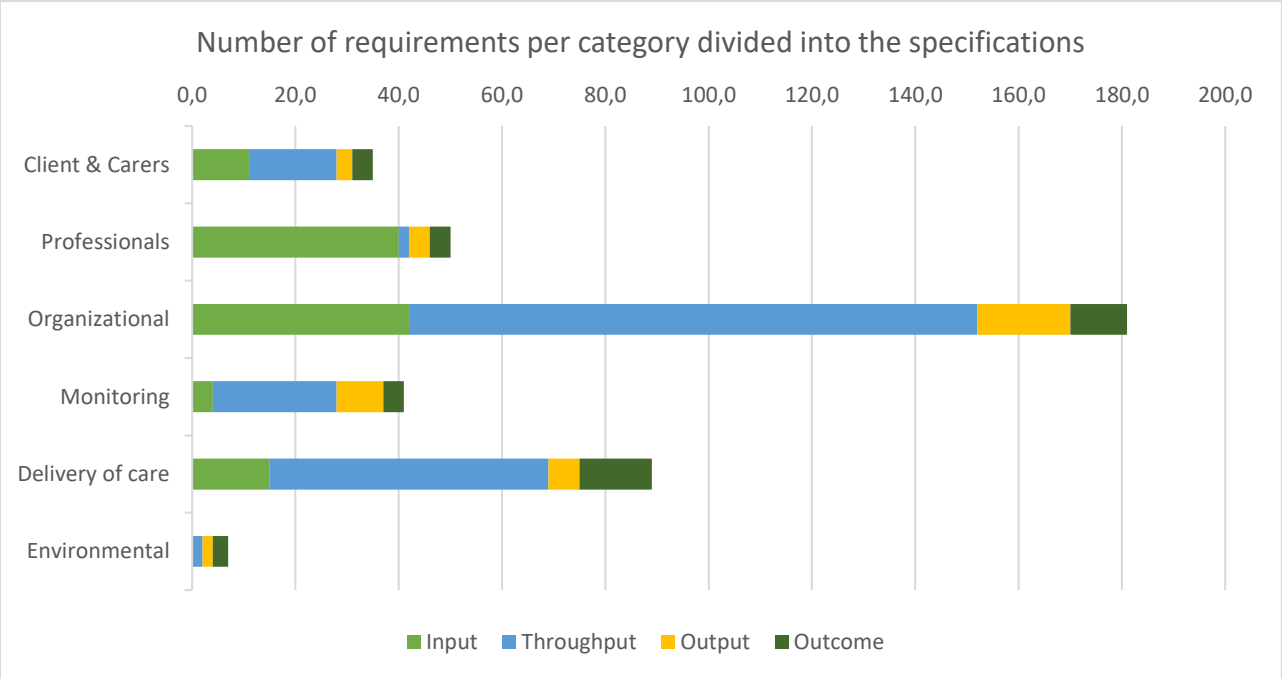
Almost all quality indicators found in literature appeared in youth care tenders. Although many requirements were formulated by municipalities themselves, not much difference was seen in the distribution of quality requirements over the quality indicators per youth care category.

Specifying the type of product or service is necessary in order to concretize the service or product that is required. These can be technical specifications - input and throughput - and functional specifications (output and outcome). The use of technical specifications might be considered as easier than the use of functional specifications as they give municipalities more power in shaping the youth care. In addition to this, technical specifications are also easier to cover the procurer for eventual mistakes by care providers. These arguments seem to are substantiated as the technical specifications made up for 82% of the total quality requirements observed. This could be interpreted in a way that municipalities seem to have little trust towards youth care providers, which is supported by the fact that nearly 90% of the quality requirements were extra requirements arranged by municipalities in addition to the mandatory national quality requirements from the Dutch law and regulations.

The administrative burden is one of the complaints from health care providers due to the (quality) requirements that municipalities require in tenders. The analysis revealed that one in five quality requirements requires some sort of administration, of which 40% requiring returning administrative tasks. Highest number of administrative requirements were seen in contracts for forced youth care.

The sections of tenders in which the quality requirements are mentioned, indicates the role of the quality requirements – from soft wishes to hard demands on the services or the providers. Most frequently quality requirements were observed in the statement of specifications, as minimum requirements. Some requirements were observed multiple times in two or even all three sections and it seems that municipalities do not use the full potential of the different sections.

Only little variety in types of requirements for the different youth care categories was observed. As the youth care in different categories varies quite a lot we argue it might be good for municipalities to critically review their requirements in tenders regarding to check if these are in line with the goals of their policy.



PREFACE

At the beginning of this year I contacted Professor Jan Telgen for a master thesis about the procurement of youth care in the Netherlands. One subject familiar, as procurement has been a course in the master health sciences, but the other quite unfamiliar. Six months later I am happy to say that these two subjects have become well known and are one of my greatest interests when thinking of the health care in the Netherlands.

This experience of working together with colleagues at the Dutch Youth institute and the Public Procurement Research Centre has helped me in developing personally and professionally and I hope that you will enjoy reading this report.

I would like to thank my first supervisor Jan Telgen for the opportunity and for his guidance throughout the research. Also do I want to thank my supervisors Marloes Driedonks and Martijn Wietmarschen for all their time, the factual consultations we had in these past months and especially for receiving me with arms wide open and giving me the feeling that I was respected.

Finally, I would like to thank Madelon Wind for her tips, thoughts and pleasant conversations in the last months.

Kindest regards,

Marjolein Wiegman

Contents

1. BACKGROUND

Since January first 2015, a new youth law was implemented in the Netherlands that obliged municipalities to purchase youth care for its citizens. The goal of the new youth law is to simplify the juvenile system and make it more efficient and effective. The ultimate goal is to strengthen the own power of the youngster and strengthening the caring and problem-solving capacity of his or her social environment (Friele, 2018). To achieve this goal, a transformation to a more integral care system is needed. For this reason, youth care procurement has shifted to municipalities to create a so called open-market for youth care providers which should increase the efficiency and effectiveness of youth care. The Dutch youth care can be divided in seven different categories, which all have different care providers. This makes the procurement of youth care a complex task for the unexperienced municipalities.

1.2 Quality requirements

Quality requirements are a tool that municipalities can use to improve the efficiency and effectiveness of youth care. Municipalities tend to specify many different requirements, especially for the quality of care, as they often think in risks and want to be as sharp as possible (Dahl, 2016). This leads to unnecessarily long legal texts, inconvenient purchasing procedures and increased administrative work for youth care providers (Friele et al. 2018; Dahl, 2016). Although municipalities are responsible to guarantee the quality requirements, it is unknown how many of these and which type of quality requirements are taken into account in the Netherlands.

Municipalities are obliged by the youth law to formulate a policy about the youth care provision in their municipality. Within this policy, nine national obligated quality requirements should be taken into consideration, see appendix 1 for the requirements (Rijn, Teeven & Opstelten, 2018). Youth care institutes and providers need to cover these nine different quality requirements according to the youth law (Rijn, et al., 2018.; VNG, 2014). These quality requirements can be extended with extra quality requirements formulated by municipalities, which most of them do to cover risks (Dahl, 2016).

1.3 Problem statement

There are complaints from care providers about the high amount of (quality) requirements municipalities include in their youth care tenders, but an overview of the exact number and the variety in the requirements is not available (Friele, 2018.; Dahl, 2016).

This study will investigate the number and the variation of quality requirements that municipalities include in their tenders for youth care procurement. The aim of this study is to gain knowledge and insight in the use of quality requirements by municipalities in the Netherlands for all forms of youth care and to provide an overview of the way municipalities apply the quality requirements in the tenders. This will be

done by answering the following research question: *In what way do municipalities apply quality requirements in the tenders for the different youth care categories?*

The outcome of this research will be relevant for societal purposes and also for scientific purposes, which both will be described in the next parts of this chapter.

1.4 Societal relevance

The outcomes of this study can be used by municipalities and organizations which are involved in the procurement or which give advice to municipalities about the procurement of youth care. The results will lead to insight in the purchasing strategy which might influence choices for youth care policy in municipalities, as it will provide an overview of the different ways Dutch municipalities use quality requirements in youth care tenders. A better understanding of the different ways, with their positive and negative effects, will lead to a more appropriate procurement strategy and eventually to a more effective youth care supply. Tenders are an important tool for shaping the youth care in the Netherlands and early detection of possible bottlenecks is desirable to protect vulnerable youth in becoming the victim of mistakes due to the lack of procurement experience.

1.5 Scientific relevance

In the years after the establishment of the new youth law in 2015, many reports have been published about the different purchasing strategies used by municipalities and the corresponding bottlenecks.

A first evaluation of the youth law has recently been published by the Dutch Youth Care institute in collaboration with ZonMW (Friele, 2018). Both, the 'Vereniging van Nederlandse Gemeenten' (VNG) and the Dutch Youth Care institute, state that not all effects of the new youth law on the procurement of youth care have been studied (Friele, 2018). The VNG and the Dutch Youth Care institute are involved in providing guidelines for municipalities for the youth care procurement (VNG, 2018).

The evaluation shows that especially data about the quality of youth care has not been systematically collected yet (Friele, 2018). Therefore, this study has scientific relevance because it will deliver insight in the focus of quality requirements that should lead to a good quality of youth care.

1.6 Readers Guide

For the first time a study about the quality requirements in youth care tenders used by Dutch municipalities will be performed. The information in this report will be organized as followed:

Chapter 2 will start with the research problem and provides the general method of the study. Chapter 3 will provide information about possible quality requirements substantiated with literature. After understanding the possible quality requirements, it is time to zoom in on the tenders. Chapter 4 will provide

information on the data collected. The analyses that will be done in this study will be discussed in Chapter 5. These analyses will lead to the results of the study, in Chapter 6. The last chapter of this report will discuss the results.

2. RESEARCH QUESTION AND METHODOLOGY

This chapter provides information about how the problem has led to the research questions of the study. After the research questions are explained, the chapter will show a general overview of the study design that will be covered in more detail in the following chapters.

2.1 Research problem and question

The aim of this study is to gain knowledge and insight as to the way municipalities use quality requirements in tenders for different youth care categories. All these youth care categories involve different care providers and institutions. Knowledge about all different categories is required to be able to make reliable decisions that will improve the efficiency and effectiveness in a specific youth care category. The different youth care categories are (Uenk, Wind, Telgen & Bastiaanssen, 2018):

1. Youth care without stay:
    a. Dyslexia care,
    b. Mental health care
    c. Ambulatory remaining
2. Youth care with stay:
    a. Day care
    b. Foster care
    c. Residential care
3. Forced management:
    a. Youth rehabilitation and protection

To perform a structured study with a useful outcome, the following research question will be asked: W*hat way do municipalities apply quality requirements in the tenders for the different youth care categories in the Netherlands?*

The goal of this study is to perform an exploratory research to gain knowledge about the way municipalities use quality requirements in tenders for youth care institutes in the Netherlands. The research will explore what variety in quality requirements are seen in tenders in Dutch municipalities and provide an overview of the ways all municipalities use the tenders to steer on quality in youth care. Figure 1 shows a general overview of the study design. This figure will become more detailed in the following chapters.

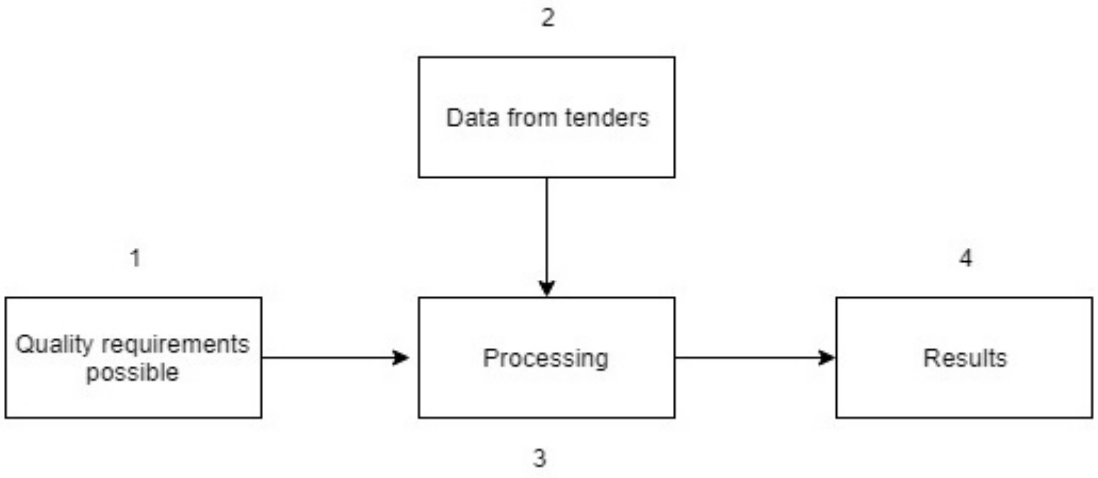


Figure 1: General overview of the study design.

Part one: Quality requirements possible

The first part of the research design is about collecting information about possible quality requirements. First, general information about quality requirements will be covered to get insight in quality requirements possible followed by two literature reviews to collect more specific information about quality requirements in youth care tenders. These literature reviews are performed to show the different types of quality requirements and in what way the quality requirements can be used in tenders.

Part two: Tenders

The second part of the study will provide the data from the youth care tenders. This part will provide more detailed information about the scope of tenders, the way these tenders are collected, the number of tenders available through municipalities and the number of procurements done by municipalities in the Netherlands. This part of the study is necessary in order to perform the analyses needed to answer the research question by matching the quality requirements to the different tenders that will be included.

Part three: Processing

This third part focusses on processing the first two parts of the study together. It provides information about the way the collected data from quality requirements and tenders will be analysed in chapter five.

Part four: Results

The last part of the study will show the results of the analyses in chapter six. It will start with the results of the overall data. After this part, a paragraph about results per youth care category will be given. The conclusion and discussion of the results is covered in chapter seven.

3. POSSIBLE QUALITY REQUIREMENTS

This chapter will start with an overview of relevant quality requirements from national law in the Netherlands. After collecting these quality requirements, literature reviews have been performed with the aim to find additional quality requirements for youth care. As there is little literature available about this relatively new subject, it is chosen to perform two literature reviews instead of one. The first literature review focusses on quality requirements in youth care tenders. The second review focusses on quality requirements used to assess the quality of youth care, collected from international literature about youth care and about services of youth care.

3.1 Obligatory quality requirements

It is not new that quality requirements are used to influence the quality of care. Since 1996, a Quality Law was established in the Netherlands which has set 4 general quality requirements (Ministry of Health, Wealth and Sports, 1997):

1. Health care institutions should deliver justified care, that has a good standard and is at least effective, efficient, patient-oriented and tailored to the real need of the patient.
2. Health care institutions should have a policy which states whom of the health care providers are allowed to do what, and who is responsible for that:
    a. Institutions should obtain enough qualified health care providers, they should have a certain degree and it should be possible for them to retrain.
    b. Institutions should have the right materials to provide care.
    c. If a health care institution provides care for over 24 hours, mental health care should be provided that is related to the religion of a client.
3. Health care institutions should have a quality-system to systematically measure the quality in an organization. The information about quality is used to examine if targets and results are achieved or that these have to be adjusted to lead to good health care (Inspection for Health care, 2017).
4. Health care institutions should write an annual quality-report in which they give account to their quality policy. At least the quality of provided care and the quality of their policy should be discussed in this annual report.

The Dutch Quality Law also states that “supervision by the Dutch inspection of health care is necessary” (Ministry of Health, Wealth and Sports, 1997).

The inspection provides reports and gives advice for health care institutions and providers. The inspection shows in a basic set of quality indicators that medical specialists have the highest direct influence

on quality of care. The indicators are: the professional standard, the distribution of responsibilities, accountability, quality control and improvement (Ministry of Health, Wealth and Sports, 1997).

Next to the quality of providers can health care institutions use a quality label to achieve monitoring, managing and improvement of care. Additionally, quality labels help in improving transparency of an organization (Inspection for Health care, 2017). Another obliged system that health care organizations need to implement according to the Dutch inspection, to guarantee its quality, is a 'report code' for domestic violence and child abuse. This report code should consist of five different steps to optimize its effectiveness and is made available by the Dutch inspection (Inspection for Health care, 2017).

Finally, health care providers can measure the quality of care by measuring client satisfaction. This client satisfaction can for example be measured when looking at the complains. Therefore, health care institutions should provide a complaints mechanism according to the Dutch inspection (Inspection for Health care, 2017). Also, client satisfaction evaluations can be done to measure the level of satisfaction among clients (Inspection for Health care, 2017).

These requirements from the Dutch Quality Law, complemented by the requirements from the Dutch inspection, were summarized in a manual for procurement from PIANOo, in which is stated that a provision is of good quality if it provides safe, effective, efficient and client oriented care; if it is tailored to the real need of the resident and if it is attuned to other forms of care or assistance that the resident receives; if it is provided in accordance with the professionals' responsibility, resulting from the professionals' standard and; if it is provided with respect for and compliance with the rights of the client (PIANOo expertise Centre for tendering, 2017).

The quality requirements that are from the national quality law and the Dutch inspection of health care are summarized as the following six requirement specifications:

1. Requirements about justified care and standards used in care, also requirements about effectiveness, efficiency, patient-oriented requirements and those tailored to the need of the patient;
2. Requirements about the policy of the health care institute, including requirements about whom is responsible or allowed to do what and requirements about materials;
3. Requirements about quality systems or monitoring of quality of care, for example client satisfaction;
4. Requirements about the ending of care to guarantee that clients, and their social network, are prepared to go further independently or requirements about a transmission to the adult care;
5. Requirements about annual or periodical reports about the quality or results or care;

6. Requirements about the nine obliged quality requirements, such as the report code and use of protocols.

3.2 Literature reviews

The literature study is divided in two different literature reviews which will be conducted to gain knowledge important for the format of the study, see figure 2.

The first literature review should answer the following question: *What quality requirements are known from previous use in tenders for youth care procurement in the Netherlands?*

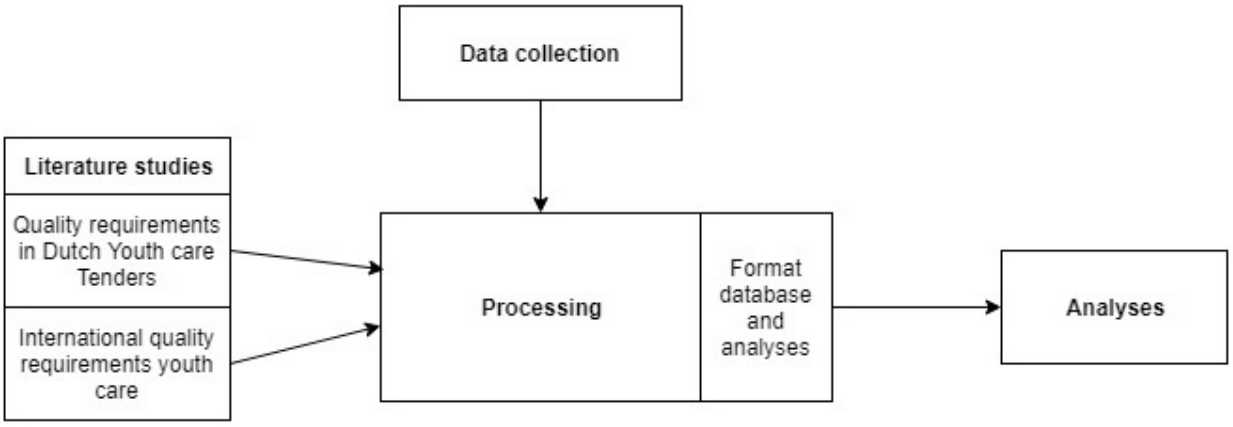


Figure 2: Research design showing the first phase of the study in more detail.

Google Scholar was used for this literature study, using the search terms ‘Aanbesteding’ OR ‘Aanbesteden’ AND ‘Jeugdhulp’ OR ‘Jeugdzorg’ AND ‘Kwaliteitseisen’ OR ‘Kwaliteitscriteria’.

Articles published since 2015 were included, which resulted in a total of 25 hits with the selected time range and search terms. Only articles of which the title or abstract showed that the article provides information about quality requirements for youth care were included, see table 1 for the number of excluded publications and the reason of exclusion. This literature review was used to determine which quality requirements should be taken into account in the quantitative data analysis and which quality requirements not.

Table 1: Exclusion criteria and the number of excluded publications of the first literature review.

Exclusion criteria	Excluded (N)
No full text available	1
Books	3
Subject different in title	4
Subject different in abstract	5
Total	13

After this first exclusion, 12 articles were read for further information about the subject. Another 5 articles were excluded, as they did not match the subject required for the literature review. Appendix 2 table 18 provides an overview of the excluded literature with a short explanation why. The 7 remaining studies were included in the study, shown in appendix 2 table 19.

3.3 Review 1: Quality requirements in Dutch youth care

Introduction

Since 2012, a procurement law is valid in the Netherlands, which requires conditions for the procurement of (youth) care (Manunza, Bouwman & Lohmann, 2015). This law includes a proportionality principle to guarantee fair ratios between differences in interests, objectives and instruments in a tender procedure (Manunza et al. 2015). The government also wants to achieve that the process of contracting will involve quality requirements with the procurement law (Andriessen, Stavenuiter & Verleun, 2015). The youth care providers who match the formulated requirements should get higher scores and higher chances on contracts (Andriessen et al. 2015). However, practice shows that it is hard to state quality requirements in contracts due to different interests between municipalities and the providing youth care institutes (Andriessen et al, 2015; Uenk, Eijkel & Ommen, 2015). This is especially the case if the quality of care is hard to measure, in for example multi-morbid cases or with prevention programms (Uenk et al., 2015).

Quality requirements in tenders

None of the Dutch publications showed examples of additional quality requirements formulated by municipalities for youth care and only technical specifications about how quality requirements should be formulated were found.

A report about the legal changes to improve tenders reveals that it is only allowed to set requirements that concern the local context which is needed to guarantee that tasks can be performed as intended and that (quality) requirements should not result in discrimination regarding the choice for youth care institutes (Manunza et al., 2015). This means that quality requirements can only be included in a contract when the municipality is able to monitor the performance of that requirement (Uenk et al. 2015).

Niels Uenk, adviser for care procurement in the Netherlands, states that some municipalities make too many demands regarding quality requirements as they think in risks (Uenk et al., 2015). This leads to more requirements than necessary, which affects especially small care providers negatively (Uenk et al., 2015). When using the administrating tendering method, care providers are allowed to participate in drafting the requirements (Uenk et al., 2015). Information whether this strategy leads to less requirements is not known yet.

Only little literature is available about additional quality requirements seen in tenders for the Dutch youth care. Nothing more than insight in technical rules for requirements was found but nothing about possible quality requirements seen in youth care tenders.

In order to collect more information about quality requirements in youth care, a second literature review will be performed, collecting international data. Also, publications since 2010 will be collected.

The second literature review should answer the following question: *What type of quality requirements are known from previous studies on youth care?*

The following search terms were used in Scopus: 'Quality of care' OR 'Quality requirements' OR 'Quality criteria' AND 'Youth care'. A total of 375 hits with the selected search terms came up. The publications published between 2010 and July 2018 were included, which resulted in 195 publications. Only publications from European or US journals were included in the study, resulting in 42 publications left for further selection based on title and abstract.

Only publications of which the title or abstract suggested that it is about the quality of youth care or the quality requirements for youth care were included. The exclusion criteria that were taken into account are displayed in table 2, which also shows the number of articles excluded per criteria.

Table 2: Exclusion criteria and the number of excluded publications of the second literature review.

Exclusion	**Excluded (N)**
Publications before 2010	180
Publications that were not from journals	22
Publications other than European or US publications	131
Publications of which the title or abstract did not match the subject	24
Total	357

A total of 18 articles were left for inclusion of the review, though 8 more articles were excluded after reading the text. In two cases the full text was not available and for other publications did the subject not match the required content for the literature review. A total of 10 articles were included and the most important findings of these studies are described in the paragraph below. Table 21 in appendix 2 provides a more detailed overview of the excluded articles and table 20 provides the most important findings per included articles.

3.4 Literature review 2: International quality requirements

Introduction

This literature review provides an overview of quality requirements or recommendations for quality of youth care. First, outcomes of different studies about early childhood care and education are shown, followed by studies focussing on residential care and eventually foster care.

Early childcare and education

Many of the included literature in this review focusses on the quality of early childhood education combined with care (Kuger, Kluczniok, Kaplan & Rossbach. 2016, pp 2, Vermeer & Groeneveld, 2017, pp 2). For both child care and childhood education is the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R) widely used to associate child care quality with child development (Kuger et al. 2016 pp 3; Gordon, Fujimoto, Kaestner, Korenman, Abner. 2013 pp 1). The scale compares in both situations the same structural factors which refers to factors that are measurable and regulated (Kuger et al. 2016 pp 2). Other factors seen in quality of care scales such as health conditions, health risks and complexity of care are too detailed to take into account for municipalities in the procurement process (Bethell, Kogan, Strickland, Schor, Rokertson, Newacheck. 2011 pp 4).

The study of Kuger et al. (2016) distinguishes two different types of structural quality factors:

1. Context factors, or also labelled as structural factors, which describe the overall characteristics of a setting such as housing and facilities, working material, staffing and;
2. Process quality, which refers to teaching and learning interactions in child-professional interactions.

Another study focussing on the early childhood educational programs also focused on structural quality. This study took the teacher–child ratio, group size, and teacher educational level into account (Hartman, Warash, Curtis & Day Hirst. 2016, pp 3). Hartman et al., states that the process quality refers to the more proximal factors of direct care given by teachers and staff which assist children in developing physically, linguistically, intellectually, emotionally, and socially (Hartman et al. 2016, pp 3). When structural quality is well regulated, process quality has been found to improve cost, quality and child outcomes (pp 3).

As structural quality factors are measurable, this study focused on the following indicators to determine the quality of early childhood programs (pp 5):

1. Group size
2. Child to teacher/staff ratio
3. Teacher education
4. Environmental quality (43 items were assessed such as space, furniture, structure etc.)

These factors showed that only 10% of the early childhood care in the US could be considered as high-quality care.

In addition to these factors measured by Hartman et al. (2016), were the following indicators found in the study performed by Kuger et al. (2016):

1. Years of teaching experience
2. Teaching satisfaction
3. Composition of a group
4. Space per child (in quadrant metres)
5. Number of staff involved
6. Staff turnover.

The study of Kuger et al. (2016) also took the process quality into account by assessing the educational processes, using the German versions of the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R) (pp 8). The results showed that context factors that were regulated by federal law (e.g., child–staff ratio, space per child) were more stable in quality outcome and that the sample of 97 classrooms in 97 settings all scored medium on the ECER-R scale (Kuger et al.2016, pp 15)

Quality is broad and can also be studied from the child's perspective. Vermeer & Groeneveld (2017) conducted a study about the stress perceived in children in childcare, measuring their cortisol levels. The results showed that children who go to childcare have increased cortisol levels compared to children who stay at home. They tried to find triggers for the children's physiological responses to childcare. The childcare quality, including caregiver-child interactions and global quality, seemed to associate with cortisol as well as the quantity of care (Vermeer & Groeneveld, 2017).

These studies about early child education provided different factors that have an influence on the quality of care and that are measurable. However, it is important to take into account that these studies did not specifically focus on childcare for children with disabilities though the quality of care will be influenced by the same structural factors as well (Gordon et al. 2013). It is also interesting to discuss what quality exactly is when looking at care settings. According to Renzou & Sakellariou (2012), the concept quality is subjective and perceived differently by researchers, parents and children. They studied this by asking parents to fill in the ECER-R scale and had a researcher fill in the ECER-R for the same classrooms as well. The results showed that parents scored overall 2 whole points more on the ECER-R scale in different settings compared to the researchers. Therefore, it is recommended to take the perspectives of all these involved parties into account when trying to evaluate the quality of care.

Another factor not taken into account in the previous studies about childhood care was the accessibility of the education and care. Vanderbroek & Lazzari (2014) performed a study to discover main causes for unequal accessibility of high quality early childhood care and education. The results of the study show that the accessibility of services should be organized on three different levels: policy level, provision level and the parental level. They recommend:

1. Public funding
2. Integrated education and care system
3. Entitlement (policy on all children)
4. Policies that regulate parental fees according to income
5. Quality monitoring
6. Democratic decision-making
7. Outreach (actively engaging with groups that tend to be less visible within the local community)
8. Flexible opening hours
9. A diverse workforce to give a welcome message to minority communities
10. Inter-agency corporation (integrated centres that cooperate across sectoral and institutional borders)
11. Parental involvement
12. Provide accessible and meaningful information

It should be taken into account that these recommendations are based on academic literature of which no search method was shown in their report. Nonetheless, many of these recommended requirements are structural and measurable and can therefore be applied in the procurement of the different youth care categories. The requirement for public funding will not be taken into account for this study, as this study focusses on quality requirements for health care providers and services. Another requirement that will not be taken into account is the requirement for a policy that regulate parental fees, as parents do not have to pay fees for youth care obliged by the Dutch youth law since 2016 (Rijn et al., 2018).

Data from the literature review for quality of mental health care performed by Baars, Evers, Arntz & Merode (2010) showed that outcome indicators and process indicators are most used measurements for the quality of care in literature about performance management (pp 2). They distinguished three common purposes of performance management: accountability, quality improvement and performance management (Baars et al. 2010 pp 3). This study focusses on the more detailed quality indicators, as these fit the three purposes of performance management.

Foster care

An intervention review including 102 quasi-experimental studies performed by Winokur, Holtan & Batchelder (2014) shows that children in kinship experience fewer behavioural problems, have fewer

mental health disorders, experience a better well-being and have less placement disruption than children in non-kinship foster care. It is therefore recommended to support the practice of treating kinship care as an out-of-home placement option for children who get removed from their homes (Winokur et al. 2014, pp 20). This outcome will be used as a requirement to stimulate out-of-home placement in the social network of a child and if the child has brothers or sisters, that these will be placed in the same family.

However, a study performed in Denmark, including data of 225 young people who entered care, showed that not the characteristics of the youth influenced the risk of care disruption, but the care environment did (Jakobsen 2013, pp 3). Caring for more than one young person in the setting increased the risk of disruption, while placement in open residential care decreased the risk. The recommendation of the study is to implement more social context in order to understand why care disruptions occur often. This is translated to a requirement about involving the young people in decision-making when drafting a health plan and in setting the goals.

It is interesting to see that these findings are the opposite of the findings from Winokur (2014) in which is recommended to place brothers and sisters all in the same kinship foster care, though Jakobsen (2013) showed that the risk of care disruption increases when there are more juveniles that need care in the same situation. This shows that these requirements found from the literature review should be used with caution.

Conclusion

Only literature about the early childcare and education, mental health care and foster care were found in this literature review. No specific requirements for the other youth care categories were collected, though most of the requirements that were found in this review are general and can be used for all youth care categories. Table 3 in paragraph 3.5 shows an overview of the quality requirements that were found in the literature review together with quality requirements found in Dutch national laws.

3.5 Overview quality requirements from literature

The possible quality requirements, or indicators, that were collected from the literature review are shown in table 3. These requirements are completed with the six quality requirements found in the Dutch Quality law and the requirements from the Inspection of care.

Table 3: The collected quality requirements from literature with the author of the source given per requirement.

Main subjects	**Quality indicators**		
Client & carers	Democratic decision making ➢ Parents/carers ➢ Children	Patient-oriented	
Professionals	Experience	Turnover	
	Education	Caregiver-child interactions	
	Satisfaction		
Organizational	Integral care ➢ With education	Accessibility ➢ Flexible opening hours	Policy ➢ Entitlement
	Protocols	Certificates	Complaints committee
	Stimulation of diverse workforce	Report code	Confidential counsellor
	Code of conduct	Client council	Actively reaching out in region
Monitoring	Evaluations ➢ By providers ➢ By parents/carers ➢ By children	Annual & periodical reports ➢ About quality ➢ About results	
	Monitoring of quality	Quality systems	
Delivery of care	Ending of care	Effectiveness & Efficiency	Stimulating social network ➢ Foster care in social network
	Justified care & standards	Evidence-based interventions	Number of staff involved
Environment	Space per child	Composition of a group	
	Group size	Environmental quality	

4. TENDERS AND DATA

This chapter will discuss the tenders and provides information about the way the data is collected. See figure 3 for an overview of this part of the study.

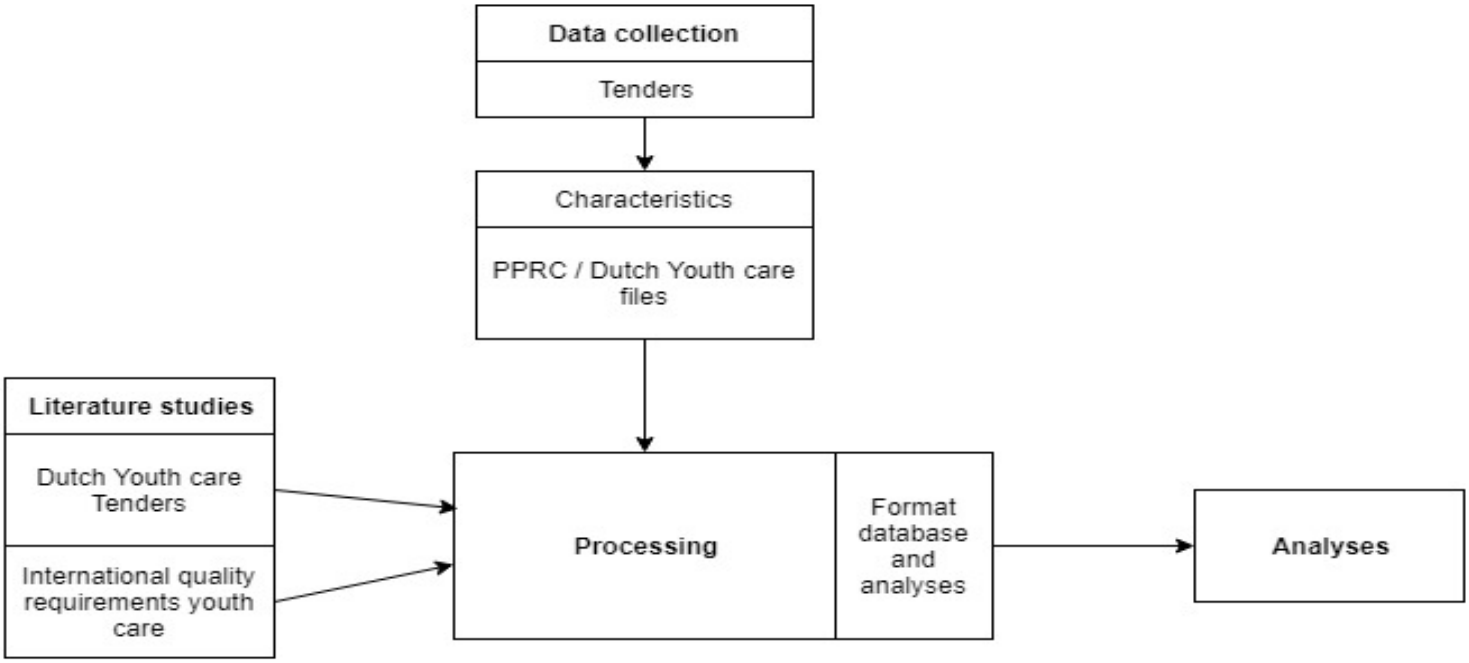


Figure 3: Research design showing the second phase of the study in more detail.

4.1 Collecting tenders

In a previous study, performed by PPRC and the Dutch Youth institute, tenders valid on January first 2018 were collected. These tenders were made available for this study. The tenders were available per municipality and seven different youth care categories were distinguished per municipality. Quality requirements for each of these seven youth care categories were collected from the tenders by reading all of them in detail.

4.2 Number of tenders

The tenders available for this study were collected from the 380 municipalities in the Netherlands. All these municipalities need to procure the seven different youth care categories, which is often done in corporation with several municipalities (Uenk, Wind, Telgen & Bastiaanssen, 2018).

The total number of tenders collected from the municipalities by PPRC and the Dutch Youth institute was 2548, which was 96% of the total tenders (7 x 380 = 2660 tenders as total).

The youth care category with the least coverage was forced management, of which 78% (N=298 municipalities) of the tenders was collected whereas the other percentages of the collected tenders in the other youth care categories was 98% (N=371 municipalities) or higher (Uenk, 2018).

The quality requirements in this study were collected by reading tender documents. The data collection stopped when at least 20% of the youth care tenders in the Netherlands was included in the study to limit the amount of work for this study.

The total number of tenders included in this study represent a total of 988 care contracts for the seven youth care categories together. Most contracts resulting from the tenders were found for the ambulatory care categories: dyslexia, mental health care and the ambulatory remaining with 154 contracts each. The least included youth care category is the forced management, with respectively 106 contracts. This can be explained by the procurement strategy that is mostly used for forced management, as nearly 20% of the forced management gets subsidized, a procurement strategy in which there is no need to use tenders (Uenk, 2018, pp 35).

In most cases, Dutch municipalities procured youth care in sourcing collaborations. Table 4 shows – broken down per category of youth care – the numbers of tenders and the total number of municipalities taking part in these outsourcing. From these results the average size of collaboration per type of youth care.

Table 4: Procurement collaborations for youth care shown per youth care category.

Youth care category	Number of outsourcing collaborations	Number of municipalities outsourcing	Average number of municipalities in a collaboration
Dyslexia	14	154	11.0
Mental health care	15	154	10.3
Remaining ambulatory	15	154	10.3
Day care	13	139	10.7
Foster care	11	138	12.5
Residential care	13	143	11.0
Forced management	9	106	11.8

Municipalities procure youth care since 2015, table 5 shows the number of contracts valid on January 2018 per starting year in the 988 contracts included in this study.

Table 5: Starting year of the total number of contracts included in the study.

Starting year	N	%
2015	205	20.7%
2016	17	1.7%
2017	289	29.3%
2018	477	48.3%
Total	988	100.0%

The number of contracts with a starting date per 2018 shows that almost half of the included contracts has been renewed after three years, which might indicate that the youth care procurement strategies are developing when comparing with the strategy that followed the 'AWBZ' rules often seen in 2015. Another notable outcome is the low number of contracts starting per 2016, only 1.7% of the included contracts did.

4.3 Representativity

To increase the representativity of the data, tenders available since 2015 were collected from all provinces in the Netherlands. A total of 38% of the available tenders in the Netherlands have been included in the study. The characteristics of these tenders, such as the collaboration size and the starting date, have been compared with data from a recent study about the procurement of youth care in the Netherlands which included almost all tenders available (Uenk et al., 2018). These comparisons show that the characteristics of the included tenders in the present study differ only slightly from the total tenders in the Netherlands. Figure 4 displays the percentage of tenders per starting year of the present tenders and the previous study performed by Uenk et al. (2018).

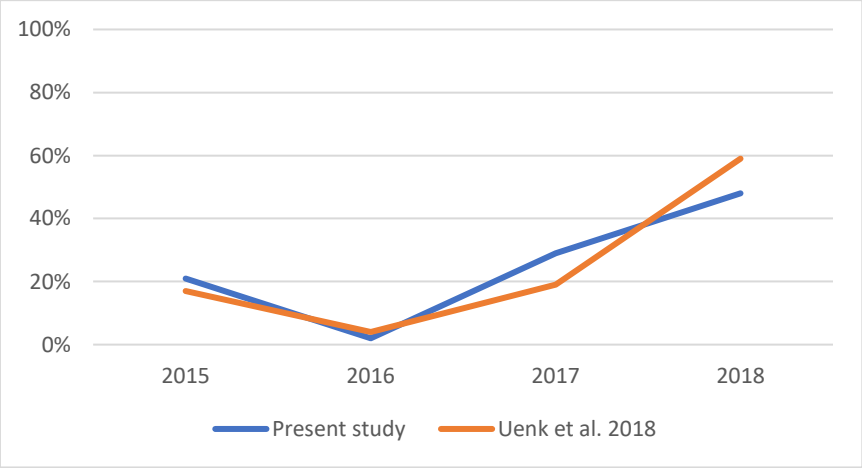


Figure 4: Comparison of the percentage of tenders included per starting year with the study results from Uenk et al. (2018).

A Chi-square test showed no significance (P=0.213) between our sample and the population, which means that the distribution of the starting dates per tender is representative for the whole population.

Another characteristic tested for significance was the number of contracts included per youth care category. The total number of contracts per youth care category for the present and previous study (Uenk et al. 2018) are shown in figure 5. Again, the chi-square test did show no significant differences between the two populations (P=0.301), which makes the present study representative.

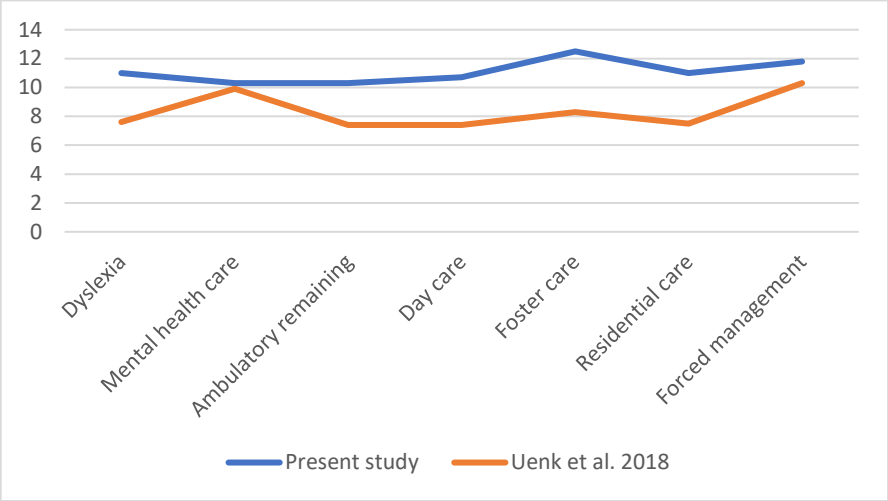


Figure 5: Number of collaborations per youth care contract shown for the present study and the study from Uenk et al. (2018).

5. PROCESSING OF DATA

The previous parts of the study have led to possible quality requirements, quality indicators and provided information about the data that were used for the analyses for this study. Also, a first overview of included tenders was given which will be expanded by information about the quality requirements. This part of the study will provide information about choices made during the data collection. After this, information will be given about the categorization of the data into four different categories, with the aim to answer the research question.

The outcome of the four different categorical analyses should answer the following questions:

1. What type of quality requirements are observed in of quality in tenders?
2. What type of service specifications are the observed quality requirements in the tenders?
3. In which section of the tenders are the quality requirements observed?
4. What kind of administrative burden is seen in the quality requirements collected from tenders?

5.1 Introduction

In order to answer the research question, it is necessary to know in which different ways municipalities can use quality requirements. It is important to look at the type of requirements that can be used in the tenders, what these quality requirements are focused on and in which section of the tenders the quality requirements are used:

1. Focus: in relation to quality indicators based on literature
    a. Client and carers
    b. Professionals
    c. Organizational
    d. Monitoring
    e. Delivery of care
    f. Environment;
2. Type: specifications of a product or service
    a. Input
    b. Throughput
    c. Output
    d. Outcome;
3. Section: in three different sections of a tender
    a. Statement of requirements
    b. Selection criteria
    c. Award criteria.

A fourth category was created in this study, in order to provide insight into the administrative burden caused by additional quality requirements. This Administration category will be divided in:

a. Administrative requirements
b. Legal requirements
c. Care related requirements
d. Requirements focusing on the skills of professionals.

5.2 Quality requirements

The different quality indicators found in literature were categorized in six main subjects which were also divided into the four specifications of services. The six main subjects observed in tenders are as stated above: Client and carers, Professionals, Organizational, Monitoring, Delivery of care and Environment.

More detailed quality requirements not mentioned in literature, but found in the tender documents, were attributed to one of the six main subjects.

When collecting the data from the tenders for youth care, all requirements that are in the sections 'selection criteria', 'statement of requirements' and 'award criteria' were collected. As these sections did contain requirements that were not specifically about the quality of care a selection had to be made. Requirements that matched the categories found in literature were recorded as quality requirements, see table 3 for the subjects that requirements should cover to be selected.

Quality requirements were split into two or more requirements when requirements were observed with more than one quality requirement in it. The total set of quality requirements was categorized regarding the quality indicators found in literature. The indicators were first divided into six subjects, shown in table 6, to provide an easy-view on the quality requirements.

After analysing the quality requirements regarding the quality indicators, the following phase of the study was to categorize the total set of quality requirements according to another four analyses, shown in figure 4.

For a better understanding of the different categories used in the study, and the analyses used to provide the deliverables, the categories are covered separately in the paragraphs below.

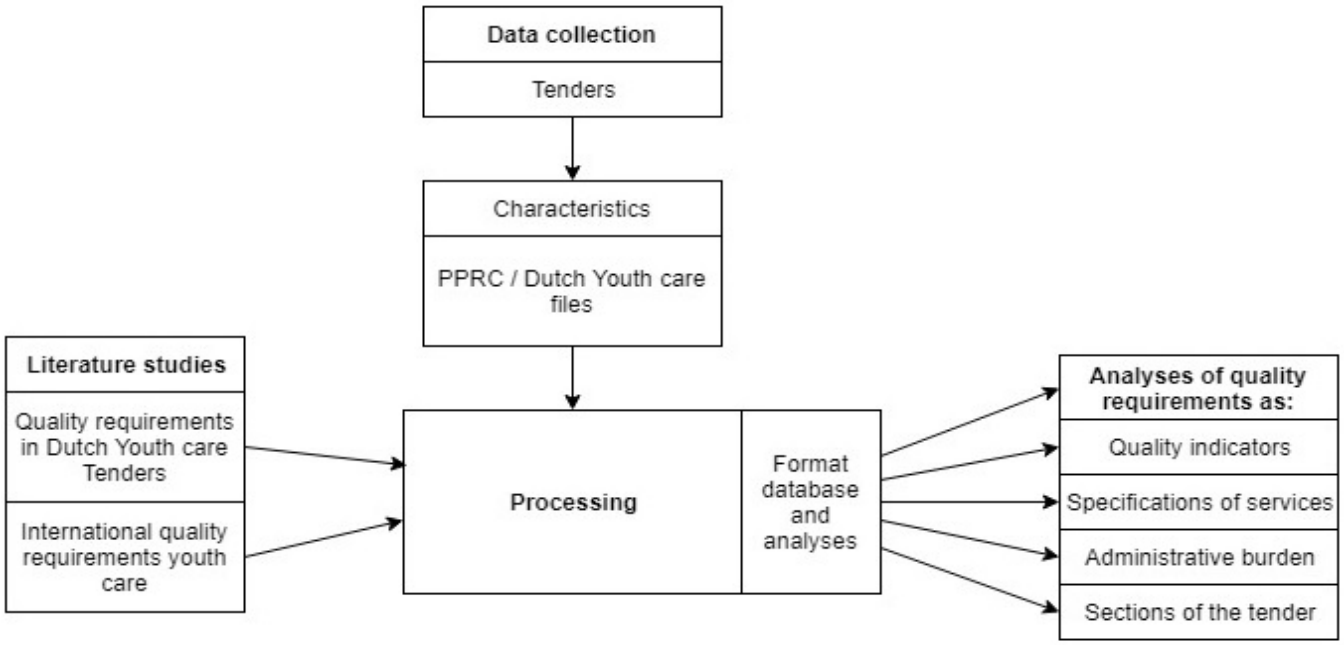


Figure 6: Research design showing the third phase of the study in more detail.

5.3 Quality indicators

The quality requirements are categorized according to the found indicators, which are displayed in six main subjects. During the data collection, 56 quality requirements were observed that did not fit any of the

indicators but did fit the context of the nationally obliged requirements. These quality requirements were also included and new indicators were added to the existing categories displayed in red in table 6.

Table 6: The quality indicators categorized in six categories, showing the indicators from literature in black and the added indicators for this study in red.

Category	Indicators			
Client & carers	Democratic decision making ➢ Parents/carers ➢ Children	Patient-oriented		
Professionals	Experience	Turnover		
	Education	Caregiver-child interactions		
	Satisfaction	Registrations		
Organizational	Integral care ➢ With education	Accessibility ➢ Flexible opening hours	Policy Entitlement	Collaboration between providers and municipalities ➢ Referral
	Protocols	Certificates	Complaints committee	Board of directors
	Stimulation of diverse workforce	Report code	Confidential counsellor	Providing information
	Code of conduct	Client council	Actively reaching out in region	Organization ➢ Applying law
Monitoring	Evaluations ➢ By providers ➢ By parents/carers ➢ By children	Annual & periodical reports ➢ About quality ➢ About results		
	Monitoring of quality	Quality systems		
Delivery of care	Ending of care	Effectiveness & Efficiency	Stimulating social network ➢ Foster care in social network	Treatment methods ➢ General ➢ Residential care ➢ Foster care ➢ Dyslexia care
	Justified care & standards	Evidence-based interventions	Number of staff involved	
	Contextualizing care		Treatment responsible	
Environment	Space per child	Composition of a group		
	Group size	Environmental quality		

Frequency tables based on these quality indicators will be delivered. The number of requirements in the six main subjects will be analysed per youth care category.

Specification of the services performed

In any procurement we have to specify the type of product or service that is required. The purchasers, in this case municipalities, can use technical or functional specifications. A technical specification describes characteristics of a system or service that must confirm to a specific metric, often very detailed (Schotanus, 2017). Requirements like these are often specific about tools used for the health care service, for example about the system that should be used to declare a service. Technical specifications are input and throughput specifications of a service. A quality requirement was labelled as an input requirement when its focus was on a specification about the professionals or products. The throughput specifications were noted when a quality requirement was about methods, interventions or other treatment-related requirements that were not about the professional or about methods for products.

Other possible requirements are functional requirements, used to describe specific behaviour or outcome of a system or service. This type of specification gives the health care service or providers more freedom to come up with designs to fulfil the requirement when comparing it whit technical specifications, which could lead to more innovation (Schotanus, 2017).

Service specifications that are functional are output and outcome specifications. The output specification was selected in the database in case a quality requirement was about output of a product. These quality requirements were often about the number of products or services delivered as the example given above for the functional requirements.

Outcome specifications are slightly different from the output specifications as these show the effect of a service. Quality requirements about the effects of services were therefore noted as outcome specifications.

These four specifications are summarized in figure 7, which divides the technical specifications on the left with a dotted line from the functional specifications on the right.

All specified requirements are analysed per quality indicator subject and per youth category.

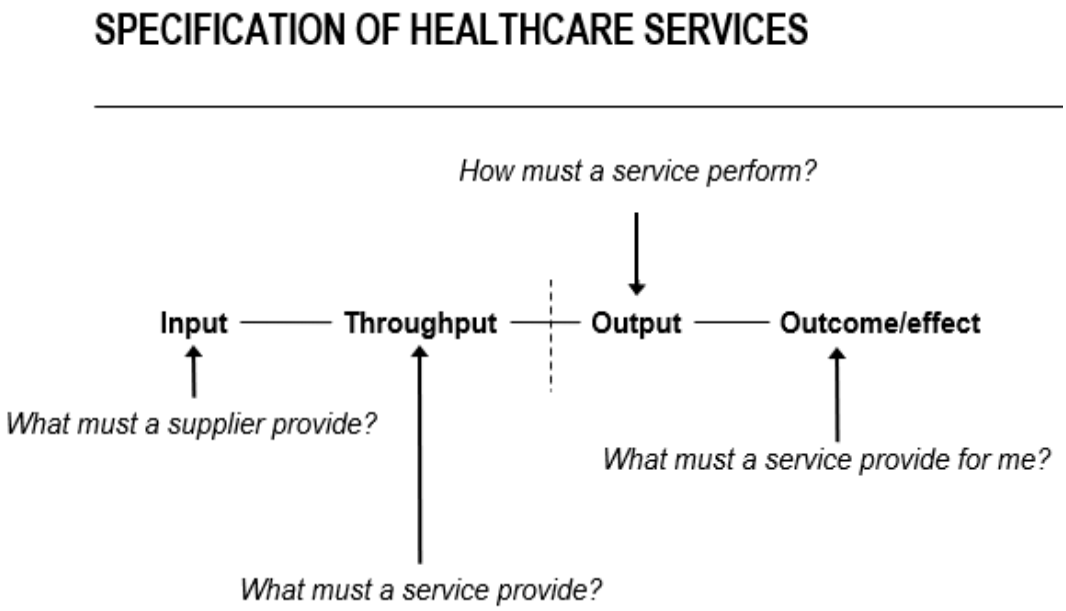


Figure 7: Service specifications, source: Axelsson and Wynstra (2002).

5.4 Role of requirements in the section of the documents

All quality requirements were collected from the three possible sections in a tender. The function of these sections differs. Often, the first quality requirements observed in tenders are in the 'selection criteria'. This section of the tender is used for minimum requirements that are used by the procurers to select specific providers. Selection criteria are related to the care provider, for example organizational criteria, which help to select providers for contracts. These criteria should not be discriminating, specific selection of care providers is only allowed when there is an objective basis and when it is in relation with the procurement (Andriessen et al. 2015).

Another section, which is used in all tenders, is the statement of specifications. The requirements in this section are also minimum requirements which are related to the implementation of the service. An example of a contract requirement is one about collaborations between the provider with volunteers (Andriessen et al. 2015).

The third possible section in tenders is that of the award criteria. The award criteria are requirements regarding the requested service. Municipalities can use these as additional requirements to stimulate providers in delivering extra quality as the providers score higher when meeting more of these award criteria (Andriessen et al. 2015).

5.5 Administrative burden

This last categorization was included to get more insight into the administrative burden that health providers have due to the quality requirements, as this is a main complaint of health care providers since the new youth law in 2015 (Friele et al. 2018; Dahl, 2016).

The categories formed for these analyses were administrative requirements, which included all requirements that required some amount of administration. This could be about evaluation reports, monitoring requirements, requirements to perform research and requirements to justify or to verify. The observed requirements in the administrative category were again categorized into different options in order to get a better understanding of the administrative burden. The administrative categories were named:

1. A onetime task in order to get a contract
2. An annual task
3. A task once per client
4. A periodical task
5. A returning task multiple times per client
6. Tasks required in unique situations

Next to the administrative requirements, remaining requirements were categorized as requirements about care, which included specifications about the delivery of care, the collaborations, health schemes, methods and so on; or categorized as skills for professionals who provide the health care, including requirements about their education, certificates an registrations and; the last category contains legal requirements that are copied from the national law.

6. RESULTS

This chapter describes the results of the quantitative data collection and the analyses required to answer the research question of the study.

6.1 Overall results

Quality requirements total

The total number of different quality requirements collected from the tenders was 433. In many of these quality requirements there were more than one requirement observed and these were split. This resulted in a total of 459 quality requirements. The average number of quality requirements per tender was 28 and ranged between 12 and 104.

Quality indicators

A total of 403 quality requirements fitted directly the quality indicators from the six main categories, based on literature. Another 56 requirements had to be categorized based on the most seen quality requirements. Figure 8 shows the total of 459 quality requirements distributed over the six main subjects for quality indicators. Figure 9 shows this distribution in more detail for all the quality indicators.

Some of the quality indicators, shown in table 6, were not observed in the youth care tenders included in this study. Quality requirements were not found for the indicators:

1. Entitlement (within the category policy)
2. Stimulation of a diverse workforce
3. Staff satisfaction
4. Composition of a group

As these indicators did not appear in any of the tenders, they were not taken into account for the following analyses.

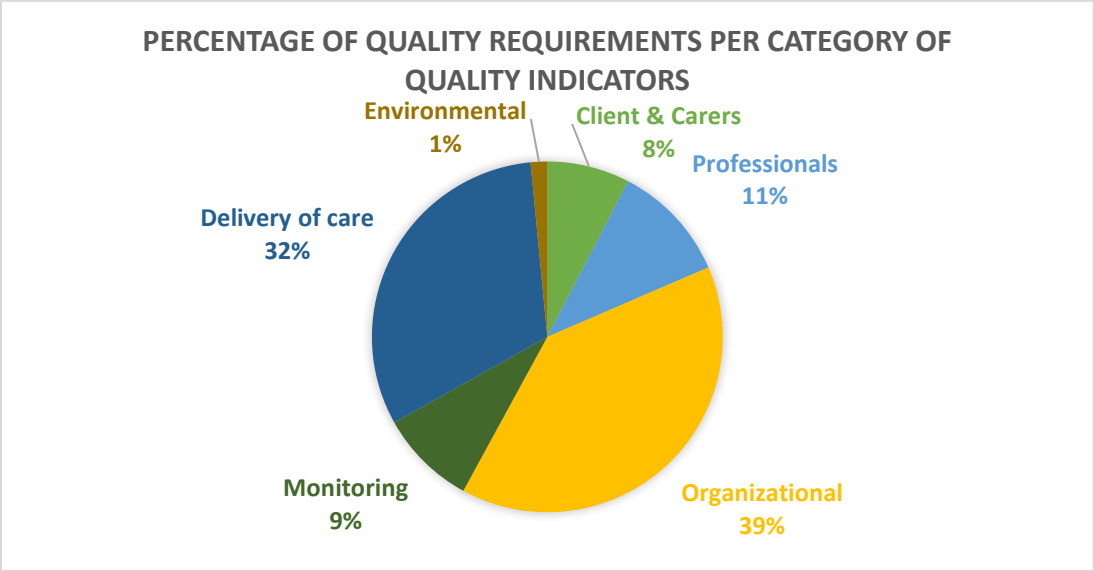


Figure 8: The differentiation of quality requirements over the six categories, displayed in percentages of the total requirements N=459.

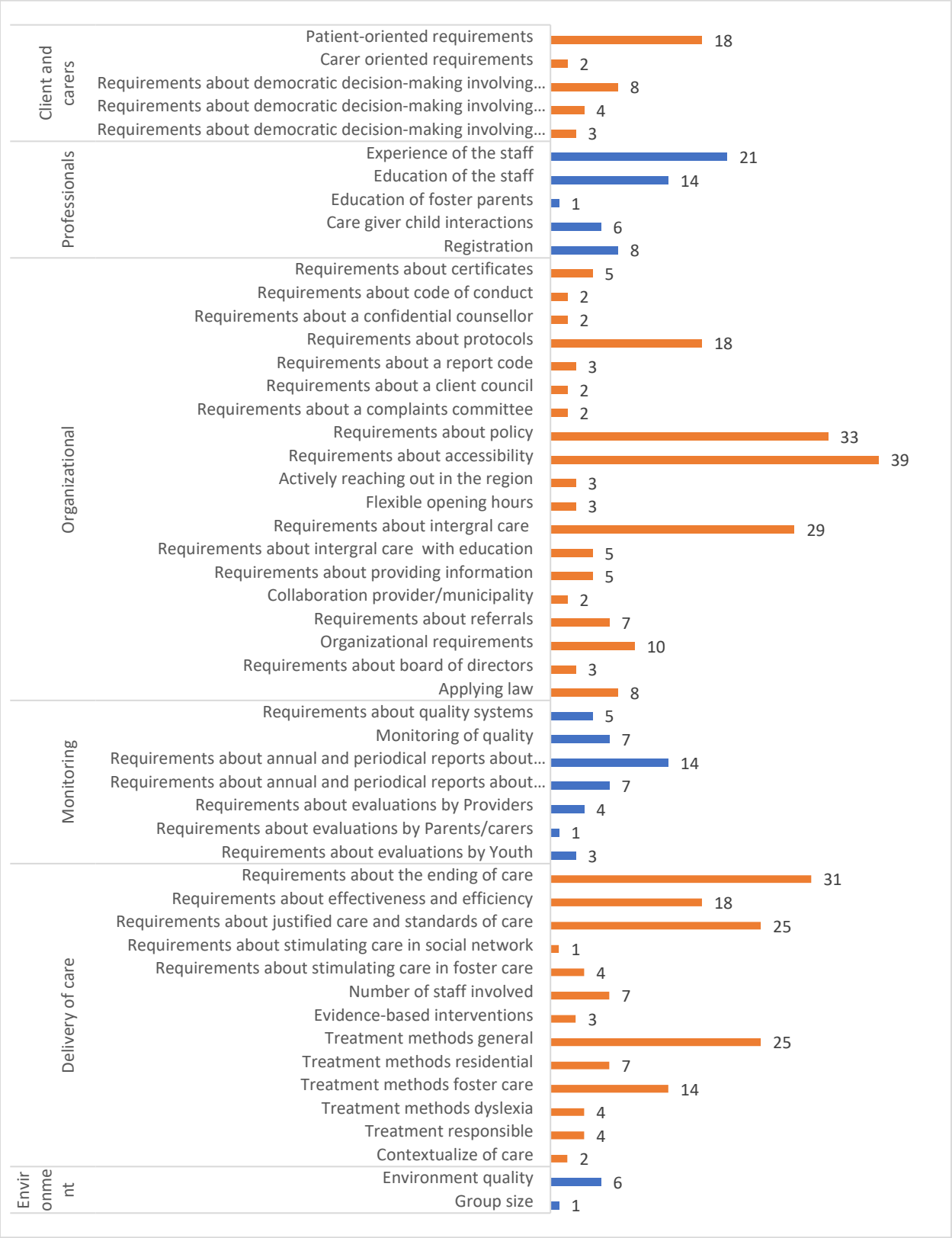


Figure 9: Distribution of the 459 quality requirements on the quality indicators.

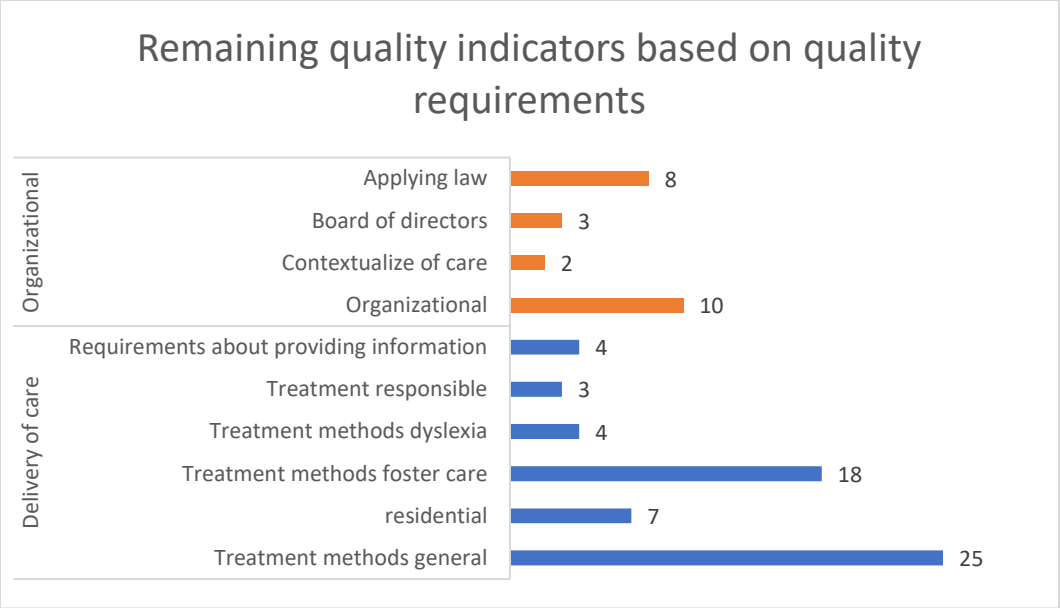


Figure 10: The total number of quality requirements found per added quality indicator, showing the yellow indicators as sub categories of the green indicator. Blue indicators are all individually.

The quality indicators found from literature were combined with the new indicators based on quality requirements observed in tenders. The distribution of the total 459 different quality requirements is shown in figures 8 and 9. The highest number of quality requirements were found in the category 'Organizational' which is mainly focused on what a supplier must provide (input). A total of 176 different requirements fitted this category, which is over one third of the total requirements.

Specifications of a service

The quality requirements in these six categories were divided in the four different specifications to explain more about the way municipalities formulate the quality requirements in tenders. Of the total quality requirements, most seen specifications are throughput specifications focussing on the process of the service. More than half of the quality requirements fitted this specification type (54% of 459 requirements). The functional specifications - output and outcome - were only seen in 13% of the requirements when looking at the total number of quality requirements. The remaining 87% of the quality requirements are thus technical specifications as these are input and throughput specifications. These leave less room for innovation compared to the functional specifications.

The specifications are also analysed per main subject of the quality requirements, showing the results in table 7. The distribution of the specifications per subject differs as expected. For example, the

category professionals consist of 84% of input specifications, which can be explained as this category focusses on the education, registration and certificates for professionals and matches the definition of what a supplier must provide.

Table 7: The percentage of the four different specifications displayed for the six main subjects.

Category	Input	Throughput	Output	Outcome
Client & carers N=35 different quality requirements	31%	49%	9%	11%
Professionals N=49 different quality requirements	80%	4%	8%	8%
Organizational N=175 different quality requirements	23%	61%	10%	6%
Monitoring N=49 different quality requirements	10%	59%	22%	10%
Delivery of care N=146 different quality requirements	17%	61%	7%	16%
Environment N=7 different quality requirements	0%	29%	29%	43%
Total N=459 different quality requirements	29%	53%	9%	9%

Examples of specifications

The input requirements are focused on what a supplier must provide. Examples of quality requirements found that are input requirements are:

"At least one of the foster parents has professional experience with youth care and has a professional education with the quality at least Community college or Higher Education and related to youth care".
"The service needs to consist of a multidisciplinary setting or an integral provision of services".
"Professionals need to have a 'Individual Healthcare Professions Act' registration".
"Professionals and volunteers need to be in possession of a certificate of conduct".

The requirements that are specified as throughput give answer to ‘what a service must provide’. Nearly half of the quality requirements observed were about the way health care providers should provide services, with requirements such as:

> “The health care provider agrees that during the treatment of dyslexia, a maximum of 12 hours is spent on diagnostics and a maximum of 58 hours spent on treatment. This is inclusive the indirect time with a maximum of 25%”.

> “Health care service can justify that the client has freedom of choice, is allowed to participate and that the client is allowed in joint decision making about client participation”.

> “A juvenile gets the opportunity to grow up at home as much as possible and receives care at home as much as possible. Other care methods will only be used if there is no alternative and you should substantiate the use of these if the municipality asks for this”.

Only 14% of the requirements were observed as output requirements, which shows that most municipalities did not focus much on the outcome of a service. The output specifications give answer to ‘how must a service perform’ without precisely explaining how providers this should achieve. These requirements deliver measurable outcome, which leads to proper monitoring of care for quality evaluations. A few examples are:

> “The contractor can prove that the service, in according with the performance targets from the contract, will be achieved or either justified”.

> “The contractor collaborates in providing care that is necessary within ten calendar days and offers an alternative in the meantime when necessary”.

> “In all cases that youth care is provided by the contractor should the result be that the juvenile functions adequate for their age in a supporting system”.

Administrative burden

Only 12% of the quality requirements were taken over from national law. The vast majority consists of additional requirements used by municipalities. The other 88% were extra requirements made by municipalities. Of these 405 extra requirements, 19% required some sort of administrative task, among other things about monitoring, delivery of justifications, cyclic evaluations and so on.

Table 8: The number of quality requirements observed in the Administrative burden category.

Administrative burden categories		
Category	**Requirements (N)**	**%**
Legal requirements	54	12%
Care	285	62%
Administrative	75	16%
Skills	24	5%

The administrative requirements difference in size, as some requirements are a one-time administrative job and others return more often during the contract:

"Contractor can prove that it works with evidence-based interventions" (observed 32 times),

and others a returning administrative task:

"The care provider composes per juvenile an Arrangement, for the benefit of the municipality" (observed 9 times);

"The contractor guarantees that the client and the parents or legal representatives of the client will be informed periodical about the progress of the care program" (observed 10 times).

The observed administrative requirements were analysed to reveal how many of these are returning requirements and how many are a one-time task, see table 8. It turns out that most of the administrative tasks, 36%, were a one-time task in order to justify specific information for the municipalities to be able to get a contract and 11% were requirements about annual reports. The four types of returning requirements; once per client, multiple times per client, and multiple times a year made up for 40% of the total administrative requirements. Another interesting result to highlight was the percentage of administrative requirements that do not occur often, which made up for 12% of the total administrative requirements. An example of a requirement that had been seen in this category is one about justification when the waiting time for youth care get over 10 weeks.

Table 9: The number of times administrative requirements return during a contract categorized by the times these tasks return during a contract.

Administrative requirements	N	%
Once for the contract	27	36%
Once in a year	8	11%
Once per client	9	12%
Multiple times per client	6	8%
Multiple times a year	15	12%
Depending on situations	9	12%
Unknown	1	1%
Total	75	100%

Section of quality requirements total

The quality requirements may appear in three different sections in the tenders: the statement of specifications, the selection criteria and the award criteria. Some quality requirements were observed in two or even all three sections. These were therefore counted double. Table 10 shows the number of quality requirements per section with the range given of the least observed requirement in that section and the most often observed requirement. The analyses in this part were performed on the 433 included quality requirements which were literally copied from the tenders. The number of quality requirements observed per section does not lead to the total of 433 different quality requirements included in the study, as requirements were observed in two or all three sections.

Table 10: Number of quality requirements per section with the range of times a requirements was observed.

Section of the tender	Total number of different quality requirements (range)
Statement of specifications	384 (1-550)
Selection criteria	50 (3-377)
Award criteria	48 (15-162)

The total number of requirements in the statement of specifications is 19,905 or 72% of the total number of requirements observed in the tenders. The most commonly used quality requirement in the section statement of specifications was to fulfil all national (quality) requirements given in the Dutch Youth Law and all requirements in other relevant laws or regulations. This requirement was also mentioned 265 times as a

selection criterion in 27% of the total contracts. See table 24 in appendix 3 for the top ten quality requirements seen in the statement of criteria.

In all 988 contracts, a total of 50 requirements were observed in the section selection criteria to select youth care providers based on these requirements. These 50 different requirements were observed 4,460 times in all contracts, or in 16% of the total requirements in tenders. One requirement was observed 377 times in 38% of the contracts. This requirement was about the need of a professional and business liability insurance for health care providers. The top ten of selection requirements is shown in table 25 in appendix 3.

Least used criteria were the award criteria as 48 different quality requirements were observed 3,154 times or in 12% of the total requirements in tenders. Most used requirement requires that health services should deliver care with qualified professionals whose skills fit the type of care provided. These professionals have professional standards and meet the quality requirements of the product or service. This requirement was adopted 162 times in 16% of the total contracts. All award requirements are shown in table 26 in appendix 3

6.2 Results per youth care category

This paragraph focuses on the analyses outcomes per youth care category. The total number of different quality requirements and the number of contracts are shown per youth care category in table 11.

The average number of requirements was the lowest in the dyslexia category, with an average of 25 quality requirements per tender, and the highest in the foster care stays with an average of 30 quality requirements. The distribution of quality requirements per youth care category shows that there is only very little variation between the seven youth care categories.

Table 11: Average number of different quality requirements observed per contract.

	Dyslexia	Mental health care	Ambulatory remaining	Day care	Foster care	Residential care	Forced management
Number of contracts	154	154	154	139	138	143	106
Total number of requirements counted	3834	4436	4414	4004	4165	3991	2675
Average number of different requirements	25	29	29	29	30	28	25

Quality indicators per youth care category

The quality indicators per youth care category are shown in table 12 below. Again, not much variation was found between the distribution of the different types of quality requirements. It is only interesting to see that next to the more intensive care categories - foster care, residential care and forced management – the care category dyslexia also has a slightly higher percentage of quality requirements about the delivery of care. This might show that municipalities have reasons to take on a controlling role towards dyslexia care.

Table 12: An overview of the percentage of the total number of quality requirements per youth care category and per type of requirements according to the six categories based on quality indicators.

Category	Dyslexia N=249	Mental health care N=301	Ambulatory remaining N=302	Day care N=280	Foster care N=264	Residential care N=264	Forced management N=181
Client & Carers	6%	7%	8%	8%	9%	8%	8%
Professional	10%	9%	10%	11%	7%	10%	7%
Organizational	41%	42%	41%	41%	39%	42%	45%
Monitoring	10%	11%	11%	1%	9%	8%	9%
Delivery of care	31%	29%	28%	28%	35%	32%	30%
Environment	1%	2%	2%	2%	1%	1%	1%

Specifications per youth care category

The results of the different specification categories per youth care category show that the variety in specifications per youth care category is also minimal. However, the results do also show that the percentage of output and outcome requirements is higher than the mean percentages of the total requirements. The composition of quality requirements is shaped more positive when looking at the care categories seperatly. About 1 in 4 requirements is about output or outcome. The number of requirements specified as throughput is the highest in all youth care categories. See the overview of specifications per care category in table 13.

Table 13: The Percentage of different quality requirements divided in the four service specifications per youth care category.

Youth care category	Input	Throughput	Output	Outcome	Total (N)
Dyslexia	30%	48%	11%	11%	249
Mental health care	26%	49%	13%	12%	301
Ambulatory remaining	27%	49%	13%	12%	302
Day care	29%	49%	11%	11%	280
Foster care	28%	51%	11%	10%	264
Residential care	29%	51%	10%	10%	264
Forced management	27%	48%	13%	13%	181

Administrative burden

When comparing the requirements based on the administrative categories, the percentage of administrative requirements per youth care category differs slightly from the total quality requirements. The average percentage of administrative requirements is slightly higher (20% versus 16%) in this perspective, which means that the composition of requirements per youth care category differs from the composition of the total requirements.

Most seen administrative requirements were in the residential care, forced management and dyslexia. The contracts for forced management also showed the highest percentage of requirements based on national law and regulation, see table 15. This result was expected as care provided in the forced management has to satisfy many different laws due to the complexity of this type of care. One would expect that for complex care, requirements focusing on the skills of the professionals involved would be observed more often than in the other youth care categories. This study shows that forced management has the least quality requirements about skills compared to the other youth care categories.

Table 15: Overview of the composition of requirements categorized by the outcome-based categories.

Youth care category	Care-based requirements	Administrative Requirements	Legal requirements	Skill-based requirements	Total requirements
Dyslexia	52%	20.%	18%	10%	249
Mental health care	54%	20%	18%	8%	301
Ambulatory remaining	55%	20%	17%	8%	302
Day care	52%	19%	19%	10%	280
Foster care	55%	18%	20%	8%	264
Residential care	53%	20%	17%	10%	264
Forced management	50%	21%	22%	7%	181

Section of quality requirements per youth care category

In all seven youth care categories, most used section for the quality requirements were the statement of specifications, ranging between 66% in day care to 79% in forced management. The results show no big variation with the analysis of the total number of quality requirements and it can be said that most tenders mainly focus on minimum requirements in the statement of specifications. See figure 11 for an overview of the percentage of requirements observed per section.

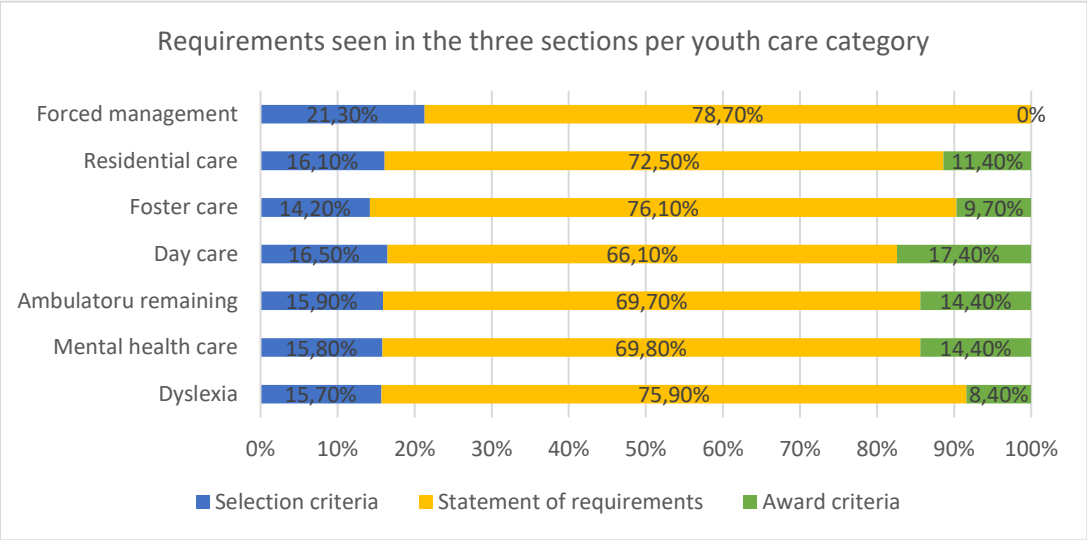


Figure 11: The percentage of quality requirements seen per section per youth care category.

The different sections were analysed by the different types of specifications which showed that the statement of specifications has similar segregation of the types of specifications with the award criteria. The selection criteria showed the highest number of requirements as input specifications whereas the statement of specifications and the statement of criteria had the highest number of throughput specifications, see table 16 below for the results.

Table 16: Overview of the number of requirements observed in each section categorized in the different specification categories.

	Selection criteria N=50		**Statement of specifications N=384**		**Award criteria N=48**	
Specifications	N	%	N	%	N	%
Input	36	72%	159	41%	23	48%
Throughput	13	26%	203	53%	25	52%
Output	1	2%	18	5%	0	0%
Outcome	0	0%	4	1%	0	0%

It is remarkable that none of the quality requirements observed as output and outcome specifications were observed in the award criteria, as this section is supposed to stimulate health care providers to score the highest on quality to be sure of a contract.

After comparing the use of all 433 quality requirements in the three different sections, results showed that 5 quality requirements were seen in all three categories. This means that for some municipality these 5 requirements are a minimum requirement whereas other municipalities see these as extra quality requirements. Another 39 requirements were observed in two sections. Of these 39 requirements, 22 were observed both in the Statement of specifications and the Selection criteria and the other 17 were seen in both the Statement of specifications and Award criteria. This again is remarkable as 17 of the total 48 requirements in the award criteria were implemented as minimum requirements by other municipalities.

The most seen requirement in the three sections is: “Professionals and volunteers need to be in possession of a certificate of conduct”, which was used 339 times in the Statement of specifications, 268 times as a Selection criterion and 120 times as an Award criterion.

The most observed requirement in both the statement of specifications and selection criteria was: “Contractor guarantees that he meets all (quality) requirements stated in the Youth Law and all other

relevant laws and regulations related to the delivery of the service". This requirement was observed 550 times in the statement of specifications and 265 times in the selection criteria.

For the combination statement of specifications and award criteria was the most seen requirement: "Contractor knows that the municipalities developed a local policy in order to perform her tasks as part of the Youth law, is familiar with this policy and the local regulations regarding youth care and acts to this", which was observed 174 times in the statement of specifications and 120 times in the award criteria of tenders.

When looking at the specifications of these requirements, the following overview is given, shown in table 17. These do not show any remarkable differences with the overall results on specifications.

Table 17: Overview of different requirements which were observed in two or three sections categorised per specification.

Observed in:	**Total**	**Input**	**Throughput**	**Output**	**Outcome**
All three sections	5	5	0	0	0
Statement of specifications and selection criteria	22	15	7	0	0
Statement of specifications and award criteria	17	6	11	0	0

7. DISCUSSION

This last chapter of the study translates the results of the descriptive analyses into conclusions that lead to an answer on the main research question. Next to that, it provides a discussion on the results and how these relate to the expectations based on literature. Some of the observations are in line with expectations based on theory and others are not. The results that are not in line with the expectations are discussed in the paragraphs below the conclusion.

After discussing the results, the limitations of the study will be discussed including its literature study, the method and the collected data. The chapter ends with recommendations for future research.

7.1 Conclusion

'In what way do municipalities apply quality requirements in the tenders for the different youth care categories in the Netherlands?'

The answer to the main question, and the conclusion of the study, is that most municipalities are focusing on the technical requirements for youth care in their tenders with detailed specifications, whereas functional requirements are more desired as these leave room for innovation. The use of technical specifications – input and throughput - might be easier than the use of functional specifications. They give municipalities more power in shaping the youth care. In addition to this are technical specifications also easier to cover themselves for mistakes. The technical specifications, made up for 82% of the total quality requirements observed when analysing the total requirements. This could be interpreted in a way that municipalities seem to have little trust towards youth care providers. This assumption is supported by the fact that nearly 90% of the included quality requirements were extra requirements arranged by municipalities in addition to the national quality requirements from the Dutch law and regulations. However, when looking at the care categories separately, the percentage of functional requirements is slightly higher and varies between 20% and 26%. Although many requirements were formulated by municipalities themselves, not much variety was seen in the quality requirements compared per youth care category. The main focus of the quality requirements was on the organizational level, which made up for more than one-third of the total requirements. Finally, the administrative requirements were analysed, showing that almost one in five of the quality requirements per youth care category required a type of administration. Of these administrative requirements, 40% are returning tasks during the contract, the other 60% are a one-time task. In 12% of the requirements has been a task described that only occur in risky situations that might not even occur during the contract.

This conclusion is established by using the sub questions of the study, which are the following answers:

1. *What type of categories are seen in the quality requirements collected from tenders?*

When looking at the total quality requirements (N=459), most seen category for the requirements is the organizational category (38%), followed requirements about the delivery of care (32%).

2. *What type of service specifications are the observed quality requirements in the tenders?*

Most seen quality requirements in the specifications for a service are requirements in the technical specifications, as the input and throughput specifications made up for 82% of the total quality requirements. A total of 53% of the quality requirements were observed as throughput specifications and 29% were observed as input specifications.

3. *In which section of the tenders are the quality requirements observed?*

The results regarding the category for the section of the tender show that most requirements were collected from the statement of specifications in tenders, a total of 19,905 times requirements were collected from the tenders which is equal to 72% of the total requirements collected.

4. *What kind of administrative burden is seen in the quality requirements collected from tenders?*

The results of the category-based analysis on the collected requirements revealed that one in five quality requirements requires some sort of administration, of which 40% requiring returning administrative tasks. Most seen administrative quality requirements were in forced management.

7.2 Discussion Results

This research presents, for the first time, a quantitative study to provide information about the number and type of quality requirements seen in Dutch tenders for youth care since 2015. The results show little variation in the use of quality requirements by the different included municipalities. The different youth care categories show almost the same distribution of specifications, administration and sections of the observed requirements.

An interesting result after categorizing the quality requirements into the quality indicators found in literature is that five of the quality indicators were not observed in the quality requirements. These quality indicators are:

1. Entitlement (within the category policy)
2. Stimulation of a diverse workforce
3. Actively reaching out in the region
4. Staff satisfaction
5. Composition of a group

Especially staff satisfaction has been mentioned in literature to be a reliable quality indicator but is not mentioned in any of the tenders (Kuger et al. 2016; Gordon et al. 2013; Bethell et al, 2011). These indicators, expect for the composition of a group, are functional indicators. This can explain why these are not mentioned, as 88% of the quality requirements were technical specifications. This focus on technical specifications leads to less possibilities for innovation in youth care, as most of the required requirements are technical and detailed about what a supplier and service must provide instead of perform. More desirable for innovation in the procurement strategies are types of functional specifications when purchasing youth care (Uenk et al., 2015). A region known for their result-based purchasing method showed slightly different outcomes regarding the number of output requirements than the average contract. This implies that the interpretation of output and outcome criteria may be different for municipalities than the theoretical explanation. Not to forget is the fear that municipalities have, as they are responsible for the quality of youth care and the access to youth care. This might be a reason why there are so many quality requirements and why so many of them are technical and detailed. Another reason might be the lack of experience in municipalities in purchasing youth care. The procurement processes are still changing over time as

municipalities are widening their vision after the first years in which it was all about making sure the youth care would be available for those in need (Uenk et al. 2018). The results of the starting date for the contracts are as expected as literature already showed that in the first year, most of the municipalities did follow the 'AWBZ' procurement. Even in 2016, the second year, it seems that municipalities took the same path, as only 2% of the included contracts had January first 2016 as their starting date.

It is high likely that after the first transition phase, the municipalities will now start to focus on important content to expand the quality of the youth care. It seems to be important to support municipalities with knowledge about different ways quality requirements can be used to make a shift from a complete technical focus to the use of requirements in both the technical and functional specifications. Also, awareness among municipalities about the high number of quality requirements should be stimulated as these lead to more administrative burdens for both parties involved in the contract. Almost one in five quality requirements required some sort of administration task. Nearly 40% of these tasks are returning tasks during the contract. The other 60% of the administration related requirements should be performed by care providers in order to receive a contract. Nearly half of the contracts in youth care ends in one or two years (Uenk et al., 2018) which means that all the contracted youth care providers need to perform the administrative requirements often. Also, when taking all observed requirements into account instead of only the quality requirements, the average number of requirements is 48 per contract. It is high likely that these contain administrative requirements as well.

Overall it can be stated that the administrative burden is definitely there for the youth care providers, though it might be less in the future when for example monitoring tasks are implemented well and does not require new actions for the care providers. Municipalities should not require unnecessary quality requirements in order to exclude all possible risks. The quality requirements that are really needed to guarantee the quality of care should be formulated as functional requirements. These require a positive approach focused on the desired outcomes of care and stimulate innovation.

Sections of requirements

Literature showed clear segregation between the three sections in tenders, stating that selection criteria are related to the care provider, award criteria regarding the requested service and the statement of specifications to the implementation of the service (Andriessen et al., 2015). This segregation was not observed in two of the sections of this study, as for example results showed that for the selection criteria only 12% of the requirements were about the professionals.

When comparing the three sections with the requirements observed in the four service specification categories, the results show more similarity with the literature. The most seen requirements in the selection criteria are input specifications (72%), which are technical specifications that might include requirements

for the providers. However, when looking at the segregation of the total quality requirements in this study, it is high likely that the input specifications would turn up as often observed. Nonetheless is the percentage of input specifications in the selection criteria section 72% versus 44% in all requirements of the study.

The other two sections do show comparable outcomes with the percentages of specifications in all included quality requirements of the study.

7.3 Limitations

Literature study

As expected, the literature research did not provide information to answer the research questions. Substantive information of tenders for youth care is hardly available, at least not with specific information about quality requirements used by municipalities. The information found with the literature study is more general, as for example the different requirements stated by the new youth law named in most literature but no extra requirements formulated by municipalities (Bruning, 2016; Aarts et al., 2017; Fenger et al., 2016).

One of the choices within this study design that can be discussed is that of searching for only Dutch literature. Specific information about tenders could have been collected from European studies, as there are European procurement rules for tenders (Metze et al., 2015). However, the Dutch situation is unique as no other European country procures youth care on the level of municipalities and therefore the choice has been made to stay focused on the Dutch literature.

Method

To make the data more valid, contracts have been included from every Province in the Netherlands. Next to that is the coverage level 38% of all the contracts available for youth care procurement, which suits the size of an acceptable sample. The data has not been collected completely random as the geographical areas were taken into account.

A limitation of this method to collect data is that contracts found when searching for specific provinces are often the ones of bigger collaborations. This is confirmed by checking the numbers of collaborations per youth care category with the numbers found in a national study that included 96% of all contracts (Uenk et al., 2015). Especially the youth care categories Dyslexia, Foster care and Residential care show noticeable differences in the average number of outsourcing collaboration. The little amount of variety in results per youth care category may be biased by the bigger regions included in the study. Two regions included around 20 municipalities in their collaboration, which means that the seven youth care categories are procured the same in 20 cases (a total of 140 contracts), times two. This already counts for 28% of the contracts included in this study. Taking this into account, it makes sense that the variety is not that big. However, it should not be forgotten that over 400 different quality requirements were collected,

which also implies that although bigger regions were included, still many different requirements are requested for the Dutch youth care.

7.4 Recommendations

Overall can be concluded that the results reveal that in the upcoming years the strategy of using quality requirements should change.

It is recommended for municipalities to critically review their requirements in tenders and to categorize requirements to see if the focus of their quality requirements is in line with their goals stated in their policy. Also, they can decrease requirements by composing functional requirements correctly, as these could cover a few technical requirements at once. The strategy using specifications of services or products can be used in differently than is done mostly, as municipalities can start with writing down their desired outcome, than decide what type of output is necessary to achieve this followed by the throughput and input. Working from the left side to the right side might help in formulating requirements that are really necessary and leave out extra requirements that do not support this desired outcome.

However, municipalities should be aware that they cannot select care institutes based on the outcome requirements, as instruments to research the causal relationship are not available yet. It is therefore recommended for municipalities to require that care institutes measure their outcome which then can be discussed together to find possible correlations between outcome and methods used.

Also, the strategy using specifications of services or products can be used in different ways than is done now, as municipalities can start with writing down their desired outcome, than decide what type of output is necessary to achieve this followed by the throughput and input. This might help in only

Another recommendation for municipalities is to critically review their requirements in order to check the administrative burden they stimulate with their requirements. Not only do care providers have increased administration, municipalities are obliged by the youth law to develop measurement methods to measure or monitor the quality requirements as well (Youth Law, 2014, chapter 2).

The results of the study show that further research will be interesting as many different results can be derived from a data collection like this. A recommendation for future research is to collect more data that matches the actual distribution of contracts in the Netherlands. An additional subject that can be taken into account is the quality of collaboration between municipalities. This might be interesting as the municipalities lead the market of youth care in the Netherlands. The quality of collaborations might therefore have influence on the quality of care.

This study did not include any qualitative data from health care services, which is recommended for the future. Involving health care services might lead to a better understanding of the situation as it creates

possibilities for more detailed analyses. It is interesting to know how many contracts one health care provider has with different municipalities and if these contracts require different quality requirements. Also, more information about the implementation of the administrative requirements might be interesting to analyse, as differences between youth care providers might occur.

Providing more information about this subject will influence the speed of a well-shaped decentralization and it gives potential for municipalities and health care providers to learn from each other.

REFERENCES

Aarts, W.L.E., Boendermaker, L., Distelbrink, M. (2017) "*Ouders ondersteunen bij opvoeden"*. Amsterdam: Kenniswerkplaats Transformatie Jeugd Amsterdam.

Andriessen, S., Stavenuiter, M., Verleun, A. (2015) "Lokaal sturen op de inzet van burgers, kan dat?" Wmo kenniscashier, volume 26, april 2015.

BDU Media. "Hoogleraar Erik Knorth met emiraat". Retrieved on 12-04-2018, from: http://dewoudenberger.nl/lokaal/hoogleraar-erik-knorth-met-emeritaat-55223.

Bellaart, H., Day, M., Gilsing, R. (2016*). "Effectief bereik van alle doelgroepen door jeugdhulp Den Haag".* Verwey-Jonker instituut, Utrecht.

Berg, van den G., Bellaart, H., Yar, H. (2015). "Een betere match tussen vraag en aanbod. Eindrapport van een onderzoek naar de aansluiting tussen de vragen en behoeften van Turks-Nederlandse jeugdigen en gezinnen en het bestaande aanbod aan preventie, ondersteuning, hulp en zorg". Researchgate, n.278671656.

Berg, van den G., Yperen, T. (2012). "Vertrouwen en Rekenschap". Gemeente Amsterdam, NJI, Utrecht, https://jeugd020.pleio.nl.

Bethell, C. D., Kogan, M. D., Strickland, B. B., Schor, E. L., Robertson, J., & Newacheck, P. W. (2011). A national and state profile of leading health problems and health care quality for US children: key insurance disparities and across-state variations. Academic Pediatrics, 11(3), S22-S33.

Bruning, M. R., Rap, S., Verkroost, D. (2016) "Kansen en momenten voor participatie in het jeugdhulptraject". Universiteit Leiden, Afdeling Jeugdrecht, Instituut voor Privaatrecht van de Faculteit der Rechtsgeleerdheid. Leiden.

Bruning, M.R. (2015). "*Kinderen beschermen: met eigen kracht of door snel ingrijpen?"* Cleveringalezing Twente, 26 november 2015.

Centraal bureau voor de statistiek. (2017). "Zorguitgaven stijgen in 2016 met 1,8 procent". Retrieved on 23-06-2018 from: https://www.cbs.nl/nl-nl/nieuws/2017/20/zorguitgaven-stijgen-in-2016-met-1-8-procent .

Centraal Bureau voor de Statistiek. Jeugdmonitor, Cijfers en publicaties, Indicatoren. Retrieved on 28-02-2018, from: http://jeugdmonitor.cbs.nl/nl-nl/indicatoren/jeugdhulpindicatoren/.

Centraal Plan Bureau, Public Procurement Research Centre. (2015) "Taken uitbesteed, maar dan? De gemeente als inkoper binnen het Sociaal Domein". CPB Notitie, 10 december 2015. Den Haag.

Dahl, I. (2016), "Markt voor kleine aanbieders zit op slot", ZORGVISIE MAGAZINE 9 september 2016.

De Koster, J. (2017), "Gemeenten en jeugdaanbieders in wurggreep". Retrieved on 26-12-2017 from: http://www.binnenlandsbestuur.nl/sociaal/nieuws/gemeenten-en-jeugdaanbieders-in-wurggreep.9559035.lynkx.

Economics Online. "Monopsony". Retrieved on 12-02-2018, from: http://www.economicsonline.co.uk/Business_economics/Monopsony.html.

Fenger, M., Chin-A-Fat, N., Frankowski, A., van der Torre, L. (2016). “Naar rechtmatige zorg in het gemeentelijke sociale domein”. Faculteit der Sociale Wetenschappen, Erasmus University Rotterdam.

Friele, R.D. et al. (2018). “Eerste evaluatie Jeugdwet”. Den Haag, ZonMw, januari 2018.

Gaynor, M. (2007), "Competition and Quality in Health Care Markets". Foundations and Trends® in Microeconomics: Vol. 2: No. 6, pp 441-508. http://dx.doi.org/10.1561/0700000024.

Gilsing, R. (2016). “Gebruik getoetst, zicht op zorg en ondersteuning van de Roermondse jeugd”. Verwey-Jonker instituut, Utrecht.

Gordon, R. A., Fujimoto, K., Kaestner, R., Korenman, S., & Abner, K. (2013). An assessment of the validity of the ECERS-R with implications for measures of child care quality and relations to child development. Developmental psychology, 49(1), 146.

Hartman, S.C., Warash, B.G., Curtis, R., Day Hirst, J. (2016) “Level of structural quality and process quality in rural preschool classrooms, Early Child Development and Care”. 186:12, 1952-1960, DOI: 10.1080/03004430.2015.1137563.

Inspectie voor de Gezondheidszorg. (2017). “Basisset Medisch Specialistische Zorg Kwaliteitsindicatoren”. Inspectie voor de Gezondheidszorg, Utrecht.

Knorth, E.J., Harder, A.T., Evenboer, E. (2016) “Jeugdhulp, wetenschappelijk verantwoord”. Researchgate, n.306288799.

Kuger, S., Kluczniok, K., Kaplan, D., & Rossbach, H. G. (2016). Stability and patterns of classroom quality in German early childhood education and care. School Effectiveness and School Improvement, 27(3), 418-440.

Manunza, E.R., Bouwman, G., Lohmann, W.M. (2015) “Juridisch leaflet Maatschappelijk Aanbesteden : Juridische mogelijkheden om de kracht van de samenleving te benutten bij aanbestedingen”. Public Procurement Research Centre (PPRC), Lunteren.

Metze, T. A. P., van den Berg, D. (2015). “Patronen doorbreken in het Amsterdamse Jeugddomein”. In W. Hafkamp, J. Koffijberg, T. Rutjens, & G. Teisman (editors), De stad kennen, de stad maken (blz. 22). The Hague: Platform 31.

Ministerie van Volksgezondheid, Welzijn en Sport. (1997) “De Kwaliteitswet zorginstellingen”. Den Haag: VWS; 1997.

Nederlands Jeugdinstituut. (2018). “Kwaliteitskompas”. Nederlands Jeugdinstituut, Utrecht.

Orde van Medisch Specialisten. (2010). “Kwaliteitskader van Medisch Specialisten”. Orde van Medisch Specialisten, Afdeling Communicatie & Informatie, Utrecht.

PIANOo Expertise Centrum Aanbestedingen, (2017). “Aanbesteden WMO 2015 en Jeugdwet, een handreiking”. Retrieved on 20-01-2018 from: https://www.pianoo.nl/sites/default/files/documents/documents/handreikingaanbestedenwmo2015enjeugdwetseptember2017.pdf.

PIANOo Expertise Centrum Aanbestedingen, (2018). “Voor welke situaties binnen het sociaal domein is (quasi) inbesteden geschikt?” Retrieved on 02-03-2018, from: https://www.pianoo.nl/metrokaart-sociaal-domein-faq/voor-welke-situaties-binnen-het-sociaal-domein-is-quasi-inbesteden-geschikt%20 .

PIANOo expertisecentrum aanbesteden. “Inkoop Sociaal domein toegelicht”. Retrieved on op 28-12-2017 from: https://www.pianoo.nl/themas/sociaal-domein/inkoop-sociaal-domein-toegelicht.

Rap, S., Liefaard, T., Rodrigues, P. (2015) “*Advies kinderrechtenmonitor 2015”*. Universiteit Leiden: Faculteit der Rechtsgeleerdheid, Afdeling Jeugdrecht/Instituut voor immigratierecht.

Rijn van, M.J., Teeven, F., Opstelten, I.W. (2018). “Jeugdwet”. Rijksoverheid, Wassenaar, 1 maart 2014.

Rijn, van. M. J. (2015). Vernieuwingsbrief zorg en ondersteuning dichtbij huis. Kamerbrief: 743438-134735-DMO. Retrieved from:

https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/kamerstukken/2015/04/ 29/kamerbrief-over-zorg-en-ondersteuning-dichtbij-huis/kamerbrief-over-zorg-enondersteuning-dichtbij-huis.pdf.

Schotanus, F. (2017, 21 november). "The purchasing processes of healthcare providers and insurers [lecture slides]". Retrieved from: https://blackboard.utwente.nl/webapps/blackboard/content/listContent.jsp?course_id=_23014_1&content_id=_1103905_1 .

Telgen, J. (2017, 24 november). "WMO purchasing [lecture slides]". Retrieved from: https://blackboard.utwente.nl/webapps/blackboard/content/listContent.jsp?course_id=_23014_1&content_id=_1103905_1.

Uenk, N., van Eijkel, R., van Ommen, W. (2015) "Taken uitbesteed, maar dan?: De gemeente als inkoper binnen het sociaal domein". Centraal Plan Bureau notitie, 10 december 2015, Den Hague.

Uenk, N., Wind, M., Telgen, J., Bastiaanssen, I. (2018). "Monitor Gemeentelijke zorginkoop 2018. Stand van zaken inkoop diensten in het kader van Wmo en Jeugdwet". Public Procurement Research Centre and NJi, Lunteren and Utrecht.

Uenk, N., Telgen, J. (2015). "Nieuw, maar niet altijd vernieuwend". University of Twente, Research Centre.

Vereniging van Nederlandse Gemeenten. (2014), "Factsheet Kwaliteitseisen jeugd-hulpaanbieders en gemeenten zoals gesteld in de Jeugdwet". Retrieved on 15-01-2018, from: https://vng.nl/files/vng/201405_factsheet_kwaliteitseisen_jeugdhulpaanbieders.pdf.

Vereniging van Nederlandse Gemeenten. "Aanbesteden van jeugdhulp". Retrieved on 12-02-2018, from: https://vng.nl/onderwerpenindex/jeugd/jeugdhulp/aanbesteden-van-jeugdhulp#Aanbesteden_van_Jeugdhulp.

Vleugels, A. (2017), "Meer kinderen in zware jeugdzorg, maar geldpot vaak leeg". Retrieved on 26-12-2017 from: https://nos.nl/artikel/2193542-meer-kinderen-in-zware-jeugdzorg-maar-geldpot-vaak-leeg.html.

APPENDIX I: NATIONAL REQUIREMENTS

Youth law, quality requirements for youth care institutes (Rijn et al. 2018; VNG, 2014):

1. All youth care institutions need to be in possession of required certificates and they are obliged to provide justified care. This includes care on a good level: safe, effective, adequate, client-centred and coordinated on the needs of the youngster or its parent;
2. All youth care providers need to be in possession of a code of conduct;
3. The youth care institutes need to provide quantitative and qualitative providers;
4. A youth care institution should have a confidential counsellor;
5. A youth care institution should work with protocols like a 'family protocol' or an 'action plan'
6. The youth care institute should have a 'report code' that provides a protocol on what to do with signals of domestic violence or child abuse. These signals should always be reported;
7. The youth care institutions should collect and register data about the quality of care in a systematic way.
8. A youth care institute should have a client council
9. A youth care institute should have a complaints committee

APPENDIX 2: INCLUDED AND EXCLUDED LITERATURE

INCLUDED

Table 18: Included literature for the first literature review, showing the author, year and most important findings.

Literature study 1: Quality requirements in tenders for youth care.			
Author(s)	**Year**	**Research Population**	**Findings**
Manunza, E.R., Bouwman, G., Lohmann, W.M.[27]	2015		Since 2012, a procurement law is operative in the Netherlands, with a proportionality principle to guarantee fair ratio's between different interests, objectives and instruments in the tender procedure. Important conditions when composing (quality) requirements are: - Requirements should concern the local context which is needed to guarantee that the task is performed as intended. - (Quality) Requirements should not result in discriminating potential youth institutes.
Uenk, N., van Eijkel, R., van Ommen, W.[29]	2015	The procurement strategies in the Social Domain of the Netherlands	- It is hard to state quality requirements in contracts due to different interests between municipalities and youth care institutes, especially when quality of care is hard to measure. - Quality requirements can only be included in a contract when municipalities can monitor the performance of youth care.
Andriessen, S.[28]	2015	Tenders for the Social domain since 2015	Requirements can be used as selection criteria - or suitability requirements -, award criteria and contract criteria - or the statement of specifications -.
Dahl, I.[30]	2016	Dutch Social Domain since 2015.	Niels Uenk, adviser for care procurement in the Netherlands, states that some municipalities make too many demands regarding quality requirements as they think in risks[31]. This leads to more requirements than necessary, which affects especially small care providers negatively[31].
Metze, T. A. P., van den Berg, D.[37]	2015		Municipalities choose for (European) tender methods to increase transparency and to create an equal playing field, though the formal requirements known in European tenders might lead to disadvantages for new and smaller providers.

			A ‘one fits all’ approach (top down) has a reverse effect in neighbourhoods, a specified personal approach per neighbourhood is more desirable.
N. Uenk, J. Telgen.[29]	2015	The procurement strategies in the Social Domain of the Netherlands	Social care can be qualified as so-called 2B-services, on which not the entire procurement law applies.
M. Fenger, N. Chin-A-Fat, A. Frankowski, L. van der Torre.[39]	2016		The government considers seven quality requirements so fundamental that they are uniformly regulated in the Youth Act: - The standard of responsible assistance, including the obligation to deploy registered professionals, unless… - Use of an assistance plan or plan of action as part of responsible care - Systematic quality control performed by youth care professionals - All youth care providers need to be in possession of a code of conduct - The youth care institute should have a ‘report code’ that provides a protocol on what to do with signals of domestic violence or child abuse. - Signals of domestic violence or abuse and calamity should always be reported - A youth care institution should have a confidential counsellor. Municipalities are allowed to set extra requirements next to these fundamental requirements.

EXCLUDED

Table 19: Excluded studies for the first literature review.

Literature review 1: Known quality requirements in Dutch youth care		
Number	**Source**	**Reason of exclusion**
1.	M.P. Knabben (2015) Jeugdzorg in verandering- Een onderzoek naar de invloed van Nieuw Publiek Management op de transitie jeugdzorg en de gevolgen hiervan voor de identiteit en het imago van jeugdzorgaanbieders in Nederland	Nothing about quality requirements after reading the abstract.
2.	B.C. Bröcking (2016) Hoe krijg je een oscar voor de regie in de jeugdhulp	No full tekst available (springer)
3.	J. Boonstra, R. van Es, M. van Twist, H. Vermaak (2017) Veranderen van maatschappelijke organisaties: praktische concepten en inspirerende praktijkverhalen	Book
4.	S. Kraaijenoord (2016) Politiek of instituties? De spanning tussen lokaal maatwerk en uniformiteit in de Wmo 2015	Title did not match subject for the review.
5.	G. Groen (2017) Control, vertrouwen en Mike. Een interpretatief onderzoek naar de verhouding tussen control en vertrouwen in de relatie tussen twee gemeenten en twee jeugdhulpaanbieders	Nothing about quality requirements after reading the abstract.
6.	G.M.N. Fleuren (2015) Intergemeentelijke samenwerking – een volmondige 'ja, ik wil' of een wel overwogen verstandshuwelijk?	Nothing about quality requirements after reading the abstract.
7.	H. Berghuis (2016) Verantwoording in de Wet maatschappelijke ondersteuning	Title did not match subject for the review.
8.	N. Brandsma, E. Huisman, B. Vermaak, C. van Weelden (2016) Medezeggenschap, 'n medicijn?:	Book

	Verschillende perspectieven en oplossingen voor medezeggenschap	
9.	W. Vanderplasschen, S. vandevelde, L. van Damme (2017) Orthopedagogische werkvelden in beweging: Recente revoluties en veranderingen in Vlaanderen	Book and focus on Belgium
10.	M. Tuncer (2017) Samenwerking als fundament voor het rolstoelenbeleid	Title did not match subject for the review.
11.	K. Kiewiet (2015) Subsidie, wat is het waard?	Title did not match subject for the review.
12.	N. Ruijs (2016) Identiteit in afhankelijkheid	Nothing about quality requirements after reading the abstract.
13.	P.L. Marijs (2016) Eén voor allen en allen voor één?	Nothing about quality requirements after reading the abstract.
	Excluded after reading	
14.	Provincie Flevoland (2015) Mededeling: RO visie Werklocaties Flevoland 2015 in ontwerp vastgesteld en vrijgegeven voor inspraak	No information about the organization of youth care and its quality
15.	J. van der Veer, M. van der Meer, A. Hemerijck (2014) Toerusting over de levensloop: naar een verbindende leerarchitectuur in het (beroeps)onderwijs	Before 2015 and focussing on education instead of youth care.
16.	A.Korsten (2015) Een stresstest van kleine gemeenten	No information about youth care or quality requirements for (youth) care.
17.	R. Gilsing, H. Boutelier, T. Nederland, B. Noordhuizen, E. Smits (2015) De gemeenteraad in een nieuwe rol	Did not discuss quality requirements for youth care procurement
18.	Korsten (2015) Waarin veel kleine gemeenten sterk en zwak zijn	Focused on the global influences on social interaction within municipalities. No information about youth care or youth procurement.

Excluded: 18

Included: 8

Table 20: Excluded literature for the second literature review.

Literature review 2: Sections of quality requirements		
Number	**Source**	**Reason of exclusion**
1.	P. van Beurden (2017) Met kaalslag bedreigd: Aantal jeugdzorgaanbieders met liquiditeitsproblemen neemt toe	No full text available (springer)
2.	B.C. Bröcking (2016) Hoe krijg je een oscar voor de regie in de jeugdhulp	No full text available (springer)
3.	F. Mulder, N. Uenk (2017) Standaardisatie in uitkomstmeting in gemeentelijke jeugdhulp	"
4.	N. Uenk (2017) Zorg aanbesteden? Er is ruimte binnen en buiten aanbesteding!: Aanbesteden verplicht?	"
5.	P.H. Peeters (2018) Jo Hermands en Robert Vermeiren:'professionele kwaliteit jeugdteams moet beter'	"
6.	Olie (2016) Inkoop jeugdhulp door Nederlandse gemeenten	Nothing about the use of tenders for the procurement of youth care in the abstract.
7.	M. van Dorp (2018) We steunen het verzet tegen te lage tarieven	No full text available (springer)
8.	M.P. Knabben (2015) Jeugdzorg in verandering – Een onderzoek naar de invloed van Nieuw Publiek Management op de transitie van jeugdzorg en de gevolgen…	Nothing about the use of tenders for the procurement of youth care in the abstract.
9.	T. Boeder (2016) Het gebruik van prestatie-informatie door managers in de jeugdzorg	Nothing about the use of tenders for the procurement of youth care in the abstract.
10.	P. de Lange (2017) Terugblik themadag sociaal domein	No full text available (springer)
11.	E. Koopman (2016) Samen grip op risico's	Nothing about the use of tenders for the procurement of youth care in the abstract.
12.	G. Groen (2017) Control, vertrouwen en Mike. Een interpretatief onderzoek naar de verhouding tussen control en vertrouwen in de relatie tussen twee gemeenten en twee jeugdhulpaanbieders	Title did not match subject for the review.

13.	W. Vanderplasschen, S. vandevelde, L. van Damme (2017) Orthopedagogische werkvelden in beweging: Recente revoluties en veranderingen in Vlaanderen	Book and focus on Belgium
14.	R. Koolen (2015) Contracten in de Wmo	Title did not match subject for the review.
15.	D.Marselis (2016) Wijkteams: werk in uitvoering	No full text available (springer)
16.	J. Boonstra, R. van Es, M. van Twist, H. Vermaak (2017) Veranderen van maatschappelijke organisaties: praktische concepten en inspirerende praktijkverhalen	Book
17.	S. Kraaijenoord (2016) Politiek of instituties? De spanning tussen lokaal maatwerk en uniformiteit in de Wmo 2015	Title did not match subject for the review.
18.	V. Mahieu, I. Ravier, C. Vanneste (2015) Naar een beeld van de gegevens aangaande geregistreerde jeugddelinquentie in het Brussels Hoofdstedelijk Gewest	Title did not match subject for the review.
19.	T. van Regenmortel (2016) Empowerment zorgt ervoor dat mensen niet steeds weer gekwetst worden	Title did not match subject for the review.
20.	A.H.D. Twijnstra (2015) Van Rijk naar Wijk	Nothing about the use of tenders for the procurement of youth care in the abstract.
21.	G.M.N. Fleuren (2015) Intergemeentelijke samenwerking – een volmondige ‘ja, ik wil’ of een wel overwogen verstandshuwelijk?	Nothing about the use of tenders for the procurement of youth care in the abstract.
22.	I.B. de Vries (2015) Jij of ik? Uitbesteding in het sociaal domein	Nothing about the use of tenders for the procurement of youth care in the abstract.
23.	M. Tuncer (2017) Samenwerking als fundament voor het rolstoelenbeleid	Title did not match subject for the review.
24.	F.Schreurs (2017) New Public Governance en de gevolgen voor de gemeentelijke rekenkamer	Nothing about the use of tenders for the procurement of youth care in the abstract.
25.	J. Akkerman (2017) Op weg naar een ris arbeidsmarkt	Title did not match subject for the review.

26.	L.H. Heuzels (2017) Decentralisations in the Dutch social care sector	Nothing about the use of tenders for the procurement of youth care in the abstract.
27.	Thoonen, E., Duijst, W., Thoonen, E., & Duijst, W. (2015). Onderzoek politiedoden onder de loep: verdragsverplichtingen en Nederlandse praktijk|. Cahiers Politiestudies, 4, 91-115.	Title did not match subject for the review.
28.	Veen, O. (2017). De macht van het volk (Master's thesis).	Nothing about the use of tenders for the procurement of youth care in the abstract.
29.	Cörvers, F., Claessen, J., & Kluijfhout, E. (2015). Onderwijsarbeidsmarkt en lerarenopleidingen op Caribisch Nederland.	Title did not match subject for the review.
30.	ROA, C. B., & ROA, F. C. (2015). ROA Technical Report.	Nothing about the use of tenders for the procurement of youth care in the abstract.
31.	Hessel, B. (2015). Het Europees toezicht op staatssteun en de beleidskansen voor decentrale overheden en de rijksoverheid. Een beschrijving van de staatssteunregels vanuit het beleidsmatig Europabewustzijn.	Nothing about the use of tenders for the procurement of youth care in the abstract.
32.	van der Veer, J. C. V., Meer, M., & Hemerijck, A. C. (2015). Toerusting over de levensloop: naar een verbindende leerarchitectuur in het (beroeps) onderwijs. Een beschouwing over institutionele herijking op het grensvlak van onderwijs en arbeidsmarkt.	Title did not match subject for the review.
33.	Vrooman, J. C., & van Echtelt, P. (2017). Weinig scholing, weinig toekomst? Mechanismen van vraag en aanbod bij laagopgeleiden. TPEdigitaal, 11(1), 37-61.	Title did not match subject for the review.
34.	Brand, B. (2017). Is concurrentie verlammend voor bestuursnetwerken? Een case study naar de invloed van netwerkstabiliteit op het vermogen	Title did not match subject for the review.

	van netwerkorganisaties om doelstellingen te behalen (Master's thesis, Open Universiteit Nederland).	
35.	Tuytschaever, S., & Ruyssen, I. Hoger onderwijs voor vluchtelingen in Vlaanderen.	Title did not match subject for the review.
36.	Antokolskaia, M. V., Coenraad, L. M., Tomassen-van der Lans, M., van den Berg, C. J. W., Kaljee, J., Roorda, H. N., ... & Schellevis, T. (2017). Evaluatie pilot preventie vechtscheidingen en pilot regierechter echtscheidingen. Raad voor de rechtspraak Research memoranda, 12(3).	Title did not match subject for the review.
37.	Uijlenbroek, J. J. M., Dijkstra, G. S. A., van der Meer, F. M., van den Berg, C. F., Van, K. F., Voet, J., ... & Vuuren, T. V. (2016). Staat van de ambtelijke dienst 2015 De overheid in tijden van verandering.	Nothing about the use of tenders for the procurement of youth care in the abstract.
38.	Ruijs, N. M. (2016). Identiteit in Afhankelijkheid Een onderzoek naar de afhankelijkheid van belangenbehartigingsorganisaties in een netwerk (Master's thesis).	Title did not match subject for the review.
39.	De Ceuninck, K., Valcke, T., & Verhelst, T. (2015). Quid pro quo? Nederlandse inspiratie voor een vernieuwde taakstelling van de Vlaamse provincies.	Title did not match subject for the review.
40.	van der Molen, I., Politie, G., & en Justitie, M. V. V. (2015). RISICOMANAGEMENT 2.0: VAN RISICO-BEWUST NAAR RISICO-GESTUURD IN EEN POLITIEK-BESTUURLIJKE OMGEVING.	Title did not match subject for the review.
41.	Warsen, R. (2016). *The city as 'simul'player: A study of the way municipalities internally coordinate their participation in intergovernmental cooperation* (Master's thesis).	Nothing about the use of tenders for the procurement of youth care in the abstract.
42.	SNELLER, O. R. V. L. IT REGIE DECENTRAAL EN CENTRAAL.	Nothing about the use of tenders for the procurement of youth care in the abstract.

43.	Thiel, S. V. (2017). Organiseren voor tevredenheid.	Nothing about the use of tenders for the procurement of youth care in the abstract.
44.	Koffijberg, J., & Teisman, G. De sociale stad. *Colofon*, 1.	Nothing about the use of tenders for the procurement of youth care in the abstract.
	AFTER READING TEXT	
45.	M. Valkestijn, P.P. Bakker, P. Hilverdink (2015) Jongerenwerk in beeld	Only focus on youth care without looking at the specific places for quality requirements in tenders
46.	Regio Twente (2016) Evaluatie samenwerking Samen14/OZJT	No information about the different places to use quality requirements in tenders
47.	M.L. van Genugten, J.A.M. de Kruif, P.J. Zwaan (2017) Samen werken aan effectieve regionale samenwerking	Nothing about award criteria, selection criteria or other places for criteria in tenders
48.	D.Busch, T.M.C. Arons, J.E.C. Gulyás, A. van den Hurk (2016) Financieel Recht	Focus on economy, no information about tenders and the quality requirements seen in them.
49.	M.V. Antokolskaia, L.M. Coenraad (2017) Evaluatie pilot preventie vechtscheidingen en pilot regierechter echtscheidingen	Tells about tenders but without any depth, no information about criteria at all.
50.	Bröcker, L. de Groot-van Leeuwen, M. Laemers (2016) Verschuiving van rechterlijke taken	Focus on the legal system during the decentralization, though no specific information about quality requirements was given: only the general requirements.
51.	Grootegoed, A. Machielse, E. Tonkens, L. Blonk, S. Wouters (2017) Aan de andere kant van de schutting	Focus on the importance of voluntary work
52.	M. Fenger, N. Chin-A-Fat, A. Frankowski, L. van der Torre (2016) Naar rechtmatige zorg in het gemeentelijke sociale domein	Subject is fraud by municipalities in youth care since 2015. Nothing about award criteria, selection criteria or quality requirements.
53.	Gevel, B. & van Diepen, A. soc bestek (2017) 79: 37. https://doi.org/10.1007/s41196-017-0545-6	No full text available (Springer)
54.	Lange, de P. (2017) Terugblik themadag sociaal domein. HEADline, 2017 - Springer	Review of a meeting about the social domain, nothing about the sections of criteria.

55.	Cockx, B., & Baert, S. (2015). Contracting Out Mandatory Counselling and Training for Long-Term Unemployed. Private For-Profit or Non-Profit, or Keep it Public?, mimeo.	Nothing about award criteria, selection criteria or quality requirements.
56.	Brouwers, J. (2015). De voorwaarden voor een bedrijfsvoeringsorganisatie.	Master thesis about organizational influences on organizational power
57.	Schuurman, J., Beerlandt, H., & Coussement, I. Hoe omgaan met de private sector in ontwikkelingssamenwerking? Het belang van het middenveld, landbouworganisaties en coöperaties. De betrokken samenleving, 61.	Belgium article about collaboration of different sectors, nothing about the sections of criteria.
58.	van de Poel, P. (2017). Decentralisatie vertroebelt governance. Skipr, 10(1), 10-21.	No full text available (Springer)
59.	N. Brandsma, E. Huisman, B. Vermaak, C. van Weelden (2016) Medezeggenschap, 'n medicijn?: Verschillende perspectieven en oplossingen voor medezeggenschap	Book and nothing about the section of requirements
60.	Valcke, T., De Ceuninck, K., & Verhelst, T. (2016). Inspiratie boven de Moerdijk? Een analyse van de territoriale, bestuurlijke, functionele en financiële organisatie van de Nederlandse provincies. *TIJDSCHRIFT VOOR BESTUURSWETENSCHAPPEN EN PUBLIEKRECHT*, *2*, 63-80.	Focus on the system of local government and no information about the sections.
61.	van Dieën, E. (2016). De opdrachtgever–2de herziene druk. Van Haren.	Book and nothing about the section of requirements
62.	Steunenberg, B., Akerboom, M., & Hutten, P. (2015). De wisselwerking tussen Europa en Nederland: Een verkenning van de Europese prioriteiten en hun invloed op de verschillende overheden in Nederland.	Focus on national and international priorities, nothing about the sections of requirements.
63.	Korsten, A. A. F. (2017). Omgaan met de regionale schaal. *update*.	About a specific region with methods for purchasing youth care and wmo, but nothing specific about purchasing strategies.

64.	Van Regenmortel, T. (2016). De gouden formule. 10 Gouden Sociale Gemeenten aan het woord.	Review of 10 municipalities about their purchasing technique, more focusing on dialogue and prevention methods instead of procurement.
65.	Janssen, R. T. (2017). Het onzekere voor het zekere, tweebenig besturen in de zorg.	Tells about the history of law and regulation for the Dutch health care with a focus on the economic influences.
66.	Putters, K. (2017). Was getekend. Op weg naar een vernieuwd sociaal contract in de zorg.	About the health care system on a broader scale, nothing about procurement strategies and tenders.
67.	Kloe, M. D. (2016). Samenwerken of concurreren?: De relatie tussen centrumgemeenten en randgemeenten in het licht van globalisering en Europese integratie (Bachelor's thesis).	Critical evaluation of the municipality Amsterdam, nothing about tenders and procurement strategies.
68.	Lupi, T. Het belang van slow s. Kenniswerkplaats-leefbaar.nl	About re-integration projects of juveniles with mental problems.
69.	Campman, M. (2015). De kanteling in de zorg.	Overview of the new possibilities with the new youth law, nothing specific about tenders and procurement techniques.
70.	HEUZELS, L. (2017). Decentralisations in the Dutch social care sector: researching approaches of municipal commissioning of social care on patient perceived quality of care and self-reliance (Master's thesis, University of Twente).	Focus on the quality of care perceived by patients without naming the use of tenders and the sections in tenders to improve quality of care.
71.	Gijsberts, B. (2015) “Ontwerp RO visie werklocaties Flevoland 2015.	About the vision of Flevoland for their conduct of business.
72.	Vrooman, J. C., Josten, E., & van Echtelt, P. (2016). De laagopgeleiden van de toekomst: meer dan een scholingsprobleem.	About the consequences of low education among citizens.
73.	Manunza, E. R., & Janssen, W. A. (2015). De inbesteding van scanwerkzaamheden: Een onderzoek naar de juridische conformiteit van de inbesteding van de scanwerkzaamheden door het Nationaal Archief aan de Belastingdienst met de aanbestedingsregels (Deel I) en naar de nut en noodzaak om de keuze voor in-of uitbesteden te reguleren (Deel II).	About ‘inbesteding’

74.	Berghuis, H. (2016). Verantwoording in de Wet maatschappelijke ondersteuning-Een kwalitatief onderzoek naar strategieën van zorgaanbieders om transactiekosten te verlagen binnen de kaders van de quasi-markt (Master's thesis).	Master thesis about procurement strategies and their advantages/disadvantages.

Excluded: 74

Included: 2

APPENDIX III: TOP TEN REQUIREMENTS PER SECTION

Table 21: Top ten requirements seen in the Statement of specifications.

Top ten quality requirements seen in Statement of specifications	Required N times	%
1. Aanbieder garandeert dat hij voldoet aan alle (kwaliteits)eisen die zijn opgenomen in de Jeugdwet en alle andere relevante wet- en regelgeven voor de uitvoering van de opdracht / Aanbieder werkt volgens de eisen omtrent de verlening van hulp en ondersteuning, zoals deze in de wetten worden gesteld waar de te leveren ondersteuning op rust. Gedurende contractperiode Landelijk	550	
2. Opdrachtnemer kent een klachtenregeling en vertrouwenspersoon (meldingsregeling calamiteiten en geweld) en handelt hiernaar / klachtenregeling die voldoet aan de in de Wet kwaliteit, klachten en geschillen zorg (Wkkgz)	540	
3. Wanneer een cliënt de jeugdhulp bij een andere aanbieder gaat afnemen, dan dient de nieuwe aanbieder een zogenaamde 'warme overdracht' van informatie en werkrelatie van de cliënt met hulpverlener van huidige naar nieuwe aanbieder te organiseren.	371	
4. VOG conform de jeugdwet (alle personeelsleden en vrijwilligers)	339	
5. Kwaliteitshandboek / kwaliteitsbeleid / HKZ-certificering / meest recente kwaliteitskader jeugd / kwaliteitsmanagementsysteem / inschrijver werkt systematisch aan het behouden en verbeteren van de kwaliteit / meest recente kwaliteitskaders die van toepassing zijn	316	
6. Aanbieder kan aantonen dat bij het opstellen van het ondersteuningsplan de cliënt en zijn naasten actief zijn betrokken; de vraag, behoefte, wensen en doelen van de cliënt zijn vastgelegd.	290	
7. Aanbieder is in staat om per ingangsdatum van de overeenkomst de door hem aangeboden dienstverlening daadwerkelijk te leveren.	281	
8. De rechten van de cliënten in het kader van privacy en gegevensverwerkingen worden door aanbieders steeds geborgd. Vastgelegd privacy beleid / privacyprotocol	267	
9. Meldcode huiselijk geweld en kindermishandeling	257	
10. SKJ/BIG registratie medewerkers	234	

Table 22: Top ten requirements seen in the Selection criteria.

	Top ten requirements seen as selection criteria (16 requirements)	Required N times
1.	Inschrijver toont aan een adequate verzekering tegen bedrijfs- en beroepsaansprakelijk te hebben	377
2.	SKJ/BIG registratie medewerkers **AND** VOG conform de jeugdwet (alle personeelsleden en vrijwilligers)	268
3.	Aanbieder is ingeschreven in het register van de Kamer van Koophandel	266

4.	Aanbieder garandeert dat hij voldoet aan alle (kwaliteits)eisen die zijn opgenomen in de Jeugdwet en alle andere relevante wet- en regelgeven voor de uitvoering van de opdracht / Aanbieder werkt volgens de eisen omtrent de verlening van hulp en ondersteuning, zoals deze in de wetten worden gesteld waar de te leveren ondersteuning op rust. **AND** Kwaliteitshandboek / kwaliteitsbeleid / HKZ-certificering / meest recente kwaliteitskader jeugd / kwaliteitsmanagementsysteem / inschrijver werkt systematisch aan het behouden en verbeteren van de kwaliteit / meest recente kwaliteitskaders die van toepassing zijn	265
5.	Aanbieder levert de hulp/ondersteuning steeds met voldoende gekwalificeerd personeel, passend bij de aard van de hulp/ondersteuning. Geldende professionele standaarden / opdrachtnemer beschikt over aantoonbaar bekwaam en gekwalificeerd personeel / personeel wordt ingezet dat aan de kwaliteitseisen van de opdracht voldoen	223
6.	Opdrachtnemer kent een klachtenregeling en vertrouwenspersoon (meldingsregeling calamiteiten en geweld) en handelt hiernaar / klachtenregeling die voldoet aan de in de Wet kwaliteit, klachten en geschillen zorg (Wkkgz)	201
7.	Inschrijver houdt zich aan de beroepscode, de bepalingen van de WGBO of soortgelijke bepalingen in de Jeugdwet over o.a beroepsgeheim en privacy	189
8.	Inschrijver staat ingeschreven in het beroeps- of handelsregister of een vergelijkbaar register in het land van vestiging van de onderneming **AND** Meldcode huiselijk geweld en kindermishandeling	133
9.	Gegadigde dient aan de hand van een (of meer) referentieopdracht(en) voor de opdracht waar hij op inschrijft aan te tonen dat hij beschikt over de gevraagde kerncompetentie/ervaring. Een referentieopdracht moet zijn uitgevoerd in de drie jaar voorafgaand aan de uiterste datum van Inschrijving. De referentieopdracht hoeft niet te zijn afgerond. Competentie: Kennis en ervaring met alle diverse cliëntgroepen(J-GGZ, JmB en J&O), problematieken en bijbehorende dienstverlening	105
10.	Aanbieder kan aantonen dat de cliënt beschikt over keuzevrijheid, medezeggenschap en inspraak / het organiseren van medezeggenschap (jeugdwet) **AND** Acceptatieplicht client, tenzij niet van hem gevraagd kan worden of opdrachtnemer aantoont dat hij niet de juiste zorg kan bieden binnen de gestelde indicatieperiode / geen uitsluiting bepaalde geloofdovertuiging, etnische minderheden of vanwege taal **AND** Opdrachtnemer hanteert bij de verwerking van persoonsgegevens de uitgangspunten van de Wet Bescherming Persoonsgegevens en de Wet Geneeskundige Behandelingoveroonkomst en respecteert de rechten van Jeugdigen en vertegenwoordigers op basis van die regelgeving **AND** Jaarlijks wordt een rapport uitgebracht over de wijze waarop invulling wordt gegeven aan het in het bestek beschreven mobiliteitsbeleid en de daarmee behaalde resultaten.Opdrachtnemer draagt bij aan de duurzaamheidsdoelstelling van de deelnemende gemeenten door te stimuleren dat: De duur en het aantal verkeersbewegingen van medewerkers, aanbieders, cliënten worden beperkt door bijvoorbeeld (dagbestedings)activiteiten in de nabijheid van klanten te organiseren, of door bevordering van Het Nieuwe Werken.•Medewerkers, aanbieders, cliënten overstappen naar voor het milieu minder belastende vormen van verplaatsen door fietsen, lopen of het gebruik van openbaar vervoer, of deelauto's te bevorderen.•Medewerkers en aanbieders duurzame voertuigen aanschaffen die gebruik maken van groen gas of elektriciteit.	98

Table 23: Top ten requirements seen in the Award criteria.

All award requirements found in the 987 contracts	Required N times
1. Aanbieder levert de hulp/ondersteuning steeds met voldoende gekwalificeerd personeel, passend bij de aard van de hulp/ondersteuning. Geldende professionele standaarden / opdrachtnemer beschikt over aantoonbaar bekwaam en gekwalificeerd personeel / personeel wordt ingezet dat aan de kwaliteitseisen van de opdracht voldoen	162
2. Aanbieder onderschrijft en implementeert vooruitlopend op het model Soepele Overgang de beschreven werkwijze (uiterlijk 6 maanden voor de 18e verjaardag van een jongere een risicoanalyse uitgevoerd…)	142
3. VOG conform de jeugdwet (alle personeelsleden en vrijwilligers)	120
4. De rechten van de cliënten in het kader van privacy en gegevensverwerkingen worden door aanbieders steeds geborgd. Vastgelegd privacy beleid / privacyprotocol	120
5. Meldcode huiselijk geweld en kindermishandeling	120
6. Aanbieder is bekend dat de gemeenten voor de uitvoering van haar taken in het kader van de jeugdwet lokaal beleid hebben ontwikkeld, is hiermee en met de lokale veroderningen inzake jeugdhulp bekend en handelt hier naar.	120
7. Opdrachtnemer verleent de toegekende jeugdhulp zonder enige (aanvullende) betalingen door cliënt/ouders/gezin. Kosten	120
8. Aanbieder werkt voor cliënten tot en met 23 jaar met een Verwijsindex (voor risicojongeren)	120
9. Aanbieder stemt in met de voorwaarden die gesteld worden aan de dienstverlening op de Friese Waddeneilanden.	120
10. Aanbieder stemt in met het administratieprotocol dat voor hem van toepassing is	120
11. Aanbieder benoemt voor opdrachtgever binnen haar organisatie één aanspreekpunt die binnen afgesproken termijn van het geval vragen beantwoord, knelpunten oplost, coördineert en bewaakt dat de gemaakte afspraak wordt nagekomen	120
12. Personeel van aanbieder (voor zover betrokken bij cliënten) beheerst passief de Friese taal.	120
13. Aanbieder organiseert voor zoveel als mogelijk de hulp laagdrempelig op de plaats en tijdstip (binnen redelijke grenzen), die jeugdige en de ouder wenst.	100
14. Aanbieder gaat akkoord met de eis dat indien zij diensten in onderaanneming aanbiedt aan/bij derden, zij te allen tijde als hoofdaannemer zal optreden en dat zij te allen tijde volledig verantwoordelijk is voor de uitvoering van de opdracht.	100
15. Aanbieder onderschrijft het uitgangspunt dat niet leeftijd, maar de ontwikkeling van de jongere leidend is.	100
16. Indien tijdens het opstellen van en/of het uitvoeren van het behandel/ondersteuningsplan blijkt dat de Jeugdige onder een ander ondersteuningsprofiel en/of intensiteit valt, om welke reden dan ook, stemt de aanbieder dit af met het gezin en GT / gemeente (in geval van regisseur)	80
17. Aanbieder informeert na het opstellen van het behandel/ondersteuningsplan het gezin over het plan en de te bereiken doelen	80
18. Zorgaanbieder onderschrijft dat een deel van de jongeren baat heeft bij het jeugdhulpaanbod op een moment dat verlengde hulp niet (meer) mogelijk is. Maatwerkbudget inzetten, domein jeugd, centrumgemeente.	80
19. Zorgaanbieder heeft een inspanningsverplichting om te voorkomen dat bij een behandeling of traject een overdracht naar een andere behandelaar of organisatie plaatsvindt omdat een jongere meerjarig wordt.	80
20. Opdrachtnemer draagt zorg voor een goede samenwerking en communicatie met de Lokale Teams en andere relevante actoren (die betrokken zijn bij het Perspectiefplan) onder goede samenwerking wordt in ieder geval verstaan onderlinge afstemming tussen eigen personeel en de overige betrokkenen of de te betrekken professionals	60
21. Aanbieder wordt gevraagd een beschrijving aan te leveren over de wijze waaropvoldoende kennis, kunde en ervaring van personeel in uw organisatie geborgd is om maatwerk per Jeugdigete leveren die tegemoet komt aan de specifieke behoefte van de betreffende Jeugdige.	45

22. Aanbieder wordt gevraagd een beschrijving aan te leveren over de wijze waarop u de nieuwe methodiek van resultaatgerichte bekostiging in uw organisatie heeft vormgegeven of gaat vormgeven, om voor uzelf, de GR-JR en Jeugdigensuccesvol te kunnen zijn	45
23. Aanbieder wordt gevraagd een beschrijving aan te leveren vande wijze waarop u reeds samenwerkt of in de toekomst gaat samenwerken met andere actoren in het veld, zoalseigen netwerk Jeugdige, JBRR, gemeenten, (huis)artsen, ZVW, 0e(welzijnsaanbieders) en 1elijns (Lokale teams) zorgaanbieders, WMO aanbieders, sportclubs en onderwijs	45
24. Het verantwoordelijke management van Opdrachtnemer en de met de uitvoering van dienst belaste personeelsleden beheersen de Nederlandse taal in woord en geschrift in voldoende mate voor zover relevant voor de uitvoering van de onderhavige werkzaamheden en de eventuele contractuele verplichting.	42
25. U gaat ermee akkoord binnen 5/15 werkdagen na dagtekening van de beschikking te starten met de uitvoering van de maatregel.	42
26. Aanbieder draagt er zorg voor dat er wordt gewerkt met een passend ondersteuningsplan en dat actieve afstemming plaatsvindt tussen de diverse hulptrajecten / lokale toegang/ overige betrokken instanties	42
27. Indien er sprake is van een voor de ondersteuning relevante verandering in de situatie van de burger, meldt opdrachtnemer dit (binnen twee werkdagen) bij de regisseur	42
28. Het vervoer moet altijd plaatsvinden overeenkomstig de normen inzake veilig vervoer, wagenpark en competenties van de chauffeurs, zoals gesteld in TX-Keur (zie bijlage). Als een taxibedrijf wordt ingezet dan dient deze daadwerkelijk te beschikken over TX-Keur of gelijkwaardig. Bij het vervoer van clienten in een rolstoel dient de code VVR (Veilig Vervoer Rolstoelen) nageleegd te worden. Dit geldt voor zowel taxibedrijven als andere mobiliteitsoplossingen.	42
29. Behalve de managementrapportages, die eens per kwartaal moeten worden aangeleverd, wordt ook een jaarrapportage van alle opdrachtnemers gevraagd. Hierin verstrekt de opdrachtnemer alle informatie die relevant is voor de uitvoering van de raamovereenkomst en de wettelijke voorschriften die betrekking hebben op de levering van de jeugdhulp. De informatie wordt uiterlijk 1 maand na afronding van het boekjaar aangeleverd.	42
30. Van gemeenten, zorgaanbieders en cliënten wordt verwacht dat zij in gezamenlijkheid, met de wetgeving (Wmo 2015 en Jeugdwet) als basis, kwaliteitsbeleid en kwaliteitsnormen (verder) ontwikkelen, de kwaliteit van zorg en ondersteuning bewaken en in een continu proces blijven verbeteren.	42
31. Naast de eigen kwaliteits gegevens moet de opdrachtnemer gegevens aanleveren aan het rijk voor landelijke monitoring (verplichting uit de Jeugdwet). Het betreft gegevens vermeld in de factsheet dataset beleidsinformatie jeugd	42
32. We hanteren een wettelijke termijn van maximaal 6 weken na melding voor onderzoek en het opstellen van een Maatschappelijk Ondersteuningsplan door de gemeente. Wanneer de hulpvraag niet kan worden opgelost door middel van eigen kracht, het eigen netwerk, algemene oplossingen of algemene voorzieningen, dan kan een aanvraag worden ingediend voor een maatwerkvoorziening. Na het indienen van de aanvraag heeft de gemeente maximaal 2 weken de tijd om te beslissen. Na het afgeven van een beschikking volgt opdrachtverstrekking aan opdrachtnemer. Op grond van de opdrachtverstrekking stelt opdrachtnemer samen met de cliënt een zorgplan op waarin duidelijk wordt op welke wijze het resultaat wordt behaald	42
33. Gemeenten werken met het regisseursmodel. In het regisseursmodel is een onafhankelijke regisseur verantwoordelijk om met zijn cliënt een bepaald resultaat te bereiken. Dat resultaat kan bereikt worden door de eigen kracht van de cliënt te benutten, gebruik te maken van informele zorg en door algemene voorzieningen of een maatwerkvoorziening in te zetten. Uitgangspunt daarbij is om de ondersteuning zo dicht mogelijk bij de cliënt te organiseren.De regisseur stelt, samen met de cliënt (of zijn/haar sociale omgeving indien de cliënt hiertoe niet zelf in staat is), een ondersteuningsplan op. Het plan beschrijft het resultaat dat bereikt moet worden en de elementen die de regisseur hiervoor wil inzetten. Na goedkeuring is het de taak van de regisseur om de kwaliteit van de uitvoering van het ondersteuningsplan te bewaken, de tevredenheid van betrokkenen periodiek te evalueren en het plan bij te stellen wanneer dit nodig is.	42
34. Aanbieder voert in ieder geval haar eigen cliënttevredenheidsonderzoek uit.	42
35. Gemeenten kunnen sturen op zo min mogelijk verschillende aanbieders/professionals per cliënt. Het is aan de regisseur van de individuele gemeente om hier in meer of mindere mate op te sturen. Dit betekent dat de inzet op deze eis per gemeente kan verschillen	42
36. Voor een goede uitvoering van de opdracht vindt opdrachtgever het noodzakelijk dat opdrachtnemers over voldoende kennis en mogelijkheden beschikken over de lokale zorgstructuur (bijvoorbeeld	42

	algemene voorzieningen) om zo de meeste effectieve en efficiënte ondersteuning in te kunnen zetten. Om die reden heeft opdrachtnemer tevens een binding met de regio Twente en beschikt hij aantoonbaar over een lokaal en regionaal netwerk	
37.	Opdrachtnnemer en haar medewerkers zijn betrouwbaar. Deze indicator omvat de volgende subthema's: •de medewerker houdt zich aan afgesproken werkzaamheden en afgesproken tijden;uiterlijk 1 dag voor het afgesproken moment wordt met de cliënt besproken als een medewerker op een andere dan de afgesproken tijd komt;••het aantal medewerkers dat voor ondersteuning bij een cliënt komt, wordt tot een minimum beperkt	42
38.	De aanbieder die bewindvoerder is voor een cliënt, mag niet zelf de ondersteuning uitvoeren	42
39.	Aanbieder wordt gevraagd een beschrijving aan te leveren over de methoden die worden toegepast voor de begeleiding en/of behandeling van Jeugdigen	30
40.	Aanbieder houdt zich aan het Protocol Dyslexie Diagnostiek en behandeling (landelijk vastgesteld	20
41.	Pleegouders worden zorgvuldig geselecteerd op hun geschiktheid om te zorgen voor het kind van een ander en goed voorbereid op de plaatsing. Pleegouders krijgen de mogelijkheid om bijgeschoold te worden, extra ondersteuning te krijgen en/of andere pleegouders te ontmoeten. afspraken maken over de wijze van verzorging en opvoeding en ondersteuning voor de ouders	20
42.	Pleegouders en pleegzorgaanbieder voldoet aan de wettelijke eisen voor pleegzorg	20
43.	Er is goede samenwerking tussen de pleegouders, de pleegzorgaanbieder, de gezinsvoogd en eventuele andere begeleiders van de jeugdige en/of ouders (één plan)	20
44.	Er is sprake van een zorgvuldige match tussen het pleegkind en de pleegouders, gelet op de leeftijd, cultuur, religie en problemen van het kind, de samenstelling en competenties van het pleeggezin en de verwachtte duur van de plaatsing.	20
45.	Aanbieder werkt aantoonbaar naar de landelijke norm van het aantal behandeltrajecten	20
46.	Zorgen voor een soepele overgang wanneer jeugdige 18 wordt. Als pleegkinderen 18 jaar worden zijn ze voor de wet volwassen. De pleegzorgvergoeding voor de pleegouders voor verblijf eindigt dan ook.	20
47.	Aanbieder speelt aantoonbaar een pro-actieve en uitdrukkelijke rol in de kwaliteitsverbetering van het taalleesonderwijs en begeleiding op school.	20
48.	Aanbieder wordt gevraagd een beschrijving aan te leveren van de wijze waarop afschaling van zorg efficiënt en effectief is georganiseerd.	15