Redesigning home care

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Redesigning home care

From a bureaucratic to a socio-technical type of provider organisation

Tom Peeters

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Redesigning home care

**From a bureaucratic to a socio-technical type of
provider organisation**

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad van doctor aan de Universiteit Maastricht,
op gezag van de Rector Magnificus, Prof. dr. L.L.G. Soete
volgens het besluit van het College van Decanen,
in het openbaar te verdedigen op donderdag 26 november 2015, om 16:00 uur

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Prof. dr. J.M.G.A. Schols

WAAR GE OK LOEPT EN WAT GE OK BINT
NIEMAND DI ZET OW WAT GOED IS OF SIECHT
NIEMAND DI WET WIE VERLUST OF WIE WINT
GE KOMT OP 'T END BEET OW DEEF TERECHT

Jack Poels, Rowwen Hèze

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Chapter 1

Introduction

1. Introduction

Homecare provider organisations in the Netherlands – hereafter provider organisations – face an environment that has presumably become more turbulent and strenuous than ever before. Over the last decade the government has taken various reform measures to rein in the growth of long-term care and safeguard its future sustainability. These measures have also affected the home care sector and have major implications for provider organisations. They are expected to quickly adjust to the new regulatory environment and do ‘more with less’. In addition, they must respond better to their clients, who increasingly expect individually tailored services offered in a timely manner. Last but not least, they need to stay healthy by performing efficiently and creating good working conditions for their workers. Given all these requirements, it comes as no surprise that managing a provider organisation has become a challenging task.

Provider organisations are aware of the growing turbulence of their environment. This has resulted in a fundamental reconsideration of the traditional way in which they are organised. There have been various initiatives to change their organisation from a bureaucratically organised type into an alternative type based upon the principles of the socio-technical design approach with the purpose of being better able to adapt to their turbulent environment. The socio-technical design approach to work and organisations aims to enhance the effectiveness of organisations by balancing the quality of organisation, the quality of work and the quality of working relations (De Sitter, 1982; 1994; 1998; Van Amelsvoort, 1999; Achterbergh & Vriens, 2010; Kuipers, Van Amelsvoort & Kramer, 2010). As we will explain in chapter 3, quality of organisation refers to the organisation’s potential to be in control, flexible and innovative. Quality of work concerns the relationship between the organisation of work and the employees in terms of meaningfulness of jobs and the employees’ ability to deal with work-related disturbances. Quality of working relations is conceptualised as the organisation’s capability to realise effective communication relationships. The socio-technical design approach rests upon Ashby’s law of ‘requisite variety’, stating that only variety can absorb variety (Ashby, 1958). Based on this law, an organisation must continuously seek to realise an architecture which can internally control the variety of requirements coming from the external environment (Ashby, 1958; 1969).

The purpose of this study is to investigate the effectiveness of initiatives of provider organisations in home care to transform their organisation according to the principles of the socio-technical design approach. This will be done by means of a comparative case study in two provider organisations. The comparative case study seeks to investigate the effectiveness of the change process and to explain the similarities and differences in both cases. It also addresses the wider question of whether the intended

change can be successful at all in the very turbulent environment which provider organisations must cope with. The effectiveness of the change will not be measured in terms of performance indicators such as total revenues, solvability rates and overhead costs. Instead, our study takes the socio-technical perspective by focusing upon the aforementioned three ‘qualities’. It also incorporates the view and attitude of the employees, given the existence of a mutual relationship between the change results and the employees’ perception. The way employees perceive the change tells us something about the results of the change. At the same time, however, their perception is also an important factor in the change process itself. If employees are positive about the change, their ‘positivism’ is likely to increase the probability of effective change. However, if they are negative, their ‘negativism’ is expected to affect the change negatively.

1.1 Subject and relevance of the study

Provider organisations increasingly realise that the bureaucratic type of organisation is no longer appropriate in the current homecare environment. In addition to developments such as the ageing of the population and a trend towards individualisation, they must struggle with environmental turbulence in their political context, now that the government is implementing a major reform of long-term care to ensure its sustainability in future. This reform, which has come into force in 2015, has significant consequences not only for residential care, but also, and presumably even more, for home care.

The concept of *environmental turbulence* has been studied widely and from different perspectives, resulting in various views and dimensions (e.g. Emery & Trist, 1965; Khandwalla, 1977; Katz & Kahn, 1978; Pfeffer & Salancik, 1978; Aldrich, 1979; Jansen, Van Den Bosch & Volberda, 2006). Volberda (2004) offers an integrated view, which is useful for this study, by defining environmental turbulence as the interplay between complexity, dynamics and unpredictability (Figure 1.1):

- *Complexity* refers to the number of heterogeneous actors in the environment as well as the interconnectedness between these actors. The environment is highly complex when it involves many heterogeneous actors who are tightly interconnected (Volberda, 2004). As we will explore in the next chapter, the environment of provider organisations is complex. Home care has gradually expanded from small-scale and local initiatives towards the current complex system consisting of numerous actors including state agencies, municipalities, health insurers, care offices, hospitals, primary care providers, nursing homes, housing agencies, and so on. Provider organisations interact with all these actors to provide an integrated package of homecare services. The introduction of the Social

Support Act (*Wet maatschappelijke ondersteuning – Wmo*) in 2007 and its revision in 2015 (known as *Wmo 2015*) particularly emphasise the importance for provider organisations of maintaining good relations with the municipalities. Furthermore, the coverage of home nursing and personal care under the Health Insurance Act (*Zorgverzekeringswet – Zvw*) as of 2015 increases the need for good relations with health insurers.

- *Dynamics* refers to the frequency and intensity of changes in the environment. It may involve various kinds of changes, such as political, technological and economic changes. The environment is highly dynamic when it entails many changes (frequency) with a high impact (intensity) (Volberda, 2004). As we will outline in chapter 2, provider organisations had to respond to various regulatory changes, including for instance the alterations in the need assessment procedure, the decentralisation of the Wmo to municipalities, the introduction of public tendering together with more competition and lower prices, and the increasing emphasis upon the measurement of quality performance. Various social-cultural trends such as individualisation and the emergence of the assertive consumer also required an adequate response. A new development is the ongoing reform of long-term care by the introduction of the Long-Term Care Act (*Wet langdurige zorg – Wlz*) and the revision of the Wmo in the new Wmo 2015. These reforms reinforce the dynamics in the homecare environment.
- *Unpredictability* refers to the availability of information on the future environment or the ignorance of information on the part of the organisation's management, which may only have a short-term perspective in mind. The environment is unpredictable when no clear information is available on the future environment or this information is ignored (Volberda, 2004). As we will explain in chapter 2, the reform measures are surrounded by many ambiguities and uncertainties. The decentralisation of tasks and responsibilities has made municipalities responsible for various homecare services and the contracting of provider organisations to accomplish the provision of these services. Municipalities have a high degree of policy discretion on how to make this obligation concrete. They are free to determine their own criteria for needs assessment and care provision. Whereas some municipalities may develop a rather generous model, others may opt for a restrictive model. The decentralisation of home care towards municipalities entails many uncertainties for provider organisations, the more so because of government-imposed expenditure cuts in home care.

Volberda speaks of high environmental turbulence, when an environment is simultaneously very complex, dynamic and unpredictable. Based on Duncan (1972), he

states that unpredictability has the greatest impact on environmental turbulence, followed successively by dynamics and complexity (Volberda, 2004).

Figure 1.1 Environmental turbulence: the interplay between complexity, dynamics and unpredictability (Volberda, 2004)

The turbulent character of their environment puts high demands on provider organisations. They notice that the bureaucratic type of organisation – which prospers in stable and predictable environments – is no longer suitable. Instead, many of them opt for a socio-technical type of design to better anticipate the turbulence in their environment. The bureaucratic type of organisation is assumed incompatible with flexibility (De Sitter, 1982; 1998; Van Amelsvoort, 1999; Kuipers et al., 2010).

This study investigates how two provider organisations seek to change from a traditional and bureaucratic architecture towards an alternative design based on the principles of the socio-technical design approach. The first provider organisation, which is given the fictitious name “Klein Zwitserland”, provides a broad spectrum of homecare services in the southernmost part of the Netherlands. The second provider organisation

with the fictitious name “Maas & Waal” delivers homecare services and residential care in the south-eastern part of the Netherlands. By developing a socio-technical type of design based upon self-organising teams, both provider organisations seek to create flexibility. Scientific research has shown evidence for the success of the socio-technical type of design in home care (e.g. Almekinders, 2006), but this research addressed the period before 2007. Our study will focus upon the period after the introduction of the Wmo in 2007, which marks a turning point in the homecare sector. However, it does not examine the impact of the fundamental reform of long-term care as of 2015, because it focuses on the period up to 2014.

1.2 Research question

The purpose of this study is (1) to investigate the effectiveness of the attempt of two provider organisations to change their organisation from a bureaucratic to a socio-technical type of design. In addition (2), it addresses the question of whether this change can be effective at all, given the turbulence of the organisational environment in which the reorganisation takes place. The following research question will be addressed:

To what extent did Klein Zwitserland and Maas & Waal effectively change from a bureaucratic to a socio-technical type of design and what are the explanations for the results achieved?

Our research question consists of two parts. The first part investigates for both cases the effectiveness of the change to a socio-technical type of design by analysing the results of the change. It should be noticed that we consistently use the term ‘type of design’, because a single bureaucratic or socio-technical design does not exist. As said earlier, specific attention is paid to the perception of the employees, because their perception tells us something about the results of the change. At the same time, however, their perception is an important factor in the change process itself. The second part aims to explain the change results. In our analysis we will focus not only on the impact of internal factors but also on the role of external factors. The term internal factors refers to factors that are specific to Klein Zwitserland and Maas & Waal respectively and the term external factors to factors in the environment of both provider organisations. We will conclude that provider organisations are squeezed by their external environment, which contains ever more bureaucratic mechanisms. As a consequence, they are locked in a so-called ‘double hold’, which refers to the situation in which provider organisations have to break their internal bureaucratic architecture, while being locked in an external environment becoming ever more bureaucratic.

Our study does not examine the effectiveness of the socio-technical design in itself. There is an increasing body of literature on this topic which offers empirical evidence for its effectiveness. Based on earlier work (e.g. Wall et al., 1986; Manz & Sims, 1993; Van Eijbergen, 1999), Van Kollenburg (2003) concluded that the socio-technical type of design leads to higher quality, lower costs and less absenteeism. In his study, which particularly focused on home care, Almekinders (2006) found that the introduction of self-organising teams enhances the viability of provider organisations, as it ‘has improved the efficiency of the care provided, the clients’ appreciation of the care, and the quality of the work carried out by care professionals’ (Almekinders, 2006, p. 164).

This study is relevant from a **societal** point of view since there is a broad societal debate on how to safeguard the sustainability of long-term care in general and home care in particular. By linking initiatives of organisational redesign to this debate, it aims to contribute to the challenging task of ensuring the future sustainability of long-term care. Additionally, initiatives to make organisations more flexible are increasingly taking root in society and are encouraged by the state in particular, for instance as an instrument to ‘bring the nurse back in the neighbourhood’ (*‘de wijkverpleegkundige terug in de wijk’*) (Kamerstuk 2010; 2012; 2013), to achieve ‘a return of the human dimension in healthcare’ (*‘het terugbrengen van de menselijke maat in de zorg’*) (Kamerstuk 2008) and to shift the focus ‘from systems to people’ (*‘van systemen naar mensen’*) (Kamerstuk 2013).

This study is also relevant from a **scientific** point of view. While previous research addressed the period before 2007, this study focuses upon the period after the introduction of the Wmo. Furthermore, existing studies address the effectiveness of a socio-technical type of design only on the organisational level. This study also examines its effectiveness in relation to the wider environment in which provider organisations operate. Finally, our study contributes to the knowledge on the applicability of socio-technical (re)design in health care, by adding insights from case study research in home care to existing studies (e.g. Almekinders, 2006).

1.3 Outline of the study

To examine the research question, the outline shown in Figure 1.2 will be followed. After this introduction, the explorative part continues in chapter 2 with an exploration of home care in its context. It unravels the provision and funding of home care in the Netherlands and investigates its environment by distinguishing three sub-environments: the homecare environment, the healthcare environment and the societal environment. The explorative part concludes with the theoretical foundation of the study (chapter 3). It provides a concise overview of the basics of organising and managing, the ideal-typical characteristics of the bureaucratic and the socio-technical

type of design as well as a framework for evaluating the change process and its results. Chapter 4 describes the methodological part of the study.

The evaluative part (chapters 5 and 6) contains a double-case study of two provider organisations which are in the process of moving from a bureaucratic to a socio-technical type of design. It evaluates for both cases the point of departure, the objective, the change process and its results. It specifically takes into account the employees' perception of the change. As will be explained in chapter 4, the first case has been selected on practical grounds: there is an opportunity to evaluate this case intensively for several years. The second case has been selected as an additional case to enrich the picture and enable a cross-case comparison.

The reflective part of the study starts with a comparative analysis of the case study results (chapter 7) to explore similarities and differences and find explanations for the (in)effectiveness of the reorganisations. It focuses on internal factors that are specific to Klein Zwitserland and Maas & Waal respectively. Chapter 8 incorporates the wider environment in which provider organisations operate. The study ends with conclusions and methodological and theoretical considerations (chapter 9).

Figure 1.2 Outline of the study

Chapter 2

Home care in its context

Definition of home care

The term 'home care' is an elastic term. Studies on home care lack precision in defining its activities, goals and target groups (Thomé, Dykes & Hallberg, 2003; Breedveld, 2004; Genet et al., 2012). According to Genet et al. (2012, p. 9), home care is defined as 'any care provided behind someone's front door or, more generally, referring to services enabling people to stay living in their own home environment'.¹ It contains *formal home care* delivered by professional caregivers and *informal home care* provided by clients' spouses or relatives, friends and other volunteers who are usually unpaid (Genet et al., 2012). This study only includes formal home care provision. A distinction can be made between long-term and short-term home care. Most home care is *long-term home care* which mainly involves provision of care for frail elderly people at home. *Short-term home care* is often provided for patients in need of home care after hospitalisation (Genet et al., 2012).

Home care has a heterogeneous structure and contains several types of services. Overall, three main types of services are distinguished. The first type involves the provision of *domiciliary care* (*huishoudelijke hulp*), which includes instrumental and low-complexity activities of daily living such as housekeeping, transportation, food preparation and using the telephone. Provision of *personal care* (*persoonlijke verzorging*) is the second type and contains personal activities of daily living such as providing assistance with dressing, feeding and washing, and getting in or out of bed. The third type comprises the provision of *nursing care* (*verpleging*) and includes complex nursing activities such as assisting with changing stomas and urinal bags, putting on prostheses and giving intravenous injections (Ipenburg, 2011; Genet et al., 2012). The scope of home care services ranges from preventive, acute and rehabilitative to palliative care. As demand is becoming ever more complex, mixed types of home care services are nowadays more prevalent (Genet et al., 2012).

A short historical overview

The current home care system is the result of many developments in the past which mirror the evolution of home care from early small-scale and mainly private initiatives to the complex system today. Table 2.1 gives a reconstruction of the work of Ipenburg (2011), who distinguishes seven periods in the development of the Dutch home care system.

¹ In this study, homes for the elderly are not included in someone's 'own home environment' and therefore not considered part of home care.

Table 2.1 The development of the Dutch homecare system (based on the work of Ipenburg, 2011)

Period	Main characteristics
<1850	<ul style="list-style-type: none"> – Mainly charity organisations, churches and municipalities feel responsible for providing financial support for the poor – As ‘potential initiators of social disruption’, the emphasis is on supporting the poor financially and ‘teaching’ them the right attitude – There are hardly any government regulations and most initiatives are left to private initiators
1850-1890	<ul style="list-style-type: none"> – Preventing social disruption is no longer the only central objective of supporting the poor. Charity and justice become leading principles too – With the rise of socialism, individuals are no longer kept solely responsible for their poverty. The government initiates regulations to preserve social security: the Poor Law (<i>Armenwet</i>) in 1854 and the Infectious Disease Law (<i>Wet op de besmettelijke ziekten</i>) in 1872 – However, government intervention is still premature
1890-1930	<ul style="list-style-type: none"> – The first signs of ‘modern’ homecare delivery can be observed – Besides supporting the poor financially, the provision of home care also becomes a key aspect: small-scale ‘organisations’ – mainly established by nuns – begin to deliver services that are now categorised as maternity care, domiciliary assistance and nursing care – After the establishment of the first cross organisation (<i>kruisvereniging</i>) in 1875, a real network of cross organisations comes into existence – Cross organisations – which are purely private initiatives and therefore paid for entirely by their members – are primarily intended to prevent diseases but rapidly become the ‘predecessor’ of modern provider organisations
1930-1950	<ul style="list-style-type: none"> – Further development, specialisation and professionalisation of cross organisations – Existing activities and services are expanded and modernised and new disciplines such as pedagogy and gymnastics for pregnant women and the elderly are introduced – Government regulation is enforced: to preserve social security, the government initiates several laws such as the Child Allowance Law (<i>Kinderbijslagwet</i>) in 1941 and the Unemployment Law (<i>Werkloosheidswet</i>) in 1949
1950-1990	<ul style="list-style-type: none"> – Marks the heyday of the Dutch welfare state in which the government feels responsible for taking care of its citizens ‘from the cradle to the grave’ – Initial small-scale and local initiatives are taken over by the government and receiving health care becomes a universal right – The increasing government involvement is demonstrated by the introduction of several regulations such as the Exceptional Medical Expenses Act (<i>Algemene Wet Bijzondere Ziektekosten</i>) in 1968 – The financing of health care in general and home care in particular is regulated by the government – Exponential development of the homecare sector resulting in more complex and large provider organisations – Home care as a service becomes more differentiated and specialised, resulting in a broad spectrum of services and specialised homecare workers with varying skills and levels of education
1990-present	<ul style="list-style-type: none"> – Taking care of its citizens ‘from the cradle to the grave’ leads to an increase in public expenditure – Large provider organisations have become too complex and bureaucratic, resulting in inefficiency, low productivity and lagging quality – Introduction of market competition to enhance efficiency within the system – Provider organisations start applying alternative organisational designs to become more flexible and adaptable to their environment
2011-present	<ul style="list-style-type: none"> – In line with the financial and economic crisis, the debate on the future sustainability of long-term care has become more intense – Significant cuts in government spending, reducing the right to several types of care and transferring tasks from central government to local authorities (decentralisation)

It took almost a century before the structure of homecare provision in its current form became visible. The development of the homecare system involves several characteristics. First, it is characterised by continuous expansion from the very beginning. Initially, small-scale and local initiatives expanded gradually towards the current extensive system. Second, expansion was accompanied by increased government involvement by means of regulations to emphasise the public character of home care and ensure its collective financing. Home care gradually evolved as a right which is enshrined in legislation and therefore claimable. Third, home care features increased differentiation and specialisation. Whereas it initially involved financial support to the poor only, it nowadays covers a broad and differentiated package of services provided by specialised homecare workers. Finally, the organisation of home care is characterised by increased bureaucratisation. Provider organisations have turned into large, complex and bureaucratic organisations.

The system of long-term care provision

Figure 2.2 gives a simplified representation of the system of long-term care provision in the Netherlands up to 2015. Long-term care is regulated by two public schemes: the Social Support Act (*Wet maatschappelijke ondersteuning – Wmo*) and the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten – AWBZ*).

Figure 2.2 Long-term care provision in the Netherlands up to 2015

As Figure 2.2 highlights, care provision starts with a client who applies for care to his or her municipality or the CIZ (*Centrum Indicatiestelling Zorg*). Which organisation should be addressed depends on the type of services. Needs assessment for services covered by the Wmo, such as household services, lies in the hands of the municipalities. Needs assessment for services covered by the AWBZ is accomplished by the CIZ. The AWBZ is implemented by regional care offices (*zorgkantoren*). In each region a single health insurer, usually the regional market leader, is charged with the implementation of the AWBZ on behalf of all insurers in the region (representation model). Provider organisations must make annual production agreements with the care office. These agreements concern the maximum amount of hours of a certain type of care that the organisation is allowed to provide. If this maximum is exceeded, the organisation itself and not the care office is responsible for the costs of overproduction. Currently, one can observe a trend towards redelegating needs assessments in several client categories to provider organisations and community nurses to reduce bureaucracy and accelerate the assessment procedure.

After a client has successfully applied for care, the municipality (Wmo) or care office (AWBZ) is responsible for the funding and provision of services. The CIZ accomplishes needs assessment for AWBZ care. If the CIZ gives a negative allocation decision, it directly informs the client about its decision. The care office is informed after a positive decision. In this case, the CIZ notifies the care office of the client's eligibility for the type and amount of care. Next, the care office informs the provider organisation preferred by the client about its decision, which in principle guarantees the organisation the funding of the care provided. After receipt of the decision the provider organisation starts the caregiving process based upon a care plan agreed with the client. It also interacts with the municipality or care office with regard to the start and end of the care process and changes in the client's needs.

This overview of the long-term care system is only a simplified representation. In practice, a provider organisation interacts with many more actors, such as hospitals and primary care providers (e.g. general practitioners). A close relationship with *hospitals* is required to promote a smooth transition from hospital care to home care. Many hospitals have a liaison office to start up and coordinate home care after hospital discharge. At the same time many provider organisations have 'transmural nurses' who work both in hospital out-patient departments and in the patients' homes (Genet, Boerma, Kroneman, Hutchinson & Saltman, 2013). *General practitioners* (GPs) are closely involved in the homecare process, for instance by visiting clients at home and discussing their needs with homecare professionals. An important recent development is the reintroduction of *community nurses* as a link in homecare provision (Genet et al., 2013). Community nurses coordinate care, living and wellbeing within a neighbourhood. They are also expected to reinforce coordination between home care

and primary care and within primary care in particular (Genet et al., 2013). This is increasingly done by creating multidisciplinary health centres consisting of a broad range of professionals such as GPs, physiotherapists, psychologists, dieticians and homecare professionals. Initiatives to revalue the coordinating role of community nurses are encouraged by the government (see for instance the policy document entitled “*Wijkverpleegkundige als spil in de wijk*” (the nurse as a pivot in the neighbourhood) (Kamerstuk, 2010)).

In 2015 a fundamental reform of long-term care has come into effect. The reform involves major institutional changes, including the introduction of the Long-Term Care Act (*Wet langdurige zorg – Wlz*), the decentralisation of large parts of non-residential long-term care to municipalities under the Wmo and the transfer of home nursing and personal care to the Health Insurance Act (*Zorgverzekeringswet – Zvw*). The text box below describes the long-term care system as of 2015.

The financing of home care

Until 2015, the financing of home care was based upon two public schemes: the AWBZ and the Wmo. The AWBZ, in place since 1968, guaranteed universal access to complex, specialised and often expensive nursing care. In 2010, €3.4 billion was spent on homecare services covered by the AWBZ (Actiz, 2012). The AWBZ is a national, compulsory and contribution-based health insurance scheme covering both residential and non-residential (homecare) services. Homecare services include personal assistance (*begeleiding*), personal care (*persoonlijke verzorging*) and nursing care (*verpleging*). It also covers other homecare services including counselling, medical treatment and accommodation. While the AWBZ was originally intended to cover only the (high) costs of complex and specialised care, ever more services were added to its benefit package: day care in nursing homes (1973), home nursing (1980), ambulatory mental care (1982), sheltered living (1989), household services (1989) and residential homes for older persons (1996) (Companje, 2014). With regard to AWBZ-funded care, clients may apply for care-in-kind. However, they may also opt for a personal budget (*Persoonsgebonden Budget – PGB*). The personal budget scheme (cash benefit programme) was introduced in the mid-1990s to give clients the opportunity to arrange their own, tailor-made packages of care. The care offices are charged with the implementation of this scheme. Users of AWBZ-funded care are required to co-pay for home care. The co-payment rate is based upon the client’s income, age, family situation and type of care. No exact data are available on the level of co-payments in home care. However, their role must not be overestimated, because extramural services are significantly less funded by co-payments than intramural care.

A simplified representation of the system of long-term care provision in the Netherlands as of 2015

As of 2015 long-term care is regulated by three public schemes: the Wmo, the Zvw and the Wlz. As the successor of the AWBZ, the Wlz aims to meet the initial intention of the AWBZ to cover only 'real' long-term care in terms of residential care for people for whom non-residential care is no longer a realistic option. The rest of the services covered by the AWBZ are shifted either to municipalities under the Wmo or to health insurers under the Zvw. As in the case of the AWBZ, the Wlz is set up as a social health insurance scheme covering the entire population and financed by means of income-related contributions (Kamerstuk, 2014c). It gives clients a right to care if the CIZ has positively assessed their needs. The Wlz has much in common with the former AWBZ and attempts to restore the initial intent of the AWBZ: only covering long-term care services in a residential setting.

As the figure below highlights, as of 2015 care provision starts with a client who applies for care to his or her municipality, health insurer or the CIZ. Which organisation should be addressed depends on the type of services. Needs assessment for services covered by the Wmo, such as household services, lies in the hands of the municipalities. Health insurers are responsible for the funding and provision of services covered by the Zvw, in particular home nursing and personal care. Needs assessment for services covered by the Wlz, including residential care for people who need life-long care, is accomplished by the CIZ. The implementation of the Wlz is delegated to care offices: in each region a single health insurer, usually the regional market leader, is charged with the implementation of the Wlz. After a client has successfully applied for care, the municipality (Wmo), health insurer (Zvw) or care office (Wlz) is responsible for the funding and provision of services.

The Wmo has been in place since 2007. It covers the financing of social support services, of which the provision of domiciliary care is the most important. In 2010, €1.3 billion was spent on Wmo care (Actiz, 2012). The Wmo is executed by municipalities, which receive a tax-funded state grant to provide services that were formerly covered by the AWBZ. In addition to domiciliary care, several other support services are covered by the Wmo, such as public transport, power wheelchairs and house adjustments. The overall objective of the Wmo is to enhance the participation of all Dutch citizens and ensure the provision of coherent and integrated social support at a local level (Rijksoverheid, 2012).

As stated earlier, many services were added to the AWBZ since 1968, many of which did not meet the scheme's initial objective: to cover the (high) costs of complex and specialised care. As a measure to constrain the rise in long-term care expenditure, some of these services have been transferred to the Wmo. The introduction of the Wmo and the transfer of services from the AWBZ to the Wmo had major consequences. It affected the accessibility of services because, contrary to the rights-based structure of the AWBZ, the Wmo is a provision-based scheme and does not guarantee entitlements. Thus, applicants have fewer rights under the Wmo than under the AWBZ. Municipalities have a high degree of policy discretion in the implementation of the Wmo.

The users and suppliers of home care

The utilisation rate of home care, i.e. the proportion of the total population that receives home care, is the largest in the Netherlands and Sweden (4.8 percent) (Genet et al., 2012). When measuring the utilisation rate in relation to the population aged 65 and over, the Netherlands has the highest score. What are the main characteristics and developments behind these numbers and who are the main recipients of home care in the Netherlands?

In January 2013, 802,000 people received long-term care with 359,000 persons receiving residential care and 443,000 receiving non-residential care. The largest category (56.4 percent) consisted of older people with 196,000 recipients of residential care and 256,000 recipients of non-residential care (CIZ, 2013; Schols et al., 2014). In 2009, 70.8 percent of homecare clients were women. The majority of them were in the age group of 80 to 85 years. The 'typical' homecare client is therefore defined as an 'elderly woman in need of complex care' (Actiz, 2012, p. 14). The increasing complexity of care is illustrated by the rising percentage of people who are in need of a mix of services: while in 2004 around 40 percent of homecare needs included the complete package of personal assistance, personal care and nursing care, this number increased to 60 percent in 2010 (Actiz, 2012). Another interesting development is the rapid

growth of extramural care in relation to intramural care. Whereas extramural care increased annually by 6.8 percent over the period 1998-2010, intramural care grew on average by only 3.2 percent (Chessa, 2012). Extramural care is expected to grow further in the future, which may increase pressure on the supply of home care.

The suppliers of home care are professionals employed by private not-for-profit provider organisations. In the Netherlands, home care is a mainly publicly funded service delivered by private non-profit providers. The total number of provider organisations increased from 460 in 2010 to 650 in 2013 (excluding independent contractors). The biggest category consisted of relatively small organisations having up to 50 employees. The number of small organisations grew from 355 in 2010 to 515 in 2013. Home care is also provided by independent contractors. The number of independent contractors grew substantially from 3,930 in 2010 to 8,255 in 2013 (CBS, 2014).

In the Netherlands, five nursing levels are distinguished. These are: the level-1 helping auxiliary (*zorghulp*), the level-2 helper (*helpende*), the level-3 nursing aid (*verzorgende*), the level-4 nurse with intermediate vocational education (*Middelbaar BeroepsOnderwijs, MBO*) and the level-5 nurse with higher vocational education (*Hoger BeroepsOnderwijs, HBO*).² These levels vary according to the level of responsibilities, the complexity of the care needed and the degree to which professionals are able to apply their knowledge and skills in different situations (Van der Boom, 2008; Ipenburg, 2011).³ Genet et al. (2012) emphasise that homecare provision is a labour-intensive and hands-on activity. Human labour can only be replaced to a limited extent with the use of modern technology. Home care requires professionals available at the right time, the right place and with the right skills. As we will see, balancing these requirements will become a challenge given the predicted shortage of healthcare personnel (Van der Velden, Francke & Batenburg, 2011; AZW, 2012; UWV, 2013). This development will put additional pressure on informal caregivers as important substitutes of formal caregivers. Since the number of informal caregivers is also expected to decrease, a gap between supply and demand is looming (Genet et al., 2012).

2.2 The homecare environment

The homecare system operates within an ever more turbulent environment. In chapter 1, we explained that the homecare environment is complex, dynamic and

² With regard to the level-3 professional, it should be noted that there is also a level-3 “IG” homecare worker, who should be placed between the regular level-3 employee and the level-4 nurse. “IG” stands for “*Individuele Gezondheidszorg*” (Individual Health care).

³ A more extensive overview of the five nursing levels and responsibilities involved can be found in Van der Boom (2008) and Ipenburg (2011).

unpredictable. A closer look at it reveals two main observations. First, home care is particularly affected by its *political context*. Second, while other healthcare sectors, such as residential care and hospital care, are also affected by reforms and market competition, the spotlight has fallen in particular on home care. The current developments in home care are associated with negative effects such as excessive bureaucracy, a deterioration of quality of care and (impending) mass layoffs and strike actions. Contrary to the introduction of market competition in the hospital sector, safety nets to minimise risks are missing in home care. Long-term care reform assumes that the demand for publicly funded residential care must be reduced and that more services must be provided in the home setting of the client (Kamerstuk, 2014b; 2014c). This development logically requires increasing capacity in non-residential care. However, this is not happening, because of significant expenditure cuts in home care. As we will see, the decentralisation of long-term care towards municipalities is following a similar pattern: they have been charged with new tasks while their budgets are simultaneously restricted.

The turbulent character of the homecare environment should be considered in the light of long-term care reform. In only ten years, the policy agenda concerning long-term care has significantly changed in the Netherlands (Maarse, 2012a). Around the year 2000, the government spent extra money to enhance accessibility to long-term care by shortening waiting times and reducing waiting lists. However, to safeguard the sustainability of long-term care, it currently believes fundamental reform is essential. The reform has resulted in several policy measures such as limiting personal budgets, reducing bureaucracy, emphasising individual responsibility and, as discussed below, moving from a rights-based to a provision-based scheme (Maarse, 2012a). Recently, an even more fundamental reform has been launched which involves major institutional changes including the shift from residential to non-residential care and the further upgrading of the role of local government. A main element of this reform is the introduction of the Wlz as a new social health insurance scheme for long-term care. The reform also involves a normative reorientation, by means of a stronger emphasis on individual responsibility and community involvement (Jeurissen & Maarse, 2015).

Already in the mid-1990s, the homecare sector began to be particularly affected. In the mid-1990s, *standardisation of needs assessment* was introduced (Maarse, 2012b). Initially, each provider organisation was individually responsible for determining whether a client was entitled to care, to what kind of care and to what amount. However, from the mid-1990s, eligibility for home care was no longer determined by the organisations themselves but by regional assessment agencies (*Regionale Indicatie Organen, RIOs*) on the basis of universal and objective criteria. Since 2005, these RIOs have been hierarchically placed under the ClZ as a national agency for needs assessment. As stated previously, nowadays there is a trend towards redelegating

needs assessments for several types of care to provider organisations and community nurses.

The government also introduced a *system of competitive tendering* under the Wmo in 2007. Provider organisations were no longer free to offer services covered by the Wmo. Instead, many municipalities organised a competitive bidding process for contracts to deliver household services. The primary objective of the Wmo is to enhance the participation of all Dutch citizens and to guarantee a coherent and integrated system of social support at a local level (Rijksoverheid, 2012). The municipalities are free to develop a policy framework that meets these objectives. In practice, they contract out services and invite local organisations to tender. The introduction of competitive tendering had considerable consequences for the provision of home care. Opponents argued that it would erode the quality of care and would result in mass layoffs and unfavourable working conditions. Several provider organisations were confronted with budgetary problems. In their struggle for survival, some of them offered their services to municipalities at below cost price. Various organisations were unable to adapt to the new market-like environment and went bankrupt. Other organisations opted for consolidations to strengthen their market position, which resulted in several mergers and the rise of large provider organisations.⁴ In 2012, both the Lower and Upper Chamber gave their approval to a law initiated by the Parliament which no longer obliges municipalities to use the system of public tendering.

The role of local government (municipalities) in homecare provision was reinforced with the introduction of the Wmo in 2007. Maarse (2012b) speaks in this respect of the *upgrading of the role of local government*. Municipalities have been given a key role in the system of competitive tendering. They have also become responsible for the funding and provision of Wmo care for their residents. The current reform further reinforces the role of local government. Several services were decentralised to local government on the assumption that local government is best informed about local needs and best able to provide an efficient, client-centred and integrated package of care that may also contain other services (e.g. housing, welfare, transport) apart from just long-term care. This efficiency argument is used by the government to justify significant expenditure cuts. The most drastic policy measure for home care involves a substantial reduction in the state budget for municipalities to implement the Wmo.

⁴ Examples are the merger between *Amsterdam Thuiszorg* and *Cordaan* in 2008 (Amsterdam) and the merger between *Stichting Thuiszorg Friesland* and *Assist Zorg in Huis* in 2009 (in the north of the Netherlands). Currently, one can observe another merger wave of provider organisations to anticipate current long-term care reforms. Examples of recent mergers are the merger between *GroenekruisDomicura* and *Vivre* (in the south of the Netherlands) as of 2014, the merger between *Stichting Laurens* and *Thuiszorg Rotterdam* (in the west of the Netherlands) as of 2015 and the merger between *Zorgpartners Friesland* and *Thuiszorg Het Friese Land* (in the north of the Netherlands) as of 2015.

Initially, the coalition government (Rutte II) proposed a reduction of 40 percent (Kamerstuk, 2014a). This reduction was heavily disputed by the municipalities. During several rounds of political negotiations on the reform the total amount of expenditure cuts was eventually scaled back significantly. Also, extra resources were made available to solve transitional problems.

The decentralisation of services under the Wmo has major consequences for clients. It involves a *shift from a rights-based towards a provision-based structure* (Maarse, 2012b, Jeurissen & Maarse, 2015). Whereas the AWBZ and Wlz as its successor give clients a right to care, the Wmo obliges municipalities to support citizens who cannot run a household on their own and cannot participate in society. The Wmo gives municipalities a high degree of policy discretion on how they should make this obligation concrete. They are free to set their own criteria to determine who is eligible for publicly funded services and who is not. This may lead to unequal access since every municipality may set its own criteria for needs assessment and care provision (social support). Whereas some municipalities may develop a rather generous model, others may opt for a restrictive model. The government intends to further decentralise all non-residential care to municipalities with the exception of community nursing. It proposes a revision of the Wmo – entitled “Wmo 2015” – containing several key elements. Municipalities are seen as the ‘director’ in the local social domain. They are responsible for delivering an integrated package of services based on an assessment of the individual client’s needs. They may do so by interviewing the client at ‘the kitchen table in the client’s home’. Under the revised Wmo applicants only qualify for services when they cannot take care of themselves and have no alternatives such as involving their social network. Means-testing remains prohibited, but municipalities are free to decide on their co-payment system (Kamerstuk, 2014b).⁵

The aforementioned developments point to an increasing influence of the political context in the homecare domain. The increasing influence of the government to rein in the growth of long-term care has major consequences for provider organisations. Already in the mid-1990s, they lost some of their control and autonomy due to the standardisation of needs assessment. This development continued with the introduction of competition as of 2007. With the exception of the market for generic drugs, competition was introduced nowhere in such a radical way as in home care. Whereas the hospital sector faced only a gradual introduction of market competition with safety nets available, provider organisations had to compete for contracts overnight.

⁵ Means-testing refers to the process of identifying a person’s income or financial capacity in order to check his or her eligibility for (publicly funded) services. Means-tested benefits are those benefits that are available only to those individuals whose income or financial capacity is below a certain level.

The recent reform further complicates the homecare environment. It assumes that the demand for publicly funded residential care must be reduced and that more services must be provided in the home setting of the client. Although this development presupposes increased capacity in non-residential care, this does not happen. Provider organisations also have to negotiate on contracts with many more purchasers (municipalities) than in the past (care office). Furthermore, they experience fierce competition because of the municipalities' focus on cost reduction and the entry of new providers. Compared to other sectors such as hospital care, the assets for starting a provider organisation are low. *Buurtzorg Nederland* (see box below) is probably the best-known new entrant seeking to challenge the established method of homecare provision by its focus on small-scale and client-centeredness. Finally, provider organisations must develop a market orientation to address private consumers who do not meet the municipality's eligibility criteria or have to make significant out-of-pocket payments.

Buurtzorg Nederland

The Dutch provider organisation Buurtzorg Nederland was founded in 2006 by Jos de Blok and his wife (Van Dalen, 2010). He was originally a nurse who had worked for several provider organisations in the Netherlands. His wife had worked as a secretary in a large healthcare organisation for eighteen years. Both noticed that the quality of home care was diminishing due to a bureaucratic approach in home care based on a high degree of division and coordination of work. They identified too much bureaucracy, inefficiency and an incorrect focus of caring. In order to reverse these developments, they established Buurtzorg Nederland. Instead of an instrumental approach which mainly focuses on the mere execution of tasks such as washing and putting on stockings, Buurtzorg Nederland emphasises a holistic relationship with its clients (Van Dalen, 2010; Buurtzorg Nederland, 2012). It considers the execution of instrumental tasks of secondary importance. The organisation only employs professionals of the three highest nursing levels, who work in self-organising teams that are responsible not only for the care process but also for other activities such as planning and scheduling, recruiting clients and maintaining their equipment. These teams are supported by an intranet system which computerises the work process as much as possible. This system only has a supporting function, just like the organisation's overhead, which only consists of 14 staff members at the head office and 10 coaches who each manage 25 teams (Van Dalen, 2010; Buurtzorg Nederland, 2012). After its small-scale start, Buurtzorg Nederland has developed towards 250 teams throughout the Netherlands (Buurtzorg Nederland, 2012). Recently, it even introduced its concept abroad. Its results are remarkable and attractive. Homecare professionals are very satisfied, since they are reunited with their professional values and no longer imprisoned in unnecessary bureaucracy. The clients of Buurtzorg Nederland are also satisfied. They appreciate the holistic perspective and the intense relationship with only a handful of professionals. Last but not least, the concept of Buurtzorg Nederland is much cheaper than regular homecare provision, because it incurs only minimal costs related to coordination. Research indicated that Buurtzorg Nederland is able to provide only 45 percent of the indicated care (Van Dalen, 2010; Buurtzorg Nederland, 2012). Despite these positive results, Buurtzorg Nederland has also been criticised by some established provider organisations. They accuse the organisation of not complying with the rules, taking away personnel and clients from established organisations, charging disproportionate fees and relying on subsidies.

2.3 The healthcare environment

Home care is also influenced by developments in the wider healthcare environment. Like most developed countries, the Netherlands faces *increasing healthcare expenditure*. Total healthcare expenditure increased from 8 percent of Gross Domestic Product (GDP) in 1972 to over 13 percent in 2010 and is expected to increase further to 19-31 percent of GDP in 2040, depending on the assumptions made (Van der Horst et al., 2011). As stated earlier, a significant proportion of these expenditures is spent on long-term care. Long-term care expenditure is expected to increase from 4.1 percent of GDP in 2010 to 7 or even 9 percent in 2040, depending on the assumptions made (Van der Horst et al., 2011).

The increase in healthcare expenditure has several causes, such as the ageing population and technological developments. The *ageing population* not only induces a growing demand for health care. It also leads to *scarcity of healthcare personnel* which may cause tension between supply and demand. From 2001 to 2010, the yearly increase in the volume of care averaged 4 percent, while the number of healthcare workers increased by only 3 percent annually (CBS, 2011). Although these numbers are only approximate – for instance they do not include the possibility of a rise in labour productivity – there are good reasons to assume future scarcity of healthcare personnel (CBS, 2011). First, the nursing sectors are ageing more rapidly than the overall population. Whereas only 16 percent of all Dutch nurses were over 50 in 1999, this percentage increased to 35 percent in 2008, which is higher than the overall share of people over 50 in society (29 percent). Second, while the absolute number of nurses is increasing, a significant proportion are not working in the healthcare sector. In 2008, almost a quarter of all Dutch nurses did not work in the healthcare sector.⁶ Third, nurses in the Netherlands choose to take early retirement more often than the overall population and the number of nurses who are unable to work is relatively high.⁷ Demanding working conditions, both physically and mentally, are cited as the main reasons for this. Fourth, many female nurses aged 30 and over often tend to work only part-time despite a government measure to stimulate full-time work participation. A part-time workforce requires a larger amount of nurses to meet the demand for care. This is reinforced by the fact that many part-time workers are not keen to opt for full-time work at a later point in time (CBS, 2011).

⁶ 12 percent of all nurses did work in other sectors and another 12 percent were part of the economically inactive population. The total share of almost 25 percent was similar for the year 1999 except that in 1999 only 9 percent of all nurses did work in other sectors and 14 percent were economically inactive (CBS, 2011).

⁷ In 2008, 36 percent of Dutch nurses took early retirement, against only 24 percent of the overall population. The proportion of nurses who are unable to work increases significantly with age. In 2008, only 0.1 percent of all nurses under 25 were unable to work, against almost 17 percent of nurses between 60 and 65 (CBS, 2011).

The healthcare sector must also deal with the effects of *technological developments*. However, technology is more a cost-driving factor in curative care than in long-term care, as technological advances seem more limited in long-term care and nursing and personal care are difficult to replace with technology. The opposite is true for the ageing population: whereas demography should not be overestimated as a cost-driving factor for curative care, it significantly increases the costs of long-term care (Van Ewijk, Van der Horst & Besseling, 2013). Various telecare and e-health projects have been set up within home care, for instance by introducing alarm systems and video communication. Alarm systems vary from a simple system that enables clients to press an alarm button in the event of a fall to extensive systems that use sensors to detect when a client gets out of bed or leaves the home. Video networks enable clients and providers to contact each other by making use of a camera and a screen. Video communication is expected to enhance clients' sense of safety and independence and to partly substitute for physical contacts (Genet et al., 2012). Improved technology enables people to live an independent life at home for longer. Patients can be discharged from hospital earlier and expensive hospital care can be substituted with less expensive home care. This is not only preferred by clients; provider organisations also take advantage of this development since it encourages the demand for home care. The use of innovations like telecare and e-health is encouraged by the government (Regeerakkoord VVD-PvdA, 2012). However, it raises new questions such as 'to what extent should we always utilise technological opportunities?' (Kamerstuk 2013, p. 7).

As stated before, policymakers worry about the future sustainability of long-term care. To control expenditure, significant cuts to long-term care spending have been proposed, many of which are targeted at home care. These cuts highlight a shift from a policy agenda of expansion to an agenda of retrenchment (Maarse, 2012b) and are part of an *overall reduction of healthcare expenditure*. The government aims to enhance the quality of care while simultaneously reducing its costs. To achieve cost containment, it proposes several measures such as controlling the volume of care provided, emphasising individual responsibility and eliminating waste (Regeerakkoord VVD-PvdA, 2012).

The experimentation with market competition in home care is part of a general *shift from a supply-induced healthcare system towards a more demand-driven system* (Van de Ven & Schut, 2008; Maarse, 2011). During the twentieth century, the healthcare system developed into a supply-driven system. It gradually became part of the public domain. The government took the lead in decision-making on issues such as health insurance, the service package and healthcare budgeting. While the supply-driven focus fitted well with the emergence of the welfare state, its side effects soon became manifest. The supply-driven system was considered inefficient, hardly innovation-

driven and not patient-centred. A shift towards a more demand-driven system was proposed by introducing market elements. This shift implied new relations in health care. Patients and health insurers were required to act as market players in relation to providers. The government was responsible only for shaping a regulatory framework with new 'rules of the game'. Because pure competition would erode public interests such as universal access, equity and affordability, strict regulations were required to safeguard these interests. The introduction of regulated competition is far from straightforward and is surrounded by many uncertainties about its effects, clashing stakeholder interests and diverging ideological preferences. Compared to other sectors such as the hospital sector, competition in home care is more radical.

2.4 The societal environment

Home care is also influenced by various societal developments. Dutch society faces an *ageing population*. Life expectancy increased from 76.2 (men) and 80.9 (women) years in 2003 to 78.3 and 82.3 years in 2008 respectively. For 2025, the life expectancy for men is predicted at 80.4 years and for women at 84.1 years. In the period to 2050, these numbers are expected to increase further to 83.8 (men) and 88.1 (women) years (Van der Lucht & Polder, 2010). On the one hand, the increase in life expectancy is good news. It can be seen as an achievement of a developed society. On the other hand, it confronts society with new challenges, for instance how to keep public services accessible and affordable. Both developments have consequences for home care. A rising life expectancy will increase the demand for homecare services. At the same time, a scarcity of healthcare personnel is looming.

As in most highly developed societies, a trend towards *individualisation* can also be observed. Individualisation can be conceptualised as a societal process in which people are placed in society more as individuals rather than as a group (Berting, 2006; SCP, 2004). It is closely associated with the rise of post-modern values such as freedom (of choice), autonomy, self-expression and self-realisation (Inglehart, 1977; Wilterdink, 1995). The individualisation trend can be seen as the result of various developments (SCP, 2004). First, the industrialisation led to increased prosperity in society. Together with democratisation and emancipation, these developments have reinforced the potential of individuals in society. Second, technological developments such as the rise of mass media enable people to form their own opinion independently of prevailing beliefs in their community. Third, secularisation, which can be described as the transformation of society from close identification with religious values and institutions towards non-religious values and secular institutions, has diminished the power and cohesion of religious groups in society (SCP, 2004). Government policymaking builds on individualisation as well. By emphasising individual responsibility, the government seems to have in mind that people must take more care of themselves.

The individualisation trend is supported by quantitative data. The Netherlands Institute for Social Research (*Sociaal en Cultureel Planbureau, SCP*) found that the number of single households has increased, from 17 percent in 1970 to more than 33 percent today (SCP, 2011). Also, it found evidence for individualisation within households: married women increasingly opt to keep their maiden name after marriage and partners do not necessarily share each other's contacts (SCP, 2004). The individualisation trend is often associated with negative consequences, such as reduced societal cohesion, erosion of solidarity and high costs of individualised automobile use. However, individualisation also implies *individual freedom of choice*. These two sides of individualisation are also manifest in home care. On the one hand, homecare providers take care for people who are well-informed and able to give their opinion. On the other hand, they increasingly meet clients who feel lonely due to crumbling social networks and diminished social cohesion. Freedom of choice is also important. Whereas it gives a provider organisation the opportunity to attract clients by distinguishing itself from other organisations, it may also lead to an exit of clients who choose other provider organisations.

Finally, one can observe a rise of *clients who are more demanding*. Often, clients no longer accept standard product quality. Instead, they expect products and services that are of the best quality, tailor-made and offered with excellent and timely service. For instance, they expect to receive home care of excellent quality provided by only a minimum number of employees and at times which fit in with their daily schedule.

2.5 Home care in its context: synthesis and conclusion

This chapter explored home care in its context by unravelling some of the complexity, dynamics and unpredictability of its environment. As for *complexity*, it showed that home care has evolved from early small-scale and mainly private initiatives to a complex system which consists of many actors. The homecare system involves various arrangements, for instance for needs assessment, the actual provision of home care and funding.

We also explored some of the *dynamics* in the homecare environment. These mainly result from the political context as a consequence of the government's retrenchment policy to safeguard the sustainability of long-term care. The homecare sector has been confronted with many developments such as the standardisation of needs assessment, the introduction of competitive tendering and the upgrading of the role of local government (municipalities). Each of these developments had a significant impact upon home care in general and provider organisations in particular.

Developments in the homecare environment also entail *unpredictability*. The effects of the reforms are surrounded by many ambiguities and uncertainties. For instance, the current emphasis on non-residential care is accompanied by significant expenditure cuts. The decentralisation of home care to municipalities entails many uncertainties for provider organisations, the more so because of government-imposed expenditure cuts in home care. The decentralisation of services under the Wmo is also a source of uncertainty for clients. It does not provide clients with a right to care and gives municipalities policy discretion on how to implement the legislation in practice.

The complexity, dynamics and unpredictability of the homecare environment are reinforced by developments in the wider healthcare and societal environment, among others, rising healthcare expenditure, the scarcity of healthcare personnel, technological advances and the shift towards a more demand-driven healthcare system. As for the societal environment, we discussed the effects of the ageing population, individualisation and the rise of demanding clients. So, to conclude, all three environments contribute to the turbulent context in which provider organisations operate.

Chapter 3

Theoretical foundation

3. Theoretical foundation

Many provider organisations take initiatives to anticipate environmental turbulence by initiating organisational redesign with the purpose of changing from a bureaucratically organised type of organisation into an alternative type of organisation based on the principles of the socio-technical design approach. This chapter explores the theoretical framework underpinning this change by following the structure as presented in Figure 3.1.

Figure 3.1 Structure of chapter 3: theoretical foundation

3.1 Basics of organising and managing

A change from a bureaucratic towards a socio-technical type of organisation affects core principles of organising and managing. Therefore, we start this chapter by exploring some basics of organising and managing. A review of the literature indicates that organising and managing are closely intertwined concepts (Mintzberg, 1974). It reveals a blurry and grey area in which numerous concepts related to organising and managing are used interchangeably without clearly indicating the boundaries between

both concepts. In this study, *organising* is conceptualised as creating an organisational architecture which sets the framework in which activities take place. *Managing* refers to those activities aimed at optimising organisational functioning within the boundaries set by organising. Making organisational processes more effective and efficient could be conceived as an example of managing. The next sections explain the system's theory on organisations, the concept of division and coordination of work and the organisational task of dealing with disturbances by means of attenuation and amplification. It should be noted that these elements obviously do not represent the whole story of organising and managing. However, we think they provide a sufficient theoretical basis before focusing upon the bureaucratic and socio-technical type of design.

3.1.1 *The systems' theory on organisations*

From a system's point of view, an organisation is considered a system which contains a set of elements that are mutually connected with the aim of transforming resources (input) into end products or services (output) (In 't Veld, 1998; De Leeuw, 2000; Achterbergh & Vriens, 2010). An organisation as a system operates within its environment or eco-system involving numerous stakeholders such as clients, families, suppliers, other care providers and the state. It is in continuous interaction with its eco-system. At the boundary between an organisation and its eco-system exchange processes take place with stakeholders. The realisation of these processes also requires exchanges *within* an organisation which are reflected by various internal processes that should be aligned to transform input into output. Transformations related to the organisation's products or services constitute the organisation's primary process (core work processes) (De Sitter, 1998). The primary process defines the function (purpose) of an organisation in society.

If we take a closer look at the organisational system, an organisation can be conceptualised as a network of nodes (De Sitter, 1998; Van Amelsvoort, 1999; Kuipers et al., 2010). As Figure 3.2 shows, an organisation as a network of nodes consists of numerous elements and relationships. The black dots illustrate activities which are either part of the primary process (A-B-C-D) or fulfil a support function for it. The process activities are connected to each other by means of dependency relationships. Usually, they are performed by people who are interconnected by mutual alignment and require resources (e.g. materials, computers, information) to perform their activities. The organisational system also contains several control relations (Figure 3.2). Hierarchical control concerns the formal hierarchical structure in the organisation: each higher layer in the system has a degree of formal power to control a lower layer. Anonymous control refers to informal control, for instance by means of informal rules and procedures (Kuipers et al., 2010).

Figure 3.2 An organisation as a network of nodes (based on Kuipers et al., 2010)

Explaining the system's theory on organisations may be rather technical. Without providing examples, it might be difficult to see the link between the theoretical explanation and a 'real' organisation. The box below attempts to apply the systems' theory on organisations for a provider organisation.

The system's theory on provider organisations

From a system's perspective, a provider organisation can be conceived as a system that operates within and interacts with its environment. Various exchange processes take place between a provider organisation and its external stakeholders. For instance, a provider organisation maintains exchange relations with clients, health insurers, other care providers, the state and supervisory agencies. Furthermore, it contains several primary processes reflecting core process activities and dependencies. These processes relate to the intake and discharge of clients and actual homecare provision. Different levels of homecare professionals (chapter 2) are responsible for executing the primary processes. These people are assisted by employees with support functions such as ICT and HRM professionals. Homecare professionals make use of several types of resources including materials for homecare provision (e.g. surgical materials, aseptic gauze and urinal bags) and computers for planning and registering. The provider organisation also contains several control relations. These involve hierarchical control relations between homecare professionals and managers, and anonymous control relations by means of informal rules and protocols.

3.1.2 Division and coordination of work

An essential building block of *organising* is the concept of division of work which sets the conditions for what needs to be coordinated. Coordination of work is a fundamental element of managing. Work contains two basic functions: an executive function and a regulatory (control) function. Whereas the executive function refers to processes to transform input into output, the regulatory function relates to the control of these processes. Division of work concerns the way in which both functions are designed. As Figure 3.3 visualises, three principles play an essential role: (1) separating the executive and regulatory function, (2) splitting up the executive function and (3) splitting up the regulatory function (Mintzberg, 1974; De Sitter, 1982; 1998; Achterbergh & Vriens, 2010; Kuipers et al., 2010; Vriens & Achterbergh, 2011).

Figure 3.3 Division and coordination of work

The *first principle* refers to the degree to which the executive and regulatory functions are separated. It gives two ideal-typical possibilities: maximum or minimum separation of both functions. Taking changing a stoma bag as an example, the executive function ('doing') refers to the realisation of the output (changed stoma bag) and the regulatory function ('thinking') to how to change the stoma bag. In the case of minimal separation of both functions, one person is responsible for the complete task of changing the stoma bag, which involves the integration of both the executive and regulatory function. In the case of maximal separation, one person is responsible for actually

changing the stoma bag (executive function) while another person is responsible for how this should be done, for instance by means of creating a protocol (regulatory function). De Sitter (1982; 1998) argues that both minimum and maximum division of work lead to organisational inefficiency and ineffectiveness. As an alternative, he proposes minimum *possible* division of work as discussed in the box below.

Three perspectives on division of work

As the figure below visualises, work can be divided from three perspectives: (1) minimum division of work, (2) maximum division of work and (3) minimum possible division of work (De Sitter, 1982; 1994; 1998). Minimum division of work (situation A in the figure) assumes that one person accomplishes the complete task of transforming input into output. If we take homecare provision as the complete task, it means that one person is responsible for all activities related to the provision of all different types of homecare services such as domiciliary services, personal care, nursing care and lending facilities and maternity care. In a provider organisation it means that each professional provides the complete task of homecare provision independently from other professionals. Maximum division of work (situation B in the figure) assumes that the complete task of transforming input into output is divided into many sub-activities which are assigned to different employees. With regard to homecare provision, it means that all activities are divided among different professionals. For instance, whereas one professional is responsible for providing assistance with dressing, another is responsible for changing a stoma and yet another for giving intravenous injections. In a provider organisation it means that the work of a professional depends greatly on the work of many others. According to De Sitter, minimum and maximum division of work cause inefficiency and ineffectiveness. Although minimum division of work involves a low probability of and sensitivity to disturbances, it requires all professionals to be highly skilled and able to provide all kinds of homecare services. Maximum division of work involves a high probability of and sensitivity to disturbances caused by internal complexity. As an alternative, De Sitter proposes minimum possible division of work to realise organisational efficiency and effectiveness. Minimum possible division of work (situation C in the figure) assumes that teams of employees are responsible for complete tasks within the overall process of transforming input into output. Each team operates independently and is responsible for both the executive and regulatory aspects of all making, preparing and support activities related to its complete task. As we will explain, the socio-technical type of design is based upon minimum possible division of work.

The *second principle* relates to the differentiation and specialisation of the executive function into executive activities. Differentiation means the extent to which activities are divided into making, preparing and supporting.⁸ Specialisation involves the extent to which activities are divided into sub-activities. For instance, the activity of changing a stoma bag can be integrated into one overall activity or can be divided into sub-activities such as removing the package, washing the skin and applying the new stoma bag. The *third principle* is the degree to which regulatory activities are differentiated and specialised. De Sitter (1994) distinguishes three main regulatory activities: monitoring, assessing and acting. Monitoring involves observing the current processes in the system; assessing means finding out whether these processes are in accordance with certain standards, whereas acting refers to interventions to ensure that processes will be in accordance with standards in the future. The specialisation of the regulatory function reflects the degree to which regulatory activities are split up into regulatory sub-activities (Vriens & Achterbergh, 2011).

By means of division of work, an organisation is designed as a set of (sub-) processes and activities which are related to people. It requires coordination of work to align processes and activities, and to respect the integral character of the organisational system. Coordination can be accomplished by horizontal and vertical coupling (Figure 3.3) (Mintzberg, 1974; Galbraith, 1977; Kuipers et al., 2010). *Horizontal coupling* comprises the coordination between activities on the same level in the hierarchical structure. For instance, in the case of changing a stoma bag, horizontal coupling involves the coordination between two nurses on how to remove the old stoma. *Vertical coupling* refers to the coordination between activities not on the same level in the hierarchical structure. Think of a manager who contacts a self-organising homecare team about its lagging productivity. Kuipers et al. (2010) also distinguish between tight and loose coupling.

Tight coupling does not allow much freedom in the coordination between activities, because coordination is standardised by rules and protocols. *Loose coupling* allows significant freedom in the coordination between activities, for instance on the basis of professional insight (Weick, 1976; Orton & Weick, 1990). In practice, several coordination mechanisms are distinguished varying from horizontal to vertical, and from tight to loose coupling. For instance, Thompson (1967) hypothesises three coordination mechanisms – standardisation, plan and mutual adjustment – whereas Mintzberg (1974) distinguishes between mutual adjustment, direct supervision,

⁸ According to De Sitter (1994), three types of executive activities can be distinguished: making, preparing and supporting. Making comprises the actual production of goods or services. Preparing relates to preparation activities prior to making. Supporting refers to all activities that are only indirectly related to making (Vriens & Achterbergh, 2011).

standardisation of work processes, standardisation of outputs, standardisation of skills and standardisation of norms.⁹

3.1.3 *Dealing with disturbances: architectural attenuation and amplification*

From a system's theoretical perspective an organisation is conceptualised as a system that is in continuous interaction with its environment. According to De Sitter (1982; 1994), organisational survival is secured when an organisation embraces an architecture which is in balance with its environment. He argues that organisational architectures contain a degree of complexity resulting from a selected type of design. As we will explain, a bureaucratic type of design entails a high degree of complexity, whereas a socio-technical type of design entails a low degree of complexity.

Organisational architectures, complexity and disturbances are related. In the case of disturbances it is relevant to distinguish between two types of disturbances: those that are and those that are not related to the organisational architecture and its complexity (Vriens & Achterbergh, 2011). For instance, people may get sick independently of the organisational architecture. De Sitter (1982; 1994) claims that architectures can be a source of disturbances themselves. In this respect, he makes an important distinction between the probability of and the sensitivity to disturbances. The probability of disturbances refers to the number of interdependent relations within the organisational system: the more an architecture is based on division and coordination of work, the higher the degree of complexity resulting in a higher probability of disturbances.¹⁰ The sensitivity to disturbances relates to the degree to which a disturbance occurring can be absorbed locally without affecting other elements in the system (De Sitter, 1982; 1994; Vriens & Achterbergh, 2011). In order to survive in a turbulent environment, De Sitter holds that the architecture itself should be no source of disturbances. Therefore, an organisation faces the challenge of designing an architecture that reduces complexity and, thus, the probability and sensitivity to disturbances caused by its architecture.

An organisation can deal with complexity and disturbances threatening organisational survival by architectural attenuation and amplification (Ashby, 1958; Galbraith, 1973; Beer, 1995, 1996; Achterbergh & Vriens, 2010; Vriens & Achterbergh, 2011). *Attenuation* refers to reducing the probability of disturbances caused by the organisational architecture and diminishing the sensitivity of the architecture to the dispersion of disturbances. The architecture should be redesigned in such a way that it

⁹ For an explanation of these coordination mechanisms see Thompson (1967) and Mintzberg (1974).

¹⁰ De Sitter (1994, p. 23) argues that the probability of disturbances for a particular activity depends on four variables: (1) the number of relations an activity has with its environment, (2) the variability of these relations, (3) the nature of environmental changes, and (4) the specificity of the norms with regard to the output and the way the activity must be accomplished.

ceases to be a source of disturbances and disturbance dispersion. As the probability of disturbances is associated with the level of complexity, reducing the probability of and the sensitivity to disturbances requires the minimisation of internal complexity. *Amplification* involves maximising the regulatory potential of the system to deal with disturbances that cannot be attenuated. It assumes that there always are disturbances beyond control and, therefore, requires an appropriate response from the organisational system. In practice, this means that the system should have enough regulatory potential to respond to a variety of disturbances in a flexible way. The box below relates these technical concepts to a 'real' provider organisation.

Attenuation and amplification in a provider organisation

A provider organisation can deal with disturbances by attenuation and amplification. As stated earlier, attenuation relates to reducing the probability of disturbances caused by the organisational architecture and diminishing the sensitivity of the architecture to the dispersion of disturbances. Traditional provider organisations are often highly functionally differentiated: the overall task of homecare provision is maximally split up into sub-tasks. In practice, this could lead to the situation in which level-1 and level-2 professionals first visit a client to provide simple assistance with daily living (e.g. dressing, feeding), followed by a level-3 professional who is responsible for providing medicines and a nurse (level-4 or -5) who is responsible for the most complex care. Such a serial coupling of tasks increases the probability of disturbances. Attenuation in this respect could mean simplifying the organisational structure by integrating tasks and function levels to minimise internal complexity and, consequently, the probability of and the sensitivity to disturbances. For instance, instead of several professionals a representative of a team of nurses visits the client to provide the whole package of care. There are also disturbances which cannot be attenuated (e.g. nurses dropping out due to illness) and require an appropriate response from the system in terms of amplification. In practice, the system should therefore develop enough regulatory capacity to respond to a variety of circumstances in a flexible way. This could be realised by increasing local regulatory capacity, for instance by giving self-organising teams of homecare professionals a high degree of autonomy to anticipate disturbances.

Essential organisational conditions: controllability and adaptability

By attenuation and amplification, an organisation can successfully deal with disturbances. Or, in other words, by attenuation and amplification it may achieve the essential organisational condition of *controllability*, which refers to the ability of an organisational architecture to achieve maximum attenuation and amplification. Controllability refers to the state in which an organisational system can optimally deal with disturbances. As Figure 3.4 shows, controllability is considered an essential condition for organisational viability. However, it is not the only one. To ensure organisational viability, an organisational system must also foster *adaptability*, which refers to the agility and rapidity with which new forms of controllability can be created in response to turbulence in the environment. It reflects the flexibility with which an organisation can apply a new design to better deal with disturbances. The interplay

between controllability and adaptability sets out the conditions for *organisational flexibility* (Volberda, 1998). This in turn is considered crucial for *organisational viability*, which is a complicated concept. It relates to Ashby's law of 'requisite variety' stating that only variety can absorb variety (Ashby, 1958). Based on this law, an organisation is considered viable when it is continuously able to internally control the variety coming from the external environment.¹¹

Figure 3.4 Controllability and adaptability as essential conditions for organisational flexibility and viability

3.2 The bureaucratic type of design

This section explores the bureaucratic type of design which, in its ideal-typical form, is based on maximum division of work. As we will see in chapters 5 and 6, the point of departure of both cases under study reflected in many respects the principles of the bureaucratic type of design. This type of design has proved successful when applied in relatively *stable* environments. However, in turbulent environments it is ineffective and inefficient.

3.2.1 Introduction

The bureaucratic type of design has its origins in Taylor's principles of *scientific management* – also called "Taylorism" – and Weber's *rational bureaucracy* (Kuipers et al., 2010). Scientific management was introduced by Taylor (1856-1915) as a theory of management that aimed to improve economic efficiency by analysing and (re)designing

¹¹ For a detailed explanation of the concept of viability and Ashby's law see the work of Achterbergh and Vriens (2010).

work processes.¹² Taylor sought to standardise and objectify work processes. His work was one of the earliest initiatives to apply scientific reasoning to the organisation of work. He was inspired by noticing natural differences in productivity between factory workers. These differences had various causes such as differences in talent, intelligence and varying motivations. He noticed that even the smartest employees were often unmotivated. Furthermore, he observed that workers behaved differently outside the factory: their self-responsible behaviour outside the workplace disappeared as soon as they entered the factory. Within the factory, employees often purposely operated well below their capacity, worked at the slowest rate that went unpunished and tended to do only the amount of work that the slowest among them did. Taylor called this phenomenon “soldiering”. Based on his findings, he concluded that a redesign of work was needed to improve job design and work motivation. He proposed a design in which tradition and ‘rules of thumb’ were replaced by scientific procedures. Science should form the basis of executing the work, developing working procedures and selecting and educating employees. In his view, this could radically improve productivity and efficiency, and the motivation and social situation of employees. The principles of scientific management fitted seamlessly into the period around 1900 when industrialisation developed rapidly. Furthermore, there was an overwhelming supply of immigrant workers who were uneducated, unorganised and unable to control their working conditions. And, finally, markets were supply-driven, as illustrated by the famous quote assigned to Henry Ford: “Any customer can have a car painted in any colour he wants as long as it is black.”¹³

As a *designer* Taylor proposed scientific reasoning in relation to the organisation of work. Weber (1864-1920) studied rational bureaucracy as a *scientist* and noticed that the organisation of work should be based upon a coherent system of formal rules and procedures. He considered this important to reduce uncertainties and variety in the execution of work. Rules and procedures should also stimulate formal, hierarchical and impersonal relations between employees considered to be important for objective and rational decision-making and behaviour (Kuipers et al., 2010).

3.2.2 A closer look

The bureaucratic type of design in its purest and ideal-typical form is based upon *maximum* division of work: it involves (1) maximum separation of the executive and regulatory function, (2) maximum differentiation and specialisation of executive activities and (3) maximum differentiation and specialisation of regulatory activities.

¹² Although Taylor had some precursors in the persons of Charles Babbage (1832) and Adam Smith (1776), he was the first person who systematically developed his ideas in two publications: *Shop Management* (1903) and *The Principles of Scientific Management* (1911).

¹³ It should be noted that there is no evidence that Ford actually spoke these words.

Maximum division of work leads to an architecture as shown in Figure 3.5. The figure shows that (1) the executive and regulatory functions are separated as much as possible, which results in executive activities that are maximally stripped from their regulatory potential. So, in other words, ‘thinking’ and ‘doing’ are separated and organised in different activities. The figure also illustrates (2) differentiation and specialisation of executive activities, which results in differentiated activities that are grouped into making, preparing and support activities. (3) The regulatory function is also highly differentiated, which means that regulatory activities are divided into numerous sub-activities, for instance with regard to the regulation of quality of care, productivity and efficiency, and client satisfaction.

Maximum division of work requires maximum coordination of work, which implies that the bureaucratic type of design is characterised by a high degree of coordinating relations between its separated activities. These coordinating relations are illustrated by the numerous arrows in Figure 3.5. The multitude of relations in the executive part indicates the *internal complexity* of the bureaucratic type of design. Although not visualised in the figure, the regulatory function also entails a high level of complexity. The bureaucratic type of design is also very hierarchical, which means there are numerous layers in the organisation which are subordinate to higher organisational layers.

Figure 3.5 The bureaucratic type of design

How does the bureaucratic type of design look when translated to a 'real' provider organisation? As we will see, the point of departure of both cases under study reflects in many respects the characteristics of the bureaucratic type of design. This means that 'doing' is largely separated from 'thinking'. Professionals are expected to provide homecare services according to external needs assessment and predefined protocols and procedures. They are often not expected to think about the most efficient and effective method of homecare provision, because this is done by the management. Furthermore, homecare provision is highly differentiated and specialised. Several nursing levels are distinguished according to education, skills and expertise. These levels indicate a high level of functional differentiation: the lowest level is responsible for the lowest-complexity care and higher levels are responsible for more complex care. The regulatory function of a provider organisation is often also functionally differentiated. It may contain various managerial departments, for instance with regard to quality of care and client satisfaction, financial performance, productivity and efficiency.

3.2.3 *The vicious circle of bureaucracy*

The bureaucratic type of design is effective and efficient within a stable environment that is predictable, certain and slowly changing. However, as we have seen, provider organisations face environmental turbulence (chapter 2). As a result, they may expect a higher probability of disturbances resulting from internal complexity. The interesting question is how bureaucratic organisations react to environmental turbulence and internal complexity. Ironically, instead of creating flexibility which is considered to be required in order to deal with disturbances, bureaucratic organisations have the tendency to respond in a bureaucratic way: reinforcing bureaucratic principles and therefore internal complexity. They create a vicious circle of bureaucracy by responding to bureaucratically induced problems in a bureaucratic way (March & Simon, 1958; De Sitter, 1982; Fruytier, 1994). Figure 3.6 visualises the vicious circle of bureaucracy. As it shows, a bureaucratic organisation rests upon control based on maximum division of work. This increases the need for coordination, which results in a complex organisational architecture sensitive to disturbances. The high sensitivity to disturbances overburdens the organisation and eventually leads to organisational ineffectiveness. Instead of an adequate response, the organisation reacts in a bureaucratic way by intensifying control based on maximum division of work. It starts a new circle of bureaucracy and eventually becomes structurally 'out of control', which means that it is no longer able to ensure controllability and adaptability to stay flexible and viable. Organisations aware of the vicious circle of bureaucracy understand that they have to break through this bureaucratic mechanism. The socio-technical type of design offers the principles to break through the vicious circle of bureaucracy.

Figure 3.6 The vicious circle of bureaucracy

3.3 The socio-technical type of design

The objective of both cases under study is a socio-technical type of design to deal with environmental turbulence and minimise internal complexity. The term 'objective' refers to a direction to move towards without specifying a specific end point. It involves rather ambiguous and unquantified results (e.g. better quality of work, more efficiency, satisfied clients). The socio-technical type of design has its origins in the so-called coal mine case in Durham in the United Kingdom and is based upon the opposite principles of the bureaucratic type of design. Contrary to the bureaucratic architecture, its main principle is the integration of the executive and regulatory function to design complete tasks by applying minimum possible division of work.

3.3.1 Introduction

De Sitter (1930-2010) is regarded as the founding father of socio-technical design thinking in the Netherlands. He was inspired by studies in the Durham coal mines which were conducted by the Tavistock Institute of Human Relations in London (Trist & Bamforth, 1951; Trist, Higgin, Murray & Pollock, 1963).¹⁴ These studies described the so-called 'Longwall method of coal getting' which replaced the traditional artisanal way of coal mining. Whereas the traditional artisanal method of coal mining was based on the assumption that all activities could be accomplished by every team of miners without division of work at team level, the Longwall method was based on bureaucratic

¹⁴ The Tavistock Institute of Human Relations was founded in 1946 by psychologists to analyse and improve human relations within social systems.

principles of assembly work. It soon became clear that this method was not suitable in the underground environment where miners were confronted with unpredictable situations and dangers. Soon, the high level of division of work caused negative psychological, social and economic results. Miners became demotivated, had conflicts with each other and faced work-related stress resulting in absenteeism. Furthermore, the Durham coal mines faced lagging productivity. The studies by the Tavistock Institute discovered for the first time that there is a strong relationship between the social and technical system of an organisation. They also indicated that problems in the social system were often caused by inadequacies in the technical system. It became clear that an organisation should no longer be considered a closed system that could be interpreted without taking into account its environment. Furthermore, the Durham case showed that there is no best way of organising and that there is 'organisational choice' as to how the organisational design should look depending on environmental requirements (Kuipers et al., 2010).

The Durham case inspired De Sitter to transform the work design insights of the Tavistock Institute into a general design theory for designing architectures that meet environmental requirements (Kuipers et al., 2010). He defined several core principles underlying the socio-technical type of design to optimise quality of organisation, quality of work and quality of working relations.

3.3.2 A closer look

Contrary to the bureaucratic architecture, the socio-technical type of design is based upon *minimum possible* division of work. Its organisational structure involves (1) minimum separation of the executive and regulatory function, (2) minimum differentiation and specialisation of executive activities and (3) minimum differentiation and specialisation of regulatory activities. In other words, it assumes maximum integration of the executive and regulatory function, and sub-activities into complete activities. This leads to an organisational structure as illustrated in Figure 3.7. As the figure shows, the socio-technical type of design includes parallel order flows (X, Y and Z). Each order flow is coupled to the production of one type of order (or the delivery of one type of service). A low level of differentiation and specialisation means that making, preparing and support activities are integrated as much as possible and therefore not split up into many short-cycled sub-activities (Vriens & Achterbergh, 2011).

Figure 3.7 The socio-technical type of design (taken from Vriens & Achterbergh, 2011, p. 416)

Unlike the bureaucratic design, the socio-technical type of design in its pure form does not have functional departments. Instead, it organises activities around autonomous parallel flows producing a specific type of output or delivering a specific type of service. Teams are the smallest organisational building block in a socio-technical architecture (Galbraith, 1973; De Sitter, 1994). Preferably, they should be responsible for all activities (making, preparing and support activities) needed to produce the output of the order flow. They should also have maximum regulatory capacity to handle disturbances that might occur. Because the separation of executive and regulatory activities is minimal, regulatory activities are ideally integrated within the teams. This means that teams have a high level of regulatory capacity and autonomy with regard to order flows, which is illustrated by “R¹” in Figure 3.7. Besides local regulatory capacity, the socio-technical type of design requires regulatory capacity to coordinate and integrate order flows. This type of regulation is illustrated by “R²” in Figure 3.7 (Vriens & Achterbergh, 2011). For instance, in the case of self-organising homecare teams, there should be an overall framework defined by the management in which all teams operate.

How does the socio-technical type of design look when translated to a ‘real’ provider organisation? Provider organisations apply the concept of self-organising teams to meet the principles of the socio-technical architecture. The function of self-organising teams is comparable to the above description of teams. Usually, teams are coupled to a particular area of clients. The heterogeneous character of home care means that care flows are rather differentiated. It is anticipated by parallelising care flows to maximally homogenise each separate flow. In practice, this could lead to three types of care flows: low-complexity care, medium-complexity care and high-complexity care.¹⁵ Each of these care flows could be dedicated to separate homecare teams.¹⁶ Homecare teams are the smallest entities in the design and are maximally responsible for all activities (making, preparing and support activities) needed to provide home care. Ideally, this means that teams of homecare professionals not only provide home care but are also responsible for other activities related to the primary process, including planning and scheduling, recruiting clients and maintaining their equipment. Teams have maximum regulatory capacity to deal with potential disturbances. This means that they should be able to act autonomously in the case of a colleague who falls ill or a client who unexpectedly needs urgent care. In addition to local regulatory capacity there is still some central regulatory potential. In practice, this reflects the management which is responsible for strategic issues.

The socio-technical type of design is based on the assumption that an organisation consists of a *social* and a *technical* system which are closely intertwined. The interconnectedness of both systems is visualised by Van Amelsvoort (1999) in the so-called “organisational temple” (Figure 3.8). As Figure 3.8 illustrates, an organisation rests upon its mission, vision and strategy as well as its main routines, principles and beliefs (RPBs).¹⁷ Organisational behaviour is determined by the way in which the organisation gives meaning to *structures* and *systems* as the ‘hard’ aspects of the organisational architecture, and *people* and *cultures* as the ‘soft’ aspects of the architecture. The organisational temple assumes an integral character. Just like a real temple, it does not work to intervene in one of the four pillars individually. Instead, a socio-technical type of design requires that all pillars are addressed on an integral basis. This should lead to an organisational architecture in which *people* experience optimal quality of work, *cultures* are externally oriented and leave room for professional autonomy, *structures* are based upon minimum division of work and maximum local

¹⁵ However, it should be noted that the parallelisation of order flows can also lead to other types of care flows in practice, such as a parallelisation in terms of location and type of services in relation to type of clients.

¹⁶ In contrast to the ideal-typical bureaucratic design, numerous socio-technical architectures are possible depending on the type(s) of output that should be created and the environmental requirements and circumstances that exist. However, as stated earlier, socio-technical architectures share the main principle of integrating the executive and regulatory function as much as possible to design complete tasks by applying minimum possible division of work.

¹⁷ For an explanation of organisational RPBs see the article of Mur and Govers (2011).

regulatory capacity and *systems* support primary processes flexibly and in a timely manner.

Figure 3.8 The organisational temple (taken from Van Amelsvoort, 1999)

Leadership plays an important role in integrally addressing the elements of the organisational temple. It is the glue to align the social and technical system of the organisation. A look into the literature reveals various leadership styles. The distinction between transactional and transformational leadership is well known (Bass & Avolio, 1994; Avolio, 1999). Transactional leadership emphasises the relationship between the leader and his followers in terms of the exchange of transactions. It is based upon agreements or contracts between the leader and his followers concerning the objectives of work. The leader rewards or disciplines his followers with regard to their performance. Transformational leadership emphasises the importance of a leader who stimulates his followers by showing role model behaviour, encouraging through inspiration, and providing consideration of their individual needs and desires (Bass & Avolio, 1994; Avolio, 1999). The socio-technical type of design mainly requires transformational leadership, because this type of leadership fits in well with the socio-technical principles including teamwork (Bass & Avolio, 1994). In our study, the role of leadership in the process of changing to a socio-technical type of design is analysed only indirectly, because our main focus is on the perception of the employees as the people who are actually undergoing the change (see section 3.6).

Socio-technical design sequence

The design of a socio-technical architecture requires a particular design sequence to be met which involves a series of design steps to be followed in the right order to realise a

socio-technical type of design (see Figure 3.9). These steps take place after a strategic positioning process (Kuipers et al., 2010). De Sitter (1994, p. 91) distinguishes between two structures of an organisational design: a production structure and a control structure. The *production structure* refers to the grouping and coupling of interrelated executive activities. It contains the executive part of the organisational design which should contain all activities necessary to realise the primary process. The *control structure* concerns the grouping and coupling of regulatory activities and their relation to the production structure. It involves the regulatory part of the organisational design. As Figure 3.9 visualises, designing a socio-technical architecture involves *first* the design of an adequate production structure and, *second*, the design of a control structure relative to the production structure. As the figure shows, the production structure is designed by thinking top-down from the macro to the micro level (from rough to fine structure). After the design of the production structure, the control structure is designed and aligned with the production structure by thinking bottom-up from the micro to the macro level (from fine to rough structure).

Figure 3.9 The design sequence of socio-technical (re)design (based on De Sitter, 1994)

The *first step* involves parallelisation of order flows to minimise internal complexity. Parallelisation refers to homogenising input flows of the primary process by categorising various input flows and organising input variety in separate flows. For instance, when input consists of three types of care (e.g. low-complexity, medium-complexity and high-complexity care), parallelisation may result in the design of three separate order flows for each type of care to reduce the occurrence of disturbances in one flow affecting the other flows. The *second step* is segmentation which refers to the

activity of splitting the complete task into segments because the complete task is too complex or extensive for one team. As the socio-technical approach assumes the integration of tasks, segmentation is required only when it leads to segments which are in themselves 'meaningful wholes'. Furthermore, the occurrence of interferences between segments should be minimised. The *third step* includes the design of teams based on the results of parallelisation and segmentation (segmentation only when the complete task is considered to be too complex or extensive). Teams should consist of 8-12 people and have maximum regulatory capacity to deal with all activities related to the primary process. Although regulatory capacity must primarily be located at the level of teams, the *fourth step* involves the allocation of inter-local regulatory capacity to create alignment between the teams. For instance, inter-local regulatory capacity between teams of homecare professionals is required in the case of a sick colleague who can only be replaced by a colleague from another team. Finally, the *fifth step* is to allocate global regulatory capacity to create uniformity with regard to performance requirements and overall objectives.

3.3.3 *The organisational survival loop*

A socio-technical type of design creates the infrastructural conditions to cope with environmental turbulence over time. It paves the way for organisations to break through the vicious circle of bureaucracy and enter the organisational survival loop. By applying the socio-technical design principles, an organisation can achieve controllability and adaptability to stay flexible and viable in future. Figure 3.10 visualises the organisational survival loop¹⁸. As it shows, a modern organisation faces turbulence from its environment. It responds to this turbulence by creating an architecture that fosters flexibility. Based on the socio-technical design principles, it reduces the sensitivity to disturbances caused by internal complexity and maximises regulatory potential to deal with remaining disturbances. In other words, it designs structures that attenuate disturbances as much as possible *followed by* structures that amplify regulatory potential to deal with disturbances that cannot be attenuated. The socio-technical architecture increases organisational effectiveness and creates a more flexible and viable organisation to anticipate environmental turbulence in future.

¹⁸ The organisational survival loop was created by Dr. M.J.G. Govers based on earlier work on socio-technical design thinking (e.g. De Sitter, 1982; 1994; 1998; Van Amelsvoort, 1999; Kuipers et al., 2010).

Figure 3.10 The organisational survival loop

3.4 Results: three essential 'qualities'

From a socio-technical point of view, the socio-technical type of design is considered an alternative for successfully dealing with environmental turbulence and minimising disturbances. A socio-technical organisation is considered capable of fulfilling various requirements including efficiency, quality, flexibility, innovation and sustainability (Kuipers et al., 2010). De Sitter (1994) distinguishes three essential variables or 'qualities' that must be realised and balanced by an organisation to survive. These are: quality of organisation, quality of work and quality of working relations. *Quality of organisation* is defined as the organisation's ability to realise and adapt its goals in an effective and efficient way. It involves the extent to which the organisation is productive, flexible and innovative, and able to realise products or services of high quality. *Quality of work* relates to the organisation of work to its employees in terms of meaningfulness of jobs and the possibility to deal with disturbances. High quality of work involves low levels of work-related stress, absenteeism and personnel turnover and a high level of work involves engagement of employees. *Quality of working relations* is conceptualised as the organisation's ability to realise effective communication relationships. It involves both internal and external relations. Internal relations refer to the communication within the organisation, for instance between employees or a team and the management, and external relations to the communication between the organisation and actors in its environment, including key partner organisations and (quasi-) state agencies (e.g. government, ClZ, municipalities, regional care offices).

According to De Sitter (1994), an organisation that applies the socio-technical type of design will generate optimal results in terms of quality of organisation, quality of work and quality of working relations. De Sitter defines essential variables to arrive at the three 'qualities', which he calls 'functional requirements'. These requirements are crucial to realise optimal quality of organisation, quality of work and quality of working relations, and so to achieve organisational viability. He distinguishes between external and internal functional requirements. External functional requirements refer to the connection between the organisation and its environment. If they are present, the organisation is in balance with its environment. Internal functional requirements concern those internal conditions that an organisation should realise to achieve the external functional requirements. If these are met, external requirements can be realised and the organisation's viability is safeguarded. Table 3.1 contains the external and internal functional requirements for each quality as defined by De Sitter (1994). Optimal quality of organisation is achieved if an organisation is able to meet quality and delivery demands adequately, if it can anticipate changes in demand flexibly and can realise process and product (or service) innovations in a timely manner. Optimal quality of work is realised if employees have the regulatory capacity to deal with work-related disturbances to minimise work-related stress, and consider their jobs to be meaningful: their jobs offer them opportunities to be involved, learn and develop. Optimal quality of working relations requires effective communication by means of shared responsibility and communication (De Sitter, 1994; Vriens & Achterbergh, 2011).

Table 3.1 Functional requirements defined by De Sitter (1994) (taken from Vriens & Achterbergh, 2011, p. 408)

Quality	External functional requirements	Internal functional requirements
Quality of organisation	Order flexibility	Short production cycle time Sufficient product variations Variable mix of products
	Control over order realisation	Reliable production and production time
	Potential for innovation	Effective control of quality Strategic product development Short innovation time
Quality of work	Low level of absenteeism	Controllable stress conditions
	Low level of personnel turnover	Opportunities to (1) be involved, (2) learn, and (3) develop
Quality of working relations	Effective communication	Shared responsibility
		Participation in communication

3.5 Change strategy: changing to the socio-technical type of design

Up to this point, the chapter has focused on the *content of change*. We found that the bureaucratic type of design hinders organisations in staying viable if they are

confronted with environmental turbulence and internal complexity.¹⁹ In a turbulent environment, bureaucratic organisations are unable to attenuate and amplify adequately, which often has an internal bureaucratic cause. As an alternative, the socio-technical type of design is assumed to enable organisations to deal with external changes properly and to minimise internally caused disturbances. The final part of this chapter provides the theoretical foundation underlying the change from the bureaucratic to the socio-technical type of design. In other words, it explores the *process of change*. It gives an introduction to the concept of change and explores how a profound change strategy looks. It ends with the introduction of four phases of change which are used in this study to examine the change process of both cases under study.

3.5.1 Introduction

Change can be referred to as the process of changing from one situation to another (De Caluwé & Vermaak, 2003). The concept of change is a container concept: it contains numerous different meanings (see Graetz & Smith, 2010). This holds true particularly for organisational change. A look into the literature reveals various change continuums and types of change. As the box below describes, some authors consider organisational change to be rather static (e.g. Lewin, 1947), while others emphasise its dynamic character (e.g. Pettigrew, 2000). Authors such as Cummings and Worley (2001), Boonstra (2004) and Burnes (2009) describe change as varying from incremental and aimed at improving to transformational and aimed at renewal. Other authors (e.g. Kezar, 2001) draw a distinction between reactive and proactive change.

Static change emphasises the planned and linear approach towards a predetermined end state by executing a specified change plan that is determined beforehand (e.g. Lewin, 1947). **Dynamic** change emphasises the dynamic, open-ended and unpredictable process of change which is unique and often the result of political and cultural processes within the organisation (e.g. Pettigrew, 2000). **Incremental** change is about following a step-by-step approach which involves taking a lot of small steps to a clear end state. It is therefore about improvement rather than renewal, thereby focusing upon parts instead of the whole. **Transformational** change aims at fundamentally changing the organisation as a whole. It aims to realise renewal rather than improvement (Cummings & Worley, 2001; Boonstra, 2004; Burnes, 2009). Kezar (2001) relates change to the occurrence of a crisis. **Reactive** change is classified as happening after a crisis which is often the result of external forces in the organisation's environment. **Proactive** change is initiated before a crisis occurs and is the result of organisational decision-making to prevent a future crisis.

¹⁹ In this respect, it should be noted that our study does not focus on common barriers to socio-technical (re)design: political barriers, design-technical barriers, bureaucratic barriers, cultural barriers, individual barriers and structural distrust (Kuipers et al., 2010). Focusing on these barriers may lead to a biased negative view of the change process. As we will explain (see section 3.6), we will analyse the change process from the perspective of the employees by focusing on four factors. In doing so, we assign a key role to the employees undergoing the change and attempt to take up a more neutral position to analyse the change process.

The literature also offers numerous change strategies. The distinction of Bennis, Benne and Chin (1979; 1985) between power-coercive, empirical-rational and normative-re-educative strategies is well known (see box below).

Power-coercive strategies assume the presence of power which is used to enforce change. Change is considered to be initiated from top-down and a threat of penalties is used to prevent undesired behaviour. **Empirical-rational strategies** consider people as acting and behaving rationally. Change takes place as a result of rational-empirical analysis, planning and communication. **Normative-re-educative strategies** are based on the assumption that people can initiate change themselves, because they are intrinsically active and willing to learn. These strategies encourage people to learn and change from the bottom up (Bennis et al., 1979; 1985).

Another categorisation is the so-called colour strategies of De Caluwé and Vermaak (2003; 2004; 2006), who distinguish between a yellow, blue, red, green and white strategy (see box below).

The yellow strategy interprets change from a socio-political perspective and considers it the result of a power game between people. The blue strategy stresses the rational-empirical perspective and assumes that change can be planned rationally. The red strategy emphasises the human aspect and assumes that people will change when they are rewarded for certain type of behaviour. The green strategy underscores the importance of learning and assumes that people will change, if the conditions for learning are present. Finally, the white strategy stresses self-organisation in relation to change. Change is assumed to occur autonomously and a system itself finds its own balance (De Caluwé & Vermaak, 2003; 2004; 2006).

These change continuums and strategies are only the tip of the iceberg. However, it is not our intention to give an overview of all different perspectives on organisational change. As an alternative, we think it is more relevant to identify key elements of a profound change strategy. According to De Caluwé and Vermaak (2003), a change process is dynamic and non-linear and requires a change strategy to leverage the change effectively. It requires clarity on the point of departure and an objective, and on how the distance between both can be bridged. It should include an intervention plan describing what actions are required to change to the design aspired to. These actions should form a coherent whole and be consistent, feasible and relevant. Consistent means that the actions should not conflict with each other, feasible that they should be executable and absorbable by the people undergoing change, and relevant that they should contribute to the objective. The change strategy should also take into account the level of motivation or resistance in the organisation (De Caluwé & Vermaak, 2003).

3.5.2 Four phases of change

The literature on organisational change contains various models for describing the change process. These models often describe a sequence of change steps and phases, and therefore assume change as rather static, linear and predictable. Based on the work of Hoogerwerf (1998), we use an alternative model to describe the change process consisting of four phases of change: the incubation phase, preparation phase, start-up phase and consolidation phase. This model is considered a more practical model for organisational change. It follows a dynamic and iterative path and is considered to fit in well with the practice of change.

The alternative model with its four phases of change is depicted in Figure 3.11. The first phase – *incubation* – starts when the organisation recognises that its functioning is not yielding optimal performance or notices difficulties in responding to (changing) requirements from its environment. Often, this involves an in-depth analysis of the external environment in relation to the internal way of organising and managing. It usually coincides with developing rough ideas for bridging the gap between the organisation's point of departure and its objective. The second phase – *preparation* – starts with the concretisation of these rough ideas by carefully considering alternatives that may range from small-scale improvements to fundamental renewal. Furthermore, it includes the selection of the alternative considered best. If the organisation opts for a fundamental renewal, usually an intensive period of brainstorming and redesigning on paper will follow. Ideally, it involves representatives of all organisational layers and results in a global change plan. The third phase – *start-up* – starts when change initiatives are actually put into practice. The start-up phase and preparation phase may go hand in hand and occur largely simultaneously. However, whereas the preparation phase is about organisational redesign on paper, the start-up phase deals with redesigning in practice. It usually does not mean implementing a ready-made blue-print change plan. Instead, it involves a period of 'trial and error' characterised by developing, experimenting, adjusting and re-adjusting. The fourth phase – *consolidation* – involves the internalisation of the changes which have brought the organisation closer to its aspiration. The purpose of this phase is to consolidate the new way of organising and managing to avoid the bureaucratic trap. Although consolidation is conceptualised as the final phase in the model, it does not mean that the change process ends here. As the organisation and its environment are developing continuously, it may turn out to initiate a 'next round' of change.

Figure 3.11 Four phases in the process of changing (based on Hoogerwerf, 1998)

Organisational change as conceptualised here in terms of four phases cannot succeed without the active involvement of the management of the organisation. The management should not only put the change on the organisational agenda, but also fulfil a leading and inspiring role. Organisational change should also be kept on track and, if necessary, be redirected. However, this is not to say that organisational change should be set up as a kind of top-down exercise. The challenge is how to involve employees actively in the change process in order to benefit from their experience and ideas, to learn from their frustrations, and so on. Active involvement can be considered an essential prerequisite for a successful change to a socio-technical type of design (e.g. Boonstra et al., 1998; De Caluwé & Vermaak, 2003; Kuipers et al., 2010).

3.6 The employees' perception

An effective change strategy incorporates the motivation or resistance of the people undergoing change: the employees (Boonstra et al., 1998; De Caluwé & Vermaak, 2003; Kuipers et al., 2010). As visualised in Figure 3.1, the change process involves a *mutual relationship* between the change strategy and the employees' perception. The change strategy chosen by the management influences the employees' perception of the change. The management may expect resistance if the interests of employees are not sufficiently taken into account. However, the view and attitude of employees also has consequences for the change strategy. Employees who were confronted with unsuccessful changes in the past may be reluctant to adopt any change strategy in future.

Importantly, another mutual relationship exists between the change results and the employees' perception. The way employees perceive the change tells us something about the results of the change in terms of three functional requirements elaborated by De Sitter: quality of organisation, quality of work and quality of working relations (see section 3.4). At the same time, however, their perception is also an important factor in the change process itself. If employees are positive about the change in terms of the three functional requirements, their 'positivism' will increase the probability of successful change. By contrast, if they are negative, their 'negativism' is likely to influence the change negatively.

In this study, the employees' perception is evaluated on the basis of narratives gathered by interviews. These interviews are supplemented with results of observation and document study. Because the literature does not provide a comprehensive model to evaluate the employees' perception of the change to a socio-technical type of design, we evaluate it on the basis of four influencing factors: *history of the case*, *conditions for change*, *system world versus life world* and *external influences*. These factors were obtained as follows. First, we accomplished an 'open' and 'theoretically unguided' analysis of Klein Zwitserland as the first of our two cases. This analysis helped us to identify four factors to study the perception of the employees in the Klein Zwitserland case. In the literature, these factors are only discussed separately and not presented as an integral model. However, as we find these factors relevant *together*, we present them as a heuristic model to analyse Maas & Waal as the second case. The next sections explore each factor and describe for each factor three indicators to operationalise it (Table 3.2).

3.6.1 *History of the case*

The first factor – history of the case – refers to the history of the organisation in relation to its current and future functioning. Several authors (e.g. Pettigrew, 1990; 1997; Kieser, 1994) emphasise that the role of history in relation to organisational development tends to be underestimated. However, there is a growing interest in its role nowadays. Organisational scientists increasingly use the potential of historical analyses to better understand organisations and change processes (Brunninge, 2009). Organisational development can only be interpreted properly by incorporating the organisation's historical context into the analysis (De Caluwé & Vermaak, 2003). Ericson (2006) states that the role of history within organisational development is primarily interpreted in terms of inertia or path dependencies. From this perspective, organisations develop their own history which influences their characteristics. The idea is that historical development paths may lead to organisational inertia, because they limit the range of strategic future options for organisations (Rhenman, 1973;

Wernerfelt, 1984; Barney, 1991). The best predictor of an organisation's structure and functioning at point t^1 is its structure and functioning at point t^0 .

Table 3.2 Evaluating the employees' perception of the change to a socio-technical type of design

Influencing factors	Indicators
History of the case	Degree of influence of changes in the past Character of influence of changes in the past (positive or negative) Particular role of 'change fatigue'
Conditions for change	- <i>Staffing</i> Ability of employees to work according to team-based design requirements Willingness of employees to work according to team-based design requirements (Sufficient) number of employees of all function levels
	- <i>Structural</i> Team size Team composition Extent to which regulatory capacity is organised locally
	- <i>Technological</i> Use of technology in relation to clients Use of technology in relation to employees Degree of embeddedness of technology use (e.g. training and education)
	- <i>Cultural</i> Flexible attitude Team atmosphere Degree of influence of acquired rights and habits from the past
System world versus life world	Degree to which the 'system world' infiltrates the 'life world' Response of homecare professionals to system world infiltration
External influences	Particular role of the 'informal organisation'
	Degree of external influences
	Character of external influences (positive or negative)
	Ability to anticipate external influences

In this study, the role of history from the employees' perspective is evaluated by examining (1) the degree of influence of past changes, (2) the character of influence (positive or negative) of past changes and (3) the particular role of 'change fatigue'. The *first indicator* refers to the extent to which the change process is influenced by the history of the case. For instance, the change process may be affected by changes in the past or organisational developments such as a merger or a period of financial unsustainability. This could vary from hardly any influence to significant influence. The *second indicator* measures whether this influence has been positive or negative. Positive means that the change process is positively affected by changes in the past; negative means just the opposite. The *third indicator* measures the extent to which employees express feelings of 'change fatigue'. Change fatigue is expected to result from negative experiences with changes in the past or too many past changes. It may be expressed by either passive behaviour or resistance of employees towards change.

3.6.2 Conditions for change

The change towards a socio-technical type of design requires some essential conditions to be met. This study distinguishes between staffing, structural, technological and cultural conditions.

Staffing conditions

Teams are the smallest organisational building block in a socio-technical design (Kuipers et al., 2010). Whereas individuals in the bureaucratic architecture are only responsible for small sub-tasks without significant regulatory capacity, in the socio-technical type of design teams of individuals are responsible for accomplishing complete tasks on the basis of maximum regulatory potential. This team-based way of working is evaluated by means of three indicators (Table 3.2). The *first indicator* involves the ability of individuals to work according to requirements of the team-based design. People should feel responsibility for organisational tasks and the team, in addition to responsibilities towards clients (Vermeer & Wenting, 2012). They also should be able to act as team players, thereby contributing to team atmosphere and having a flexible attitude. Furthermore, team members should be versatile and be able to accomplish a multitude of executive, regulatory and innovative functions (Emery & Thorsrud, 1976). The *second indicator* refers to the extent to which people are willing to work in self-organising teams. Teams assume maximum regulatory potential and responsibilities on the side of employees. More than being able to work in teams, individuals should be willing to bear these additional responsibilities (Vermeer & Wenting, 2012). According to Wall, Clegg and Jackson (1978), individuals identify with a team more easily than with the overall organisation. The *third indicator* is that ideally all different nursing levels are present in a team in order to accomplish complete tasks.

Structural conditions

The socio-technical type of design also requires structural conditions which directly relate to the team-based concept. For instance, teams should be able to anticipate the variety of external requirements. Based on Ashby's law of 'requisite variety' stating that only variety can absorb variety, the diversity of actions and reactions of the team should be in accordance with the variety of external requirements (Ashby, 1958; 1969). The *first indicator* in this study is team size, which is considered a crucial precondition for successfully operating teams (Almekinders, 2006; Kuipers et al., 2010; Van Dalen, 2010). On the one hand, teams should not be too large to encourage optimal team atmosphere and team work. On the other hand, they should not be too small to avoid vulnerability with regard to the availability of sufficient team members. Generally, a maximum team size of 20 people and a minimum team size of five people have been suggested (Almekinders, 2006; Kuipers et al., 2010). Van Dalen (2010) proposes an ideal maximum team size of 12 people. The *second indicator* concerns the composition of

teams. We have already discussed the importance of teams containing all function levels to produce the output of the order flow. Furthermore, it is crucial that all team members fit in the team and contribute to the functioning and atmosphere of the team. This usually involves an intensive period of actively encouraging team development (Van Amelsvoort & Van Jaarsveld, 2000). The *third indicator* is the extent to which regulatory capacity is organised locally. Self-organising teams are at the core of the socio-technical type of design. They should be maximally responsible for all activities relating to the primary process (including regulatory activities), such as accomplishing the intake of clients, monitoring clients' indications, scheduling and planning, and monitoring the quality of the work. Ideally, the organisation's management only determines *what* teams should accomplish and gives maximum freedom on *how* to achieve this.

Technological conditions

Technology is important in modern homecare provision and hence also in the socio-technical type of provider organisation (e.g. Van Dalen; 2010; Ipenburg, 2011; Genet et al., 2012; Dohmen, 2013). It involves the application of technological possibilities to improve the quality of home care from the perspective of the client, for instance by providing e-health services. Technology is also used to improve homecare provision from the perspective of the employee, by providing employees with smartphones that can be used to communicate en route or computers to do administrative work at home. However, the application of technology is a precarious and challenging task. Technology should be domesticated by clients and employees (e.g. Frissen, 2004). Its successful application therefore requires intensive development in accordance with its users, and training and education to embed technology in the work processes. Technological conditions are examined in this study by investigating three criteria. The *first indicator* reflects the extent to which the organisation applies technology to improve the quality of home care from the perspective of the client. The *second indicator* refers to the extent to which technological possibilities are used to improve the quality of work of employees. The *third indicator* relates to the degree of embeddedness of technology use within the organisation by providing training and education.

Cultural conditions

The team-based way of working requires cultural conditions to be fulfilled. Bureaucratic organisations usually feature deeply rooted closed cultures which reject any influence from outside. However, a socio-technical architecture requires open cultures susceptible to change (Kuipers et al., 2010). To realise a socio-technical type of design, organisations should be able to 'pull themselves out of the bureaucratic swamp' (Fruytier, 1994). Teams should also develop the ability to realise 'double loop learning' in addition to 'single loop learning' (Argyris & Schön, 1978). Whereas single loop

learning refers to improving the current way of working in accordance with standards, double loop learning starts by questioning the accuracy of these standards. This study distinguishes three criteria with regard to culture which are important for successfully operating self-organising teams (Vermeer & Wenting, 2012). The *first indicator* relates to the flexible attitude of employees (Vermeer & Wenting, 2012). Maximum regulatory potential and responsibilities increase the freedom and autonomy of employees. However, they may also place high demands on flexibility, because people should be available for colleagues continuously or may feel obliged to be so. This may have significant consequences, for instance, for the work-life balance. The *second indicator* is team atmosphere, as mentioned earlier. Teams should be able and willing to develop a team culture that optimises team atmosphere and performance. This requires putting the right people together by matching personalities and characters. There should also be a culture of giving and receiving feedback in which all team members are encouraged to make that extra effort to let the team flourish. Finally, the *third indicator* is the degree of influence of acquired rights and habits from the past. In the bureaucratic organisation, employees may have become used to acquired rights and habits such as fixed days off or a fixed working schedule. In the socio-technical type of design, they should behave in a more flexible way.

3.6.3 System world versus life world

The third influencing factor – system world versus life world – involves the characteristics of the context in which the change to a socio-technical type of design takes place. As this study investigates provider organisations in home care, we should unravel the unique characteristics of their context. Basically, this context contains two different domains which are conflicting, but which come together in the organisation and provision of home care. On the one hand, home care starts from the relationship between the professional and the client. In home care one person is caring for another person. It is provided in the client's home and 'soft' aspects are dominant, such as personal meaning and values. On the other hand, the organisation behind this care relationship has a formal, 'business-driven' and large-scale character and is about performance and control, and achieving 'hard' aspects such as productivity, effectiveness and efficiency (Philipsen, 1987; Kunneman & Slob, 2007; Van der Boom, 2008).

The distinction between these two domains goes back to the well-known classification of Habermas (1981) between a "system world" and a "life world" (Figure 3.12). He conceptualises the system world as the domain in which economic, political and administrative norms are dominant. It has a 'system orientation' in which system-oriented principles have a leading role. It is about calculable performance and control and achieving 'hard' aspects, such as productivity, effectiveness and efficiency. The life

world, by contrast, reflects the domain in which personal meaning and moral commitment have the leading role. It entails a 'people orientation' in which people-oriented values are dominant: it is about personal relationships and realising 'soft' aspects, such as mutual respect, human warmth and integrity. According to Habermas (1981), both worlds are important in terms of the life world incorporating the 'soft' elements and the system world with its focus on productivity, effectiveness and efficiency. However, and this is key in Habermas' theory, the system world almost automatically infiltrates and undermines the life world, as a consequence of which there is no longer a balance between both domains (Figure 3.12).

Figure 3.12 Increasing dominance of the "system world" over the "life world" (Habermas, 1981)

This study addresses the system world versus the life world by means of three indicators. The *first indicator* examines the extent to which the system world infiltrates the life world from the perspective of homecare professionals. The *second indicator* addresses their response to the infiltration of their life world by the system world. These two criteria are particularly relevant because homecare professionals fulfil an intermediary position between both domains (see overlapping area in Figure 3.12) (Kunneman & Slob, 2007). The *third indicator* addresses the particular role of the 'informal organisation' (French & Bell, 1999). If homecare professionals perceive formal rules and regulations as ineffective, they create their own (informal) rules which in their view fit in better with homecare practice.

3.6.4 External influences

The fourth influencing factor – external influences – concerns the relationship between both cases and their external environment. As described in the introductory chapters, provider organisations are increasingly confronted with environmental turbulence in their political context (see chapter 2). This study incorporates three indicators to address the relationship between provider organisations and these external influences. The *first indicator* examines the degree to which the work of homecare professionals is influenced by external influences. The *second indicator* investigates the character of external influences (positive or negative) and the *third indicator* the degree to which homecare professionals are able to respond to external influences.

3.7 Summary

This chapter provided the theoretical foundation of the study. It followed a structure similar to that which will be used for the evaluation of both cases. The first part (subsection 3.1) introduced the basics of organising and managing. We explored the system's theory on organisations by explaining an organisation as a network of interconnected nodes and explored the concept of division and coordination of work. Division of work involves the extent to which the executive and regulatory functions are separated and activities are differentiated and specialised. Coordination of work is the consequence of the applied division of work and can be realised by several coordination mechanisms. Furthermore, we discussed the importance of attenuation and amplification to deal with disturbances.

The second part (subsection 3.2) addressed the bureaucratic type of design. We explored its origins by means of Taylor's scientific management and Weber's rational bureaucracy. We established that the bureaucratic type of design in its ideal-typical form is based upon maximum division of work, which implies (1) maximum separation of the executive and regulatory function, (2) maximum differentiation and specialisation of executive activities and (3) maximum differentiation and specialisation of regulatory activities. Bureaucratic organisations respond to disturbances in a bureaucratic way and so enter a vicious circle of bureaucracy.

The third part (subsection 3.3) addressed the socio-technical type of design. We explored its origins from the Durham case. In contrast to the bureaucratic type of design, its main principle is the integration of the executive and regulatory function to design complete tasks by applying minimum possible division of work. Teams should have maximum regulatory potential to deal with disturbances. We explained that a socio-technical type of organisation creates the infrastructural conditions to cope with environmental turbulence over time. It enables organisations to break the vicious circle of bureaucracy and enter the organisational survival loop.

The fourth part (subsection 3.4) described the organisational results of a socio-technical type of design in terms of three essential variables or 'qualities': quality of organisation, quality of work and quality of working relations. These qualities must be realised and balanced by an organisation to be able to anticipate numerous requirements such as efficiency, quality, flexibility, innovation and sustainability.

The final part of the chapter addressed the process of changing from the bureaucratic to the socio-technical type of design. After a definition of the concept of change and a brief overview of some change continuums and strategies, subsection 3.5 explored essential elements of a profound change strategy. It also introduced a model containing four phases of change: the incubation phase, preparation phase, start-up phase and consolidation phase. Subsection 3.6 discussed the interconnectedness between the employees' perception and the change strategy. Furthermore, we discussed four types of factors which are influenced by the change strategy but also influence it.

Chapter 4

Methodological foundation

4. Methodological foundation

This chapter contains the methodology section of this study. It consists of three parts. The first part (subsection 4.1) introduces three cornerstones underpinning the design of the study. These are: qualitative research, applied scientific research and case study research. The second part (subsection 4.2) explores the design of the study, by explaining its three main research steps: (1) double-case study, (2) comparative analysis and (3) reflection. Finally, the third part (subsection 4.3) addresses the methodological quality of the study. It explains triangulation, reliability and validity, as well as the actions undertaken to enhance these aspects in this study.

4.1 Introduction

This study is qualitative in nature and follows an explorative approach (subsection 4.1.1). It consists of various steps and phases which are interrelated and iterative and form a coherent whole. It is based upon principles of applied scientific research (subsection 4.1.2) and follows the case study research approach (subsection 4.1.3).

4.1.1 *Qualitative research*

Qualitative research is used to gain an in-depth understanding of a phenomenon within its context, thereby incorporating the role of human behaviour in relation to this phenomenon (Creswell, 2007; 2009; Yin, 2009; Neuman, 2011). The process of qualitative research is iterative and incremental. In this respect, Creswell (2009) refers to the emergent character of qualitative research with a cycling back and forth from data collection and analysis to problem reformulation and back. This also means that (temporary) findings are continuously compared with earlier findings and may give impetus for new findings (Maso & Smaling, 2004; Verschuren & Doorewaard, 2007). Based on the work of Rossman and Rallis (1998), Creswell (2009) describes important characteristics of qualitative research presented in the text box below.

Characteristics of qualitative research (taken from Creswell (2009, pp. 181-183).

Natural setting

Qualitative research involves the collection of data in the setting in which people experience the phenomenon under study. People or objects are not examined in a laboratory setting. Instead, information is gathered by directly talking to, interviewing and/or observing people behaving and acting in their natural setting.

Holistic account

Qualitative research aims to grasp the phenomenon under study from a holistic perspective. This often results in a comprehensive and complex picture containing multiple perspectives and actors involved.

Emergent character

Qualitative research is emergent rather than strictly predetermined. Several aspects emerge or may change during a qualitative study, such as research questions or the process of data collection. The emergent character of qualitative research makes it difficult to describe a strict qualitative research plan at the early research stage.

Interpretive character

Qualitative research involves interpretive inquiry in which the researcher makes an interpretation of what he sees, hears and understands. It should be realised that his interpretation cannot be separated from his own background, history, context, prior interpretations and knowledge.

Inductive reasoning

Qualitative research has an inductive rather than deductive character. This means that the researcher builds his findings, patterns and theories from the bottom up, by organising the data into more abstract units of information. This involves working back and forth between the findings until the researcher has found a comprehensive set of results.

Theoretical lens

Qualitative research usually involves the researcher viewing his (temporary) findings through a theoretical lens. This lens may provide information on which follow-up data should be collected and analysed and in what way. It may also help the researcher in interpreting his findings.

Researcher as key 'instrument'

The key instrument of qualitative research is the researcher himself. Instead of relying solely on instruments or questionnaires developed by other researchers, the researcher himself is engaged in gathering the information by examining documents, observing behaviour and/or interviewing participants.

Multiple methods

Qualitative research usually involves the use of multiple methods (e.g. interviews, observations, documents) rather than relying on one single method. The combination of these methods forms the basis for analysis.

Participants' meaning and involvement

Qualitative research should incorporate the meaning or interpretation of participants with regard to the phenomenon under study. This means that the researcher should pay attention to the view of participants as well as incorporating his own interpretations or expressions from the literature.

4.1.2 Applied scientific research

Applied scientific research differs from empirical-analytical research, which is often referred to as predictive, theory-driven and striving for a controlled experimental setting in which one or more variables are manipulated to gain insight into causal relations (Van Strien, 1997). Applied scientific research has a practice-driven orientation. It aims to diagnose and explain the situation under study and tends to generate input to improve the situation rather than testing objective theories and hypotheses (Van Eijnatten, 1992; Van Aken, 1994; Van Strien, 1997; De Leeuw, 2001). Applied scientific research follows a 'from practice to theory' approach which is shaped by the interaction of the regulative cycle of Van Strien (1975; 1986) and the reflective cycle of Van Aken (1994).

Figure 4.1 From practice to theory: following the regulative and reflective cycle

Figure 4.1 shows the regulative cycle of Van Strien (1975; 1986) and the reflective cycle of Van Aken (1994). The regulative cycle – the lower part of Figure 4.1 – is the starting point of the 'from practice to theory' approach. It contradicts the empirical cycle of De Groot (1961). Whereas the empirical cycle involves theory-driven and empirical-

analytical research, the regulative cycle represents the methodology of professional practice.²⁰

The regulative cycle starts with the identification of a problem situation. The second step – analysis – is a diagnosis of the problem situation and the creation of a ‘mini-theory’ on possible causes and solutions of the phenomenon under study. The third step – plan – contains the development of a plan of action to tackle the problem. As the fourth step, the plan of action is followed by an intervention to realise a change to the desired direction. Finally, the fifth step evaluates the new situation which may generate input for beginning the next regulatory cycle or starting the reflective cycle.

When relating the regulative cycle to the topic of this study, the problem identification leads to the discovery that provider organisations have difficulties with their turbulent environment. The diagnosis or analysis of the problem indicates that these difficulties may be rooted in their bureaucratic organisational design. A plan of action is designed to describe interventions to change from a bureaucratic to a socio-technical type of design. Finally, these interventions are evaluated, for instance by accomplishing a process and outcome evaluation of the change.

Whereas the regulative cycle is intended to generate an answer to a practical problem, the reflective cycle (upper part of Figure 4.1) aims to develop a practical theory for a class of (practical) problems. It consists of three steps. The first step – analysis – seeks to answer the question ‘why does the intervention (not) work?’. Answering this question usually reveals conjectures and hypotheses which are investigated during the second step – reflection. The third step – documentation – involves documenting (the results of) the previous steps to encourage generalisability and enable learning from the past.

4.1.3 Case study research

As this study evaluates and analyses two practical cases, the final part of the introductory section explores principles of case study research. Case study research builds upon the basics of qualitative research and applied scientific research (Creswell, 2009). It is intensively examined and described by Yin (2009). According to Yin (2009,

²⁰ Van Strien (1997, p. 684) distinguishes three fundamental points in which professional practice differs from theory-driven, empirical-analytical research. It is exactly these points that require the regulative cycle as the basic methodological rule of practice, instead of the established empirical cycle. First, professional practice is directed towards the individual case ($n=1$), whereas empirical-analytical research usually addresses a large number of cases. Second, while empirical-analytical research approaches a phenomenon purely as something to be explained (explanandum), professional practice addresses a phenomenon as something to be changed as well (mutandum). Third, whereas pure empirical-analytical research involves a controlled experimental setting without interference from the researcher, in practice-oriented research researchers are actively involved in the problem situation.

p. 18), it ‘investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between the phenomenon and its context are not clearly evident’. As Yin continues, it ‘relies on multiple sources of evidence with data needing to converge in a triangulating fashion’ and it ‘benefits from the prior development of theoretical propositions to guide data collection and analysis’. Gerring (2007) adds to Yin’s definition that case study research is intended to study one particular case thoroughly instead of observing lots of cases superficially. However, case study research may also include multiple-case studies. Such studies may even be recommended over single-case studies since the ‘analytic benefits of having two or more cases may be substantial.’ (Yin, 2009, p. 61). The conduct of multiple-case studies is not self-evident because it can require extensive resources and time beyond the means of a single researcher.²¹

4.2 Explaining the design of the study

Figure 4.2 illustrates the design of the study, which consists of four main steps: double-case study, comparative analysis, reflection and documentation. The study started with a study of two cases which were in the process of changing from a bureaucratically organised type of organisation into an alternative type of organisation based upon the principles of the socio-technical design approach. The double-case study examined for both organisations their point of departure (bureaucratic design), objective (socio-technical type of design) and results. It also addressed the change process to bridge the gap between the point of departure and the design aspired to. The comparative analysis aimed to compare both cases and find explanations for the (in)effectiveness of the changes. The reflection phase incorporated the wider environment in which provider organisations operate and explored its influence on the ability of provider organisations to change to a socio-technical type of design. The reflection was intended to generate conclusions, which were documented in the documentation phase together with the results of the previous phases. The next subsections address each of these steps more in detail.

²¹ According to Yin (2009, p. 53), ‘multiple-case designs have distinct advantages and disadvantages in comparison to single-case designs. The evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust (Herriott & Firestone, 1983). At the same time, the rationale for single-case designs cannot usually be satisfied by multiple cases. By definition, the unusual or rare case, the critical case and the revelatory case all are likely to involve only single cases’.

Figure 4.2 Design of the study

4.2.1 Step 1: Double-case study

The double-case study contained an evaluation of two provider organisations which were in the process of changing from a bureaucratic to a socio-technical type of design. In 2009 and 2010, the researcher had the opportunity to conduct practice-driven research in the *first case* with the fictitious name Klein Zwitserland. This research consisted of various small-scale evaluation studies on continuity of care, client and employee satisfaction, and productivity and efficiency. The purpose of these studies was to support decision-making by the management of Klein Zwitserland. In mid-2010, there was an opportunity to extend these small-scale evaluation studies to a PhD study which involved the selection of a *second case* in 2012. The second case with the fictitious name Maas & Waal was selected as an additional case to put our study into perspective and enable comparison with Klein Zwitserland. A quick scan of Maas & Waal in mid-2012 suggested that the organisation had made more progress in the process of transforming than Klein Zwitserland. Maas & Waal had started the change a

few years earlier. It was also included to test the validity of our model to analyse the employees' perception (see element F) in another case. As we will explain, this model resulted from an inductive analysis of Klein Zwitserland as the first case.

A quick scan of Maas & Waal in mid-2012 suggested that the organisation was also trying to change from a bureaucratic to a socio-technical type of design. The double-case study ended in early 2014 with the conducting of in-depth interviews in Maas & Waal (see element F). Both Klein Zwitserland and Maas & Waal were comparable on the basis of the inclusion criteria as explained in Table 4.1.²²

Table 4.1 Inclusion criteria

	Inclusion criteria	Explanation
1	The organisation should deliver the three main types of homecare services	As explained in chapter 2, the three main types of homecare services are: domiciliary services, personal care and nursing care.
2	The organisation should be mature	Maturity of organisations is a versatile and multidimensional concept which depends on the sector in which the organisation operates. In this study, the organisation is considered to be mature when it, or its constituent units, exists for at least 10 years.
3	The organisation should have the intention to change from a bureaucratic to a socio-technical type of design	The organisation should have made the (formal) decision to start a change from a bureaucratic to a socio-technical type of design. This means that the organisation should have passed the stage of considering whether organisational renewal would be an option or not.
4	The organisation should be willing and able to participate in the study	Participating in case study research involves significant efforts on the part of the cases under study. Therefore, the organisation should be willing and able to participate in the study taking into account the burden and efforts involved.
5	The organisation should be able to guarantee the independence of the researcher	As stated earlier, the researcher plays a key role in qualitative research and case study research in particular. Therefore, the organisation should be able to guarantee the researcher's independence during the period of investigation.

Figure 4.3 illustrates the design of the case study. It consists of the elements A to G, which were evaluated equally for both cases. Element A provides an introduction to the case. Element B describes the bureaucratic type of design as the point of departure, followed by element C which explained the socio-technical type of design as the objective. While element D addresses the results of the change process, elements E and F explore the mutual relationship between change strategy and the employees'

²² Although both cases were comparable in terms of the inclusion criteria, we accepted natural differences between both cases, such as the unique history of each case and different working areas. The design of the evaluation was therefore a mix between the so-called "most different systems design" and the "most similar systems design" (Mill, 1970; Przeworski & Teune, 1970; Lijphart, 1971; 1975). The *most different systems* design includes cases which are different on as many explanatory variables as possible but similar on the dependent variable. The *most similar systems* design contains cases that are similar on as many explanatory variables as possible but different on the value of the dependent variable.

perception of the change. The case study ends with a summary of the case (element G). As we will explain, a combination of research methods is used to evaluate the elements A to G. The purpose of this evaluation is to give a reconstruction of both cases on the basis of the theoretical lens explored in chapter 3. The reconstruction is based on the interpretation by the researcher.

Figure 4.3 Design of the case study

Elements A to C: introduction, point of departure and objective

The elements A to C are evaluated by means of an analysis of documents which describe the organisation's self-view and self-assessment. Several types of documents, such as strategic reports, policy documents, memos and meeting minutes, were studied and analysed in a systematic way. Systematic means that all documents were scrutinised for valuable information. Valuable information was brought together and formed the basis for a summarised representation of these elements in chapters 5 and 6. To enhance empirical validity, representatives of both cases were asked to confirm the interpretation by the researcher.

Element D: results

Element D examined for both cases the results of the change process. After exploring the objectives versus results, it evaluated the results of the change in terms of quality

of organisation and quality of work. As explained in chapter 3, the socio-technical design approach also optimises quality of working relations. However, quality of working relations was not evaluated in this study for two reasons. From a pragmatic point of view, we intended to evaluate quality of working relations in both cases at the beginning of 2014. However, as one of the two cases merged with another organisation in January 2014, we could no longer ensure comparability between the two cases. Therefore, we decided not to evaluate quality of working relations. Furthermore, we could not identify a validated model to evaluate quality of working relations. Quality of organisation reflects the organisation's potential to be in control, flexible and innovative. Quality of work involves the extent to which jobs are meaningful and employees have the capacity to deal with work-related stress (De Sitter, 1994). As these qualities were already explained in chapter 3, we continue with the methodological part of how they were evaluated.

Quality of organisation

Quality of organisation was examined by evaluating the degree of organisational flexibilisation (or bureaucratisation as the other (unintended) side of the coin). This study applied the method of the so-called Aston Group (e.g. Weber, 1972; Pugh & Hickson, 1976; Pugh & Hinings, 1976; Kubicek & Welter, 1985; Perrow, 1986) to estimate organisational bureaucratisation, which was used before in the studies of Zuurmond (1994) and Govers (2003).²³ Zuurmond empirically validated a model to evaluate the level of bureaucratisation by means of five characteristics of an organisational design.²⁴ These characteristics are: centralisation, hierarchisation, formalisation, standardisation and specialisation. The idea is that the higher the scores on these aspects, the more an organisational design is characterised by bureaucratisation.

In this study, we considered flexibilisation and bureaucratisation as two ends of the same continuum. We took flexibilisation as the starting point, because a change to a socio-technical type of design aims to realise flexibilisation and not bureaucratisation. Furthermore, by presenting quality of organisation in terms of flexibilisation we attempted to avoid negative scores. When taking flexibilisation as the starting point, a trend of flexibilisation involves low scores on centralisation, hierarchisation, formalisation, standardisation and specialisation. These scores were weighed equally, because the empirical validation by Zuurmond did not yield arguments to give these

²³ The Aston Group was attached to Aston University in Birmingham. Based on Weber's theory of rational bureaucracy, the Aston Group tried to operationalise the concept of organisational bureaucracy by means of centralisation, hierarchisation, formalisation, standardisation and specialisation. For more information on the Aston Group see the work of Zuurmond (1994).

²⁴ After testing the model with a specific set of cases to achieve empirical validation, Zuurmond applied the validated model to a wide range of cases. For an extensive description of the model see Zuurmond (1994).

characteristics different weights. The text box below explains each of the five characteristics and describes how they were operationalised in this study.

The level of flexibilisation was determined by estimating the level of (1) centralisation, (2) hierarchisation, (3) formalisation, (4) standardisation and (5) specialisation. The operationalisation of these characteristics in this study, which was based largely on the work of Zuurmond (1994) and Govers (2003), is described below.

Centralisation is the extent to which decision-making is concentrated within a particular location or part of the organisation. Like all characteristics, it involves a threefold operationalisation. First, the formal structure of the organisation was studied to identify where in the organisation decisions are taken about major issues (e.g. personnel, investments, budgets, working procedures). Second, power relations between groups of employees were observed to investigate how powerful a group of employees considers its position in relation to other groups. Third, employees at the operating core were observed and asked about their perceived autonomy and freedom to act.

Hierarchisation is the process of vertical arrangement and reflects the extent to which positions or organisational layers are formally connected to superior positions or layers. First, the vertical organisational structure was studied by examining the amount of organisational layers between the top of the organisational pyramid and its operating core. Second, the development of span-of-control was scrutinised, which involves the average amount of subordinates per supervisor. The assumption is that the smaller the span-of-control, the more an organisational structure is characterised by hierarchisation. Third, the ratio between management and support staff and executive employees was calculated. It is assumed that the higher this ratio, the more hierarchisation there is.

Formalisation is the process of maximising specification as the extent to which actions, decisions and rules are formally documented. First, the extent to which employees must document their performance for control was examined. We assume that the more these performances are documented, the higher the level of formalisation will be. Second, the extent to which processes are based upon predefined standards, guidelines and protocols was examined (the more standards, guidelines and protocols, the higher the level of formalisation). Third, the extent to which key documents of the organisation are formalised was examined.

Standardisation is the extent to which work is based upon routines that are determined by formalisation. First, the level of routinisation in terms of repetitiveness of tasks was examined. It is assumed that a high level of repetition of tasks involves a high level of standardisation. Second, the strictness of rules and procedures was examined. This implied finding answers to questions such as 'how strictly are rules monitored?', 'to what extent are employees free to establish their own rules?' and 'how often do employees follow their own (informal) rules instead of the formal ones?'. Third, the perception of employees on the use and obeying of rules and procedures was examined.

Specialisation is the division of tasks into several sub-tasks on the basis of the workers' knowledge and expertise. First, completeness and the integrated character of job content were studied by checking the variety of aspects covered within job content. It is assumed that the less complete and integrated a job, the more the organisation of work is characterised by specialisation. Second, the functional departmental structure of the organisation was studied by examining the types and amount of departments within the organisation. The assumption is that the more departments there are, the higher the level of specialisation will be. Third, the level of multi-employability was examined, which reflects the ability of employees to accomplish other than regular and basic tasks. It is assumed that the less multi-employability there is, the higher the level of specialisation will be.

Table 4.2 contains the research method(s) used for each characteristic. It should be noted that some operationalisation criteria (span-of-control and ratio between types of employees) allowed for quantification, whereas others could only be estimated qualitatively.

Table 4.2 The operationalisation of organisational *flexibilisation* (based on Zuurmond (1994) and Govers (2003))

Characteristic	Operationalisation	Main method(s) used
Centralisation	Formal structure of the organisation	Document study
	Power relations	Observation and talks with employees
	Employees' perceived autonomy and freedom to act	Observation and talks with employees
Hierarchisation	Vertical organisational structure	Document study
	Span of control	Calculation based on internal data
	Ratio between management & support staff and executives	Calculation based on internal data
Formalisation	Formal documentation of employee performance	Document study
	Standards, guidelines and protocols in primary process	Observation and talks with employees
	Formalised policy documents, meeting documents etc.	Document study
Standardisation	Routinisation in terms of repetitiveness of tasks	Observation and talks with employees
	The strictness of rules and procedures	Observation and talks with employees
	The employees' perception of rules and procedures	Observation and talks with employees
Specialisation	Completeness and integrated character of job content	Observation and talks with employees
	Functional departmental structure	Document study
	Multi-employability of employees	Observation and talks with employees

Quality of work

The change result was also evaluated in terms of quality of work. In this study, the *NOVA-WEB* survey was used to determine quality of work, which consists of a validated questionnaire (in Dutch) for establishing risks of well-being in relation to the organisation of work (Vaas, Dhondt, Peeters & Middendorp, 1995; Kraan, Dhondt, Houtman, Nelemans & Vroome, 2011). It focuses on the balance (or imbalance) between work-related stress risks on the one hand and employees' learning opportunities and regulatory capacity on the other hand. The questionnaire addresses 13 aspects of quality of work: completeness of work, skills capabilities, qualification, short-cycled tasks, degree of difficulty, level of autonomy, organisational tasks, provision of information, job demands, regulatory problems, emotional burden, payment and job security and time autonomy (Vaas et al., 1995; Kraan et al., 2011).

These aspects are further explained in appendix A, which also provides more information on the background of the NOVA-WEBA survey.

Three main steps were followed to conduct the NOVA-WEBA in accordance with the survey's manual (Kraan et al., 2011).²⁵ The *first step* involved the preparation of the general and standard version of the questionnaire for use in both cases under study. It involved the application of general questions and descriptions to the specific context of home care. It resulted in two final versions of the questionnaire for each of the two cases. The preparation phase was accomplished in close consultation with the Works Council (*Ondernemingsraad*) of both organisations.

The *second step* comprised the distribution and conducting of the questionnaire. In accordance with the survey's manual, the questionnaire was distributed among executive employees, managers and support staff with a minimum of five respondents per job category (Kraan et al., 2011). In both cases, the conducting of the survey was introduced by cover letters to inform employees about the survey and motivate them to participate. These cover letters were developed in close consultation with representatives of both cases. The actual conducting of the survey was guided closely by the researcher, who tried to be physically present as much as possible to support participants in completing the questionnaire. This offered the researcher the possibility of giving instructions, answering questions and clarifying possible unexpected misinterpretations. As an alternative to the hard-copy version of the questionnaire, participants also had the opportunity to complete a digital version which was identical to the hard-copy one. They had to fill in the digital questionnaire without the direct assistance of the researcher.

The *third step* involved the processing and analysis of data in accordance with the procedures defined in the survey's manual (Kraan et al., 2011). This step was taken in close consultation with a statistical expert. The processing phase involved entering data into an SPSS data file, categorising and labelling data, creating scales and scale scores, and running the data multiple times. The analysis phase involved the interpretation of data focusing on outlying results in particular. It gave a score between 0 and 1 for each of the 13 aspects of quality of work. A score of 0 means no risks to well-being related to the organisation of work; a score of 1 means risks to well-being related to the organisation of work. These scores were compared with the scores of a reference file containing data of over 10,000 people randomly selected from the Dutch labour force (Houtman, Bloemhoff, Dhondt & Terwee, 1994; Kraan et al., 2011).

²⁵ The original versions of the NOVA-WEBA questionnaire and the NOVA-WEBA manual can be obtained from TNO Work & Employment, which is a Dutch independent research organisation performing research projects on numerous organisational and societal issues.

Element E: change strategy

Element E included an overview of the change process. It gave a historical reconstruction of the change actions involved and the change strategy followed by the management. Element E was based on the researcher's interpretation of documents supplemented with data gathered by observation. For Klein Zwitserland, the period of participative observation took place from July 2010 to December 2012, and for Maas & Waal from September 2013 to December 2013. The evaluation of element E resulted for both cases in a description of the change trajectory.

Element F: employees' perception

Element F examined for both cases the employees' perception of the change. As explained in chapter 3, the results of the change and the perception of employees are interconnected. The employees' perception gives information on the results of the change. At the same time, however, it is also an important factor in the change trajectory itself. The change strategy proposed by the management affects the way in which employees perceive the change. However, the perception of employees also has consequences for the change strategy.

The employees' perception of the change was analysed on the basis of a model consisting of four factors: *history of the case*, *conditions for change*, *system world versus life world* and *external influences* (chapter 3). Conditions for change are further divided into staffing, structural, technological and cultural conditions. The presentation of this model (chapter 3) may suggest that this model was developed before the start of the double-case study. However, this was not the case and the four factors were obtained as follows. We started with an inductive analysis of Klein Zwitserland (first case) which provided the four factors to study the perception of the employees in Klein Zwitserland. In the literature, these factors are usually discussed separately and not presented as an integral model. However, as we found them relevant together, we presented them as a heuristic model to analyse Maas & Waal (second case). Our model contains three indicators for operationalisation per influencing factor. Because the influencing factors and their indicators for operationalisation were explained in chapter 3, this section continues with the methods used to analyse them.

Table 4.3 describes the methods that were used to analyse the influencing factors. As the table shows, the conducting of interviews was the main research method. With regard to Klein Zwitserland, interview data were gathered by means of conversations with employees during intensive periods of observation by the researcher. From July 2010 to December 2012, the researcher observed and interviewed over forty employees, both homecare professionals and representatives of the management and support staff. A policy officer was asked to select the employees and the formal

interviews were complemented with informal conversations during observations. These conversations were not tape-recorded in order to avoid a disturbance of the natural setting. Afterwards notes were made to record the main points in the conversation. As in Klein Zwitserland, the researcher had many informal conversations in Maas & Waal during the period September 2013 to December 2013. In addition, semi-structured and fully tape-recorded in-depth interviews were conducted with three homecare professionals at the end of 2013 and early 2014. The Works Council and the management of both organisations were asked to suggest respondents, which resulted in a heterogeneous group of interviewees in terms of age and work experience. A checklist with open-ended questions was prepared for the interviews focusing on each of the influencing factors. The main advantage of conducting semi-structured interviews was that we could pose additional questions to generate more in-depth insights. Respondents were asked for their informed consent prior to the interviews and data were analysed anonymously.

Table 4.3 Evaluating the employees' perception: methods used for operationalisation

Influencing factors	Indicators	Main methods used
Conditions for change	History of the case	Degree of influence of changes in the past Interviews*, document study
		Character of influence of changes in the past (positive or negative) Interviews*, document study
		Particular role of 'change fatigue' Interviews*, observation
	- Staffing	Ability of employees to work according to team-based design requirements Interviews*, observation
		Willingness of employees to work according to team-based design requirements Interviews*
		(Sufficient) number of employees of all function levels Interviews*
	- Structural	Team size Interviews*, document study
		Team composition Interviews*, observation
		Extent to which regulatory capacity is organised locally Observation
	- Technological	Use of technology in relation to clients Interviews*, document study
		Use of technology in relation to employees Interviews*
		Degree of embeddedness of technology use (e.g. training and education) Interviews*
	- Cultural	Flexible attitude Interviews*, observation
		Team atmosphere Interviews*, observation
		Degree of influence of acquired rights and habits from the past Interviews*, observation
System world versus life world		Degree to which the "system world" infiltrates the "life world" Interviews*, observation
		Response of homecare professionals to system world infiltration Interviews*, observation
		Particular role of the 'informal organisation' Interviews*, observation
	External influences	Degree of external influences Interviews*, observation
		Character of external influences (positive or negative) Interviews*, observation
		Ability to anticipate external influences Interviews*, observation

* including semi-structured and fully tape-recorded interviews and numerous informal conversations during observations

In addition to interviews, observation and document study were used. Observation entailed the observation of homecare professionals during their daily work. Document study involved the exploration of strategic reports, policy documents, memos and meeting minutes for information. This combination of research methods – interviews, observation and document study – allowed us to triangulate the data in order to increase the validity and reliability of conclusions.

Element G: summary

The evaluation phase ended with a conclusion to integrate the insights of the elements A to F. It brought together the different perspectives of the evaluation and generated the general picture for both cases based on the various research methods used.

Validation

The chief executive of Klein Zwitserland and the head of the unit of Maas & Waal under study were given the opportunity to read the draft of the case study chapter and to comment on it. The purpose of this procedure was to check the empirical validity of the description and the conclusions drawn. For each case study the description and conclusions were confirmed. At the same time, however, the procedure resulted in some helpful additions which were incorporated in the final version of each chapter.

4.2.2 Step 2: Comparative analysis

The second step contained a comparative analysis of the case study results. Figure 4.4 visualises our analysis, which consisted of two elements. It started with *element X* to identify differences and similarities between both cases.

After comparing both cases, we intended to find explanations for the differences and similarities. As a first look, we addressed the question of the extent to which internal explanations could explain the case study results. These explanations refer to explanations *within* the organisational context of both cases. This first look resulted in *element Y* to explore internal explanations. As a second look, we addressed the question of the extent to which external explanations explain the evaluation results. This type of explanations concerns the impact of factors in the environment of both organisations. The exploration of the external world was not part of the comparative analysis, but was addressed in the reflection phase (*element Z* in Figure 4.4).

Figure 4.4 Design of the cross-case comparison and analysis phase and reflection phase

4.2.3 Step 3: Reflection

The third step in the design of the study involved a reflection on the findings from the perspective of the external world (*element Z* in Figure 4.4). The comparative analysis showed that external influences also played an important role with regard to organisational change. The reflection phase focused on these influences by investigating the influence of the homecare environment on the ability of provider organisations to change in the direction of a socio-technical type of design. It addressed the question to what extent the change to a socio-technical type of design could be effective at all, given the turbulent environment provider organisations operate in. Because this question concerns provider organisations in general, we took a wider perspective and did not limit the reflection to Klein Zwitserland and Maas & Waal.

The design of the study (Figure 4.2) also contained a fourth and final step: **documentation**. This step involved the creation of this dissertation to give a comprehensive representation of the main steps of the study (evaluation, analysis and comparison and reflection) and their results.

4.3 Methodological quality of the study

This section discusses the reliability and validity of our study. Furthermore, attention is devoted to the topic of triangulation.

4.3.1 *Reliability*

Reliability refers to the consistency and repeatability of research activities. According to Neuman (2011), it is more closely related to quantitative than to qualitative research, because a quantitative study naturally fits in better with principles of consistency and repeatability. Qualitative research – and this study too – often focuses upon phenomena that are dynamic and unstable over time. For instance, an organisation as a phenomenon is continuously developing, which results in a continuous and unique series of organisational configurations and combinations of people interacting with each other. Under these circumstances guaranteeing reliability appears a challenging task, the more so because of the researcher's participative role in this study (Creswell, 2009; Neuman, 2011).

The reliability of this study is enhanced by working according to the principles of formalisation and explicitness. Each major research activity was documented as explicitly and in as much detail as possible. Results of observations were documented in written reports and planned interview sessions were tape-recorded. Furthermore, for the NOVA-WEBA survey and the semi-structured interviews, research protocols were developed to enhance consistency in consultation with representatives of Klein Zwitserland and Maas & Waal. The findings were checked in consultation with the supervisors.

This dissertation as such is also an instrument to enhance formalisation and explicitness. It comprises a written overview of all major research steps and activities, findings and conclusions. Furthermore, all research protocols and plans, reports, memos, notes and other documents are stored and accessible for further analysis of reliability. This also applies to the raw data of the study.

4.3.2 *Validity*

Validity refers to the accuracy or truthfulness of research findings (Creswell, 2009; Neuman, 2011). It involves the extent to which a study corresponds to reality or, in other words, investigates what it claims to investigate. In qualitative research, validity is often referred to as achieving authenticity instead of truthfulness. This is because qualitative research is 'less concerned with matching an abstract construct to empirical data than with giving a candid portrayal of social life that is true to the lived experiences of the people we study' (Neuman, 2011, p. 214). So, validity within

qualitative research refers to the relation between the conceptualisation of the social world in the study and what is actually occurring in reality.

The validity of this study is enhanced in several ways. First, various sources of information are used to study the phenomena under study from different perspectives, which is expected to enhance construct validity (Creswell, 2009).²⁶ Second, member checking is used to confirm the accuracy of findings. Interpretations by the researcher are presented to representatives of both cases for accuracy. Third, the limitations of the study will be clarified to enable transparent communication on (potential) bias. To reduce bias due to the participative role of the researcher, activities were undertaken to make the analysis comprehensive, confirmed and structured (Creswell, 2009). *Comprehensive* means that both cases are intensively studied over a period of several years, using triangulation of methods. This involves *confirmation*, whereby interpretations are checked for accuracy by representatives of both cases, and *structuring*, whereby both cases are evaluated and analysed as far as possible in an equal and systematic way. Fourth, the researcher will spend prolonged periods in the field with the purpose of getting an in-depth understanding of the phenomena under study. According to Creswell (2009), long and intensive periods of field research contribute to the validity of the study. Finally, we regularly discussed our findings with fellow researchers, experts and practitioners (peer debriefing).

4.3.3 Triangulation

The final part of this chapter addresses the concept of triangulation, which is an important mechanism to enhance reliability and validity. According to Neuman (2011), a richer and more comprehensive picture can be generated by observing a phenomenon from multiple perspectives and by using multiple methods rather than by looking from one perspective and by using only one method. Embracing multiple points of view is also expected to enhance the methodological accuracy and strength of the study (e.g. Denzin, 1978; Jick, 1979; Creswell, 2009; Neuman, 2011). It is based on the assumption that weaknesses in a single method can be compensated by the counterbalancing strengths of another (Jick, 1979; Creswell, 2009). A qualitative study should therefore use triangulation defined as 'the combination of methodologies in the study of the same phenomenon' (Denzin, 1978, p. 291).

This study embraces three main strategies to triangulate according to the classification of Neuman (2011). The first strategy consists of taking multiple aspects of the phenomenon into account (triangulation of measures). For instance, the five

²⁶ Construct validity refers to the accurate interpretation of different concepts applied in a study (Creswell, 2009; Neuman, 2011). It can be enhanced by using various sources and considering concepts from different perspectives.

characteristics to determine quality of organisation (centralisation, hierarchisation, formalisation, standardisation and specialisation) each have a threefold operationalisation, meaning that each of them is considered from three perspectives. The same applies to the operationalisation of the influencing factors to analyse the employees' perception. As a second strategy, we combine several theoretical perspectives (triangulation of theories). Finally, we make use of a combination of methods including observations, interviews and document study (triangulation of methods).

Chapter 5

Case study of Klein Zwitserland

5. Case study of Klein Zwitserland

This chapter evaluates Klein Zwitserland as the first of our two cases. Figure 5.1 visualises the structure of the chapter.

Figure 5.1 Structure of chapter 5: case study of Klein Zwitserland

The first part introduces the case (subsection 5.1), describes its bureaucratic architecture as its point of departure (subsection 5.2) and explores the socio-technical type of design as its objective (subsection 5.3). It contains a summarised representation of documents²⁷ that reflect the management perspective. However, it also addresses what policy documents do not describe. The chapter continues with the results of the change towards the new design in terms of quality of organisation and quality of work (subsection 5.4). Specific attention is paid to the relationship between objectives and results. The second part of the chapter explores the change process by an overview of the change actions in a timeline and an analysis of the change strategy based on a document study, observations and interviews with employees (subsection 5.5). Next,

²⁷ We do not refer to specific documents here. Our observations are inferred from a multitude of internal reports, minutes and memos. Key documents with a description of the need for change, an outline of the socio-technical type of design and the change strategy are not available (contrary to our second case).

the change strategy is analysed from the perception of the employees (subsection 5.6). The chapter ends with a brief conclusion of the case (subsection 5.7).

5.1 Introduction

Klein Zwitserland provides a broad spectrum of homecare services in the southernmost part of the Netherlands. In addition to the three main homecare services – domiciliary services, personal care and nursing care – it delivers maternity care, child care, advice and information, and lending facilities. It operates in a hilly and rural area in which only one main city is located. The area contains several unique elements which distinguish it from other regions in the country. Its inhabitants are often characterised as enjoying the good things in life and being relatively modest and docile. The region has a great cultural and natural richness and with its tourism and idyllic landscape it is often referred to as “*Klein Zwitserland*”. Its population is ageing more rapidly than in most other parts in the Netherlands (De Jong & Van Duin, 2010).

Klein Zwitserland has a history of homecare provision dating back more than a hundred years. It evolved from a small-scale organisation closely related to a cross organisation into a large provider organisation in 2013. Klein Zwitserland in its current form is the result of a merger between two provider organisations in 2006. One merger partner specialised in personal and nursing care, while the other had a strong division in domiciliary care. The objective of the merger was to improve the (financial) viability of the new organisation. However, the merger turned out to be difficult and had profound consequences for the organisation. In the first years after the merger, the viability of the new organisation rapidly worsened.

According to the annual reports, the total revenues of Klein Zwitserland developed from €51.4 million in 2006 to €50.9 million in 2010 and €54.6 million in 2012. The total number of employees developed from 2,312 in 2006 to 1,680 in 2010 and 1,817 in 2012. These numbers include traditional home care (domiciliary care, personal care and nursing care), youth care, maternity care, dietary care and lending facilities.

Klein Zwitserland already had experience with self-organisation in the 1980s and 1990s, when home care was provided by small teams of highly educated community nurses who were responsible for coordinating the care process and communicating with the clients, their relatives and other actors. Policy documents show that various developments such as the standardisation of needs assessment and the professionalisation of home care had gradually turned Klein Zwitserland into a bureaucratic and functionally differentiated organisation. Furthermore, the director mentioned that the organisation had become centralised and supply-driven in response to the introduction of market competition in home care. Around 2009, the Executive

Board of Klein Zwitserland considered that a return to small-scale and team-based homecare provision was the only way to survive.

Figure 5.2 Organogram of Klein Zwitserland (in Dutch)

Figure 5.2 shows the organogram of Klein Zwitserland in 2013. As the figure visualises, the organisation is directed by the Executive Board, which is accountable to the Supervisory Board. The Executive Board is supposed to closely involve other bodies in its decision-making, including the Works Council and the Client Council. Klein Zwitserland is organised in a function-oriented way: the organisation's design rests upon its main functions in terms of the provision of a broad package of services which are both traditional homecare services and other services such as child and maternity care. The services depicted in bold represent the three main homecare services. *Huishoudelijke Hulp* refers to domiciliary services and *Verpleging & Verzorging* to personal care and nursing care. This study focuses on the organisational element *Verpleging & Verzorging*, because this is the part the organisation aims to transform from a bureaucratic to a socio-technical type of design.

5.2 Point of departure

Around 2009, the management noticed various developments with adverse consequences for the quality of home care. Its documents particularly referred to the standardisation of needs assessment, functional differentiation and the bureaucratisation of care in general. Due to its bureaucratic architecture, these developments had not been well anticipated. The architecture produced suboptimal results for clients, employees, the organisation and its key partners. Clients faced poor quality and discontinuity of care, employees experienced poor quality of work, the organisation itself struggled with internal complexity and key partners were dissatisfied about its cumbersome functioning. An alternative design was considered necessary to better deal with these developments. This recognition was the basis for the decision to move towards a new type of design resembling socio-technical principles.

5.2.1 Bureaucratic architecture

Figure 5.3 gives a simplified representation of homecare provision at the point of departure. As it shows, the process of homecare provision contained three main steps. First, clients entered the organisation by contacting the central office. Second, the central office investigated their needs, after which the planning office linked each client to several homecare professionals depending on the complexity of the client's needs, the professionals' level of expertise and their employment contract. The planning office also took into account the care needs of other clients and efficiency criteria such as travel time of employees. It furthermore sought to prevent over-qualification by scheduling a highly educated nurse only for complex care and a less qualified professional for low-complexity services. The result of avoidance of over-qualification was that clients were often visited by a large number of professionals with different levels of expertise. An internal study²⁸ in 2010 among 249 randomly selected clients showed that 25.3% of clients were visited by 6-10 employees, 22.1% by 11-15 employees and 22.5% by 16-20 employees over a period of four weeks. 29.3% of the clients were even visited by more than 20 employees. After these two steps the caring process started (third step).

Figure 5.3 illustrates the organisational *complexity* of homecare provision as the result of its bureaucratic architecture. In reality the organisation of homecare provision was even more complex, because it also involved coordinating processes from the central office and planning office to the client and from the homecare professionals to the central office and planning office. The complexity was the result of bureaucratic principles. First, the design featured a rigorous separation of the regulatory and executive parts. Homecare professionals at the operating core were only responsible

²⁸ This study was performed by the researcher.

for providing small parts of the caring task (“doing”), which were planned entirely by the planning office (“thinking”). Second, the executive part was very differentiated. Homecare provision was split into several sub-tasks with the result that a client could be visited by numerous professionals. Third, the regulatory part was also differentiated, since the central office contained several departments involved in the intake of clients, planning and scheduling, and the management of complaints. We conclude that the organisational structure of Klein Zwitserland at the point of departure was consistent with the principles of the bureaucratic organisation.

Figure 5.3 Homecare provision under the bureaucratic architecture (simplified representation)

5.2.2 Shortcomings

As stated before, Klein Zwitserland felt around 2009 that its bureaucratic architecture was causing suboptimal results for clients, employees, the organisation and its key partners (Figure 5.4). Many **clients** said they had complaints about the poor quality of care. They were dissatisfied about the fragmentation and discontinuity of care which were the result of functional differentiation. The most serious complaint was the large number of professionals involved in the provision of care. Management information indicated that in 2010 on average 18.7% of all complaints were about discontinuity of care. Clients also complained about the expertise of professionals (13.9%), personal treatment (21%) and the failure to meet time appointments (34.9%). 11.5% were other complaints. Finally, Klein Zwitserland noted that clients experienced insufficient

participation in the care process and that their specific wishes were often insufficiently taken into consideration.

The organisation also referred to the National Prevalence Measurement of Care Problems 2008 (*Landelijke Prevalentiemeting Zorgproblemen 2008*), which indicated worse scores than average for Klein Zwitserland (Halfens et al. 2008). For instance, Klein Zwitserland scored relatively high for the prevalence of pressure ulcers (7.2% versus 6.7% sector-wide) and malnutrition (13.8% versus 12.5% sector-wide).

Figure 5.4 Suboptimal results with regard to clients, employees and the organisation

Employees were dissatisfied about the rigorous task fragmentation and simplification of tasks. Homecare provision was divided into small sub-tasks which in their view had hollowed out their work and the homecare profession in general. They saw themselves also more and more confronted with dissatisfied clients, which further diminished their quality of work. The low quality of work was expressed by an absenteeism rate of 9.3% in 2009, which was higher than the overall absenteeism rate in home care of around 5% (Hesslink, Hooftman, De Weerd & Koppes, 2010).

The bureaucratic architecture also had a negative impact on the **organisation**. Policy documents described the organisation as very bureaucratic in terms of internal complexity with a strong focus on controlling instead of supporting professionals in the primary process. Its bureaucratic structure generated suboptimal organisational performance in terms of productivity. The productivity level – which was defined by the organisation as any care provided behind the clients' front door – fluctuated around

61.5% on average in 2009. Furthermore, management information showed that in 2009 on average 10% of working time of homecare professionals was spent on traveling between clients. The management considered these numbers unacceptable.

Finally, **key partners** including the local hospital, general practitioners and municipalities were dissatisfied. The provision of home care required good relationships with these partners. However, policy documents showed that general practitioners in particular were critical about the organisation's performance.

5.2.3 Change decision

According to the management of Klein Zwitserland, the bureaucratic architecture was no longer appropriate to serve the interests of clients, employees, the organisation and its key partners. An alternative design was required to optimise the quality of care, improve the quality of work and reduce the organisation's complex structure. For this reason, it decided in 2009 to initiate an organisational change in the *Verpleging & Verzorging* unit by introducing self-organising teams.

The need to revitalise the functioning of Klein Zwitserland became clear soon after the merger in 2006. The two objectives of this merger were to better anticipate significant external developments, in particular the introduction of public tendering and the new style of contracting by the regional care office, and to benefit from the complementarity of both organisations: whereas one partner specialised in the provision of personal care and nursing care, the other had domiciliary services as its core activity. The system of public tendering was introduced under the Wmo in 2007. Provider organisations were no longer automatically contracted to provide domiciliary services. Instead, they had to participate in competitive bidding, organised by the municipalities. The new style of contracting by the regional care office was to guarantee provider organisations only a certain percentage (usually 95 percent) of their former budget and to make the allocation of an extra budget dependent on performance criteria relating to efficiency and quality. The merger partners considered a strong market position indispensable under the new regime.

While the merger was intended to strengthen its organisation, it soon produced negative results and, according to statements in a few annual reports, even almost led to the bankruptcy of Klein Zwitserland. Documents of the organisation described how the merger partners had a different organisational culture both on the management level and on the level of the operating core. Employees of one partner accused employees of the other partner of being spoiled with regard to scheduling and days off. The newly formed Executive Board was unable to develop a new culture. Furthermore, it had difficulties in balancing direct and indirect costs. The merger also led to much

unrest in the organisation, lagging productivity, high absenteeism and several management changes. In financial terms, Klein Zwitserland had a negative financial result in 2006. In the period from 2007 to 2009, the focus was on rebalancing direct and indirect costs by reducing overheads. For this purpose, significant financial and staffing cuts were implemented to improve its performance. These measures further reinforced the unrest among employees. Nevertheless, the interventions eventually led to a positive financial result. From 2009 onwards, Klein Zwitserland was ready to gradually shift its focus from ensuring its survival to creating a healthy and sustainable organisation.

5.3 A socio-technical design as objective

Although its policy documents nowhere explicitly refer to the principles of socio-technical redesign, the management of Klein Zwitserland seems inspired by some of these principles. Specifically, it decided to introduce self-organising teams to tackle the shortcomings of its bureaucratic design. The choice of self-organising teams is based upon the assumption that it will have many advantages for clients, employees, the organisation and its key partners (Figure 5.5). A team-based model of homecare provision is expected to improve the quality of care for **clients** and reduce the prevalence of care problems such as pressure ulcers and malnutrition. Furthermore, the quality of care is assumed to increase, because teams are able to better handle the variety of client needs. Continuity of care is also postulated to improve, because clients are visited by only a few homecare professionals. The organisation furthermore assumes that client participation can be reinforced, because teams operate close to clients.

Klein Zwitserland also expects advantages for its **employees**. Their quality of work will increase, because it is enriched by means of task integration and the provision of tasks which are as complete as possible. It also predicts a decrease of work-related stress, absenteeism and personnel turnover because of improved possibilities to deal with work-related problems and disturbances. It finally expects that professionals will face less client dissatisfaction, which will further increase the quality of their work.

The **organisation** of Klein Zwitserland will also benefit from the new design. Now that a substantial part of higher management activities will no longer be necessary because of the decentralisation of regulatory capacity to the teams, overhead costs are assumed to decline. Instead of a managing and controlling function, the management should primarily fulfil a supportive function towards the teams. Furthermore, the decentralisation of regulatory capacity will decrease the number of non-care-related rules and protocols. Klein Zwitserland postulates that the team-based design will reduce internal complexity and enhance organisational flexibility.

Figure 5.5 Objectives and assumptions of the new design with regard to clients, employees and the organisation

Finally, the introduction of self-organising teams is expected to improve the relationship with *key partners*. Placing the teams close to GPs and the hospital should improve communication, cooperation and, consequently, satisfaction.

Figure 5.6 gives a simplified representation of homecare provision after the reorganisation. Just as under the bureaucratic architecture, the process of homecare provision includes three main steps. First, clients with various needs enter the organisation by contacting the central office. Second, the central office links each client to a self-organising team based on his/her zip code. Third, from the moment that the central office has informed the team about the client, the team becomes responsible for providing the required services to the client. It should start up the provision of care by accomplishing the intake and preparing the next steps in the care process. Furthermore, it becomes the main point of contact for the client. A team consists of homecare professionals with varying levels of expertise to address all possible care needs. It may contact support staff when it needs support.

However, as will be explained in subsection 5.4.1 in greater detail, planning and scheduling are only *partially* decentralised, as the team-based design continues to include a central planning office which offers each team a weekly ‘optimal’ planning based on criteria similar to the criteria under the bureaucratic architecture. The central planning for a team also continues to take into account the needs of other teams operating close to the team’s zip code area. This is considered necessary to anticipate

disturbances such as employees dropping out due to illness. Contrary to the bureaucratic organisation, however, the team is allowed to adjust the planning. For each team a planner, located at the team's district office, is available to contact about unforeseen problems. With regard to planning and scheduling, the director of Klein Zwitserland noticed significant differences between teams. Whereas some teams were able and willing to take up these activities proactively, other teams were lagging behind.

Figure 5.6 Homecare provision after the introduction of teams (simplified representation)

Team-based concept

Self-organising teams are at the core of the socio-technical type of design. In the view of Klein Zwitserland these teams have one primary objective: to contribute to the clients' well-being by providing a broad package of services, thereby making client-centeredness central. To realise this objective the organisation considers it important to locate the teams in district offices within the clients' neighbourhoods in order to stimulate the contact between homecare professionals, their (potential) clients and the key partners.

Policy documents state that a team 'should be small' and 'should become responsible for the provision of all care and support in a predetermined area'. The teams are given 'much regulatory capacity' and 'responsibilities are locally embedded'. Teams are also made responsible for the intake of clients, monitoring clients' indications, observing team members' efforts and monitoring the quality of their work. These activities should be accomplished in addition to regular caring activities.

Policy documents are rather silent on the arguments for only partially decentralising planning and scheduling. Planning refers to the planning of the care processes. It involves the planning of the routes to visit clients. Scheduling refers to the planning of employees based on their level of expertise and the employment contract. Given that planning and scheduling are part of the primary process, it is remarkable that they are only partially decentralised. Furthermore, policy documents are not specific with regard to team size. Whereas an ideal maximum team size of 12 people is recommended (see chapter 3), the teams of Klein Zwitserland initially often consisted of more than 20 people. In the course of time, however, team size has gradually decreased; in 2013 teams consisted of 8-18 persons.

According to the management, the care coordinator plays an important role in the team-based concept. Each client is assigned a care coordinator who is part of the team and acts as the main point of contact for the client on behalf of the team. The care coordinator starts up the care process, monitors and evaluates it with the client and coordinates the activities of all professionals involved. The coordinator furthermore maintains relationships with key partners in the care process. In addition to at least one care coordinator per team, the intended design includes cooperative team leaders. The cooperative team leader is usually a nurse who is charged with the daily management of the team in addition to caring activities. An important task of the cooperative team leader is to monitor and improve team performance. In practice, however, the cooperative team leader often took the responsibility for leading more than one team. The management of Klein Zwitserland considers this as a possible explanation for the large team size, because cooperative team leaders frequently held common team meetings and even merged whole teams in everyday practice.

Policy documents state that teams should operate in a result-oriented way, which means that the management defines which objectives teams should achieve, but gives freedom on how to achieve these objectives. It uses performance indicators to monitor client satisfaction, quality and continuity of care, absenteeism and productivity. It also sets clear targets for each indicator. Teams are aware of these targets and periodically receive information on their performance. They are expected to initiate improvements if targets are not met. The information is presented to the teams by means of a so-called cockpit system using gauges like those used in aviation. The process of

maintaining and improving team performance is monitored by regional managers. A regional manager is appointed for a group of about three teams. In addition to monitoring team performance, regional managers assist teams in their daily work and may intervene when team performance structurally lags behind. They primarily seek improvements together with the team. Stringent measures, such as transferring employees to other teams, are only considered if they see no other options.

5.4 Results

In the first part of this chapter we introduced Klein Zwitserland and described its bureaucratic structure at the point of departure of organisational change. We also gave an overview of the reorganisation and its underlying assumptions on the advantages for clients, employees, the organisations and key partners. This subsection addresses the results of the envisaged change.

5.4.1 Objectives versus results

Using the metaphor of the organisational temple (see chapter 3), Figure 5.7 shows the intended design versus the realised design by the end of 2013. A reorganisation based entirely on the principles of socio-technical redesign would have included interventions in each of the four organisational pillars. With regard to *structure*, Klein Zwitserland states in its documents that it intends to decentralise as many responsibilities as possible to the teams: the purpose is to achieve maximum decentralisation of regulatory capacity. However, in 2013 it had only partially decentralised regulatory capacity. Although some teams took up planning and scheduling in a proactive way, others were lagging behind in this respect. Furthermore, Klein Zwitserland still used a central planning office for the general planning of the teams. There were also activities which Klein Zwitserland had not decentralised in spite of its original intention. It did not decentralise the monitoring of clients' indications, because of the financial risks involved. It also abstained from decentralising the recruitment of new team members, because most teams were not considered mature for this task. With regard to *systems*, the management's objective was to realise systems which support the primary process. Although the cockpit system of performance indicators may support the teams in enhancing team performance, it was primarily used as a controlling system. Furthermore, the organisation continued to make use of a central planning system. With regard to *culture* and *people*, the intention was to realise an open and flexible culture in which employees accept new roles and changing relationships and managers accept that their former role of controlling and managing the primary process is largely replaced by coaching and supporting the teams. However, as we will see in the final part of this chapter, it turned out to be very difficult to abandon bureaucratic cultures and internalise new roles and relationships.

Figure 5.7 Objectives versus results

5.4.2 Quality of organisation

As explained in chapter 3, the socio-technical type of design is expected to optimise three essential qualities: quality of organisation, quality of work and quality of working relations.²⁹ Quality of organisation is investigated by examining the degree of organisational flexibilisation (or bureaucratisation as the other (unintended) side of the coin). It evaluates the extent to which the organisational design is characterised by (1) centralisation, (2) hierarchisation, (3) formalisation, (4) standardisation and (5) specialisation from t^0 to t^{now} where t^{now} represents the situation at the end of 2013. Figure 5.8 gives the evaluation of these five aspects for Klein Zwitserland. The scoring results represent the researcher's interpretation. To empirically validate this interpretation, the management of Klein Zwitserland was asked to confirm the scoring.

Centralisation refers to the extent to which decision-making is concentrated in one particular location or part of the organisation. The degree of centralisation was investigated by (1) studying the formal structure of the organisation to identify where in the organisation decisions are taken about major issues (e.g. personnel, investments, budgets, new products and services, working procedures), (2) examining power relations between several groups of employees, and (3) identifying the perception of employees on centralisation. As Figure 5.8 shows, centralisation is assessed as "decreased" in the period from t^0 to t^{now} . This conclusion is based on the observation that some regulatory capacity was decentralised with the introduction of self-

²⁹ As discussed in chapter 4, quality of working relations is not evaluated in this study.

organising teams. In contrast to the bureaucratic architecture, teams have become responsible for important activities in the process of caring. They are now responsible for accomplishing the intake of clients and observing the efforts and quality of the work of individual team members. However, whereas teams may adjust the planning locally by contacting their planner at the district office, it is still centrally initiated. Furthermore, the organisation still decides centrally on the monitoring of client indications and the recruitment of staff. Caregivers therefore still experience significant top-down influence (see also section 5.6). Managers also find it difficult to shift their focus from managing and controlling towards supporting the teams.

Figure 5.8 Quality of organisation within Klein Zwitserland

Hierarchisation refers to the process of vertical structuring in which one or more positions in the organisation are vertically linked to superior positions. The degree of hierarchisation was investigated by (1) studying the verticality of the organisational structure, (2) examining the development of span of control as well as (3) the ratio between management and support staff, and executive employees. Based on these criteria, hierarchisation is assessed as “increased” in the period from t^0 to t^{now} . This conclusion is based on the observation that the span of control decreased from about 50 employees per manager in 2010 to an average of 37 employees per manager in 2013. The ratio between management & support staff and executive employees *hardly*

changed from 1 : 5.49 in 2010 to 1 : 5.72 in 2013.³⁰ However, a policy officer of Klein Zwitserland indicated that the numbers for span of control give a distorted picture of reality, because in the new design managers are supposed to do executive work in addition to their management activities. Furthermore, the numbers do not correspond to the management decision to significantly reduce the number of middle-line managers under the new design, which would logically imply an increase of span of control.

Formalisation involves the extent to which actions, decisions and rules are formally documented. The more actions, decisions and rules are formally documented, the higher the level of formalisation. The degree of formalisation was measured by (1) examining the extent to which employees must document their performance for control, (2) evaluating the extent to which primary processes are based on predefined standards, guidelines and protocols, and (3) investigating the extent to which documents of the organisation (e.g. policy documents, minutes, memos) are formalised. As Figure 5.8 shows, formalisation is given a score of 0 and assessed as “unchanged” in the period from t^0 to t^{now} . This conclusion is based on observations and interviews which suggest no significant changes in formalisation. In general, interviewees suggest that the work of homecare professionals is still highly based on formally documented rules and regulations. They refer to both care-specific and administrative documents. They do not experience a major de-formalisation as a result of team-based working.

Standardisation refers to the extent to which work is based on standards and routines. It is closely related to formalisation. Whereas formalisation involves the formal documentation of standards and routines, standardisation relates to the standards and routines themselves. The degree of standardisation was investigated by (1) examining the level of routinisation in terms of repetitiveness of tasks, (2) identifying the strictness of the rules and procedures, and (3) evaluating the employees’ perception of standardisation. As Figure 5.8 shows, standardisation is assessed as (slightly) “decreased” in the period from t^0 to t^{now} . Our observations suggest that homecare professionals face increased variety of work and decreased task repetitiveness under the team-based design. However, no major changes were found with regard to the strictness with which rules and procedures must be followed and the employees’ perception of standardisation. Except for increased variety of work, the general impression is that the work of homecare professionals had remained highly standardised with many procedures to be followed strictly.

³⁰ The calculation of span of control and the ratio between management & support staff and executive employees was made in close collaboration with a policy officer of Klein Zwitserland.

Specialisation refers to the division of tasks into sub-tasks and the coupling of tasks to different job functions on the basis of the workers' knowledge and expertise. The degree of specialisation was investigated by (1) examining completeness and the integrated character of job content, (2) studying the functional departmental structure of the organisation by examining the types and amount of departments of the organisation, and (3) investigating the level of multi-employability within the organisation. As Figure 5.8 shows, specialisation is assessed as (slightly) “*decreased*” in the period from t^o to t^{now} . The results of interviews and observations suggest that the integrated character of job content and multi-employability increased because homecare professionals had become responsible for several activities in addition to their caring tasks. However, no significant changes were found with regard to types and amount of departments.

To *conclude*, the estimation of quality of organisation indicates a *slight* trend towards flexibilisation and a small increase of quality of organisation. Except for the estimated increase of hierarchisation and the neutral score for formalisation, all characteristics were assessed as “*decreased*”.

5.4.3 Quality of work

The NOVA-WEBA survey was used to determine quality of work (see Appendix A). As suggested in the NOVA-WEBA user manual (Kraan et al., 2011), the general version of the questionnaire was slightly adapted to make it applicable to Klein Zwitserland. Appendix B contains the final version of the questionnaire. Appendix C contains the cover letter used to introduce the survey and motivate employees to participate.

Table 5.1 characterises the group of respondents. 72 employees of Klein Zwitserland completed the questionnaire. The vast majority (n=54) were employees with executive functions. These are homecare professionals ranging from the level-2 helper to the level-5 nurse. Nearly all respondents (93.1%) were female employees with on average a relatively high age (44 years) and a long history of working in the organisation (12 years and 4 months and 4 months) and working in the current function/job (16 years and 3 months).

Table 5.1 Characteristics of the NOVA-WEBA respondents of Klein Zwitserland

number of respondents	n=72
with executive functions	n=54
with managerial functions	n=8
with supporting functions	n=10
average period working within the organisation	12 years and 4 months
average period working in current function/job	16 years and 3 months
% of respondents executing (hierarchical) managerial activities	24.3% (75.7% not)
% of female respondents	93.1% (6.9% are male respondents)
average age of respondents	44 years

Table 5.2 contains the overall NOVA-WEBA results for the 13 dimensions of quality of work as explained in Appendix A. It compares the results of Klein Zwitserland with a reference file which includes the scores of over 10,000 people reflecting the overall Dutch labour force (Houtman et al., 1994; Kraan et al., 2011). The presented data were checked for significance by a statistical expert by following the procedures as described in the NOVA-WEBA user manual. The scores are statistically significant ($p < 0.05$). As the table shows, all scores vary between 0 and 1. A score of 0 means no risks to well-being related to the organisation of work (hence optimal quality of work); a score of 1 means risks to well-being related to the organisation of work (hence suboptimal quality of work). In addition to the average scores (mean), the table also includes standard deviations (SD).

Table 5.2 NOVA-WEBA results of Klein Zwitserland

Dimension	Reference file (mean)	Reference file (SD)	Klein Zwitserland (mean)	Klein Zwitserland (SD)
Completeness of work	0.53	0.22	0.30	0.20
Skills capabilities	0.14	0.23	0.03	0.09
Qualification	0.23	0.42	0.11	0.23
Short-cycled tasks	0.10	0.30	0.23	0.18
Degree of difficulty	0.76	0.26	0.78	0.25
Level of autonomy	0.27	0.26	0.41	0.28
Organisational tasks	0.31	0.31	0.07	0.14
Provision of information	0.28	0.24	0.20	0.14
Job demands	0.43	0.35	0.68	0.29
Regulatory problems	0.44	0.30	0.57	0.34
Emotional burden	0.18	0.21	0.77	0.17
Payment and job security	0.11	0.24	0.43	0.21
Time autonomy	0.47	0.32	0.57	0.35

The NOVA-WEBA results show a *mixed* and *slightly negative* picture. The measured quality of work is less than the intended quality of work. Klein Zwitserland scores ‘better’ than the reference file on five dimensions: completeness of work, skills capabilities, qualification, organisational tasks and provision of information. However, it scores ‘worse’ on eight aspects: short-cycled tasks, degree of difficulty, level of autonomy, job demands, regulatory problems, emotional burden, payment and job security and time autonomy. Respondents not surprisingly experience their work as emotionally demanding (emotional burden). They are also critical about payment and job security. Despite the decentralisation of regulatory capacity to the teams, they are (still) critical about the level of autonomy and the existence of small and repetitive tasks (short-cycled tasks). Interestingly, they experience their work as relatively (too) difficult (degree of difficulty) with high job demands and regulatory problems or disturbances occurring.

It should be noted that several factors may have biased the NOVA-WEBA results. Quality of work is a dynamic concept, which means that the employees' perception of it may change over time. Their perception may also be influenced by the turbulent historical context of the change process. As the NOVA-WEBA questionnaire was completed only once at one particular moment in time, we could not properly correct for these factors. Furthermore, although the questionnaire was adapted for use in accordance with the NOVA-WEBA user manual, respondents commented that questions were difficult to understand and often did not fit the context of home care.

5.5 Change strategy

The reorganisation of Klein Zwitserland involves a series of change actions which can be classified in four phases: incubation, preparation, start-up and consolidation (chapter 3). Figure 5.9 provides an overview of the main change actions of Klein Zwitserland. It gives the researcher's interpretation of document study, observations and interviewing which was confirmed by the management of Klein Zwitserland.

The **incubation phase** started around 2009. After a difficult period of financial and staffing cuts, Klein Zwitserland had sufficiently improved its financial situation. The management considered the preparation and introduction of self-organising teams a necessity. However, the rationale behind this reorganisation was not new. As stated before, until the 1990s home care was provided in small teams of nurses who worked on the basis of self-organisation and had a lot of freedom to coordinate the care process. Nurses were located in the neighbourhoods and had close contact with clients, their relatives and other actors involved. From the 1990s onwards, homecare provision was confronted with several developments which decreased its small-scale character. In its policy documents, Klein Zwitserland referred to the consequences of market competition, the separation of personal and nursing care, the standardisation of needs assessment and functional differentiation. Consequently, homecare provision had become more bureaucratic and centralised, and Klein Zwitserland had gradually developed into a functionally differentiated and complex organisation.

Figure 5.9 Historical reconstruction of the reorganisation of Klein Zwitserland

Klein Zwitserland intended to realise the change towards self-organising teams by means of two projects. The implementation of both projects reflects the **preparation phase** and **start-up phase** of the change trajectory. The first and most important project – “*Project Wijkteams*” – was launched in 2010 to develop the socio-technical type of design. It consisted of the preparation and step-by-step implementation of the team-based concept within three areas.³¹ In 2010, the introduction of self-organising teams in area 1 was prepared. The preparation mainly included activities to create awareness among employees of the necessity and consequences of team-based homecare provision. These activities involved informative meetings between the management and care coordinators, cooperative team leaders and regional managers. Employees were also prepared for the partial decentralisation of planning and scheduling. Furthermore, the organisation used newsletters to inform its employees. The preparation of area 1 was followed by the actual implementation of self-organising teams at the beginning of 2011.

The implementation of teams in area 1 was evaluated in order to learn for the preparation and implementation of teams in areas 2 and 3. The evaluation report stated that planners, cooperative team leaders and regional managers had difficulties in internalising their new roles: instead of supporting and coaching the teams, they often fell back into old managerial routines and behaviour. To improve the situation, the organisation sought to better prepare its employees for their new roles and relationships by intensifying information and communication. It successively implemented the team-based concept in areas 2 and 3 at the end of 2011, in a similar way to the preparation and implementation in area 1. “*Project Wijkteams*” was accomplished under the guidance of an external consultancy firm.

The second project – “*Project Zichtbare Schakel*” – involved a nationwide project to enhance the role of nurses as key players in the neighbourhood. The project’s objective was to deploy additional community nurses in about forty marginal areas in the Netherlands. These nurses were given regulatory capacity to act as independent players in the provision of an integrated package of care, prevention, living and welfare facilities.³² Klein Zwitserland participated in this national project to prepare its nurses for their important role in the team-based concept. As Figure 5.9 shows, “*Project Zichtbare Schakel*” started in 2010 and ended at the end of 2012.

³¹ Klein Zwitserland divided homecare provision into three areas based on its clients’ zip codes. Please note that these areas have ‘real’ names in practice, but we decided to use the fictitious names “area 1”, “area 2” and “area 3” to guarantee anonymity.

³² More information on “*Project Zichtbare Schakel*” can be obtained from ZonMW, the Netherlands Organisation for Health Research and Development.

During the **consolidation phase** the team-based concept was further refined. The focus in this phase was on empowering the role of community nurses from 2013 onwards, since it had been noted that the effectiveness of self-organising teams largely depended on the role of community nurses. This was also the reason for Klein Zwitserland to participate in “*Project De wijkverpleegkundige terug in de thuiszorg*” as the successor of “*Project Zichtbare Schakel*”, which had similar focal points. The consolidation phase also involved the reduction of team size. The organisation found that on average its teams contained too many employees, which hindered team performance. For this reason, the team size was reduced to a maximum of fifteen employees.

The reorganisation of Klein Zwitserland can be characterised as an ‘ongoing concern’. It had a hybrid character and involved the interplay between two contradictory movements. On the one hand, it was the organisation’s objective to decentralise as many responsibilities as possible to the people who were actually ‘doing the work’. On the other hand, the organisation had difficulties in freeing itself from bureaucratic structures and cultures. It often stagnated in old routines and behaviour which were deeply rooted in the organisation. Managers had difficulties in replacing their traditional role of managing and controlling with a supportive function towards the teams. Homecare professionals, on the other hand, often had difficulties in internalising a flexible and proactive attitude, because they were not used to having much regulatory capacity. The difficulty in giving up bureaucratic principles and routines was further reinforced by the increasing turbulence in the organisation’s environment due to new government regulations on home care (see chapter 2).

The realisation of the new design requires an effective change strategy which should give clarity on how to move from the point of departure to the design aspired to. At the same time, however, the strategy should be flexible to adapt to unforeseen developments. Furthermore, it is essential to mobilise employees and involve them from the very start in the change process as much as possible. Based on our reconstruction of the change process, we draw the following conclusions with regard to the change strategy of Klein Zwitserland. First, the results suggest that the decision to change was initiated in response to the turbulent historical context of the organisation rather than to proactively anticipate the future. However, whereas the turbulent historical context was described in its documents, the management did not specifically incorporate it in its change strategy. This is remarkable because our results suggest that the history of Klein Zwitserland had a significant influence on the reorganisation. For instance, employees indicate a negative influence of past changes upon the organisation today in terms of change fatigue (see section 5.6). Second, although the management of Klein Zwitserland seemed to be inspired by some of the socio-technical principles, it does not strictly adhere to these principles. The management decided to

introduce self-organising teams, but it neglected important socio-technical design principles including the assumption that all activities related to the primary process should in principle be organised in the teams. Furthermore, it seemed to be unaware of the important team size criterion, as teams were too large. In this respect, it is also interesting to refer to the documents of Klein Zwitserland, which hardly contain any socio-technical language. Third, the results suggest that the management tended to adhere to a more top-down approach rather than a more bottom-up approach to bring about the change. The many documents on the strategy present a detailed and blueprint change plan including a step-by-step implementation path for two change projects. Particularly at the start of these projects, there tended to be little attention devoted to the participation of employees. Although newsletters and informative meetings were used to inform employees, they felt they were not really involved in the change process. They often had the feeling that informative meetings were organised after decisions were made and they did not feel truly involved in the decision-making process (see section 5.6). Furthermore, our results give the impression that the management did not invest extensively in the preparation of the employees for their new roles and responsibilities. Neither do they suggest the existence of an intense programme for team development.

5.6 The employees' perception

As explained in chapter 3, organisational change involves a *mutual relationship* between the change strategy of the management and the employees' perception of it. The change strategy not only has consequences for the employees, but is at the same time influenced by their perception of these consequences and the conditions for successful implementation. Based upon our analysis of the Klein Zwitserland case study, we developed a heuristic model consisting of four factors: history of the case, conditions for change, system world versus life world and external influences. These factors not only indicate how employees perceive the change process and its results, but can also be conceptualised as factors influencing both the process and results. Our observations will be enriched with interview quotes.³³ Although we collected multiple quotes for each conclusion, we will give only one typical quote per conclusion for the sake of brevity. However, we will present more quotes if they have additional value or suggest counter indications.

5.6.1 History of the case

History of the case refers to the role of organisational history in relation to its current and future functioning. It is evaluated by examining (1) the degree of influence of past changes, (2) the character of influence (positive or negative) of past changes and (3) the

³³ It should be noted that most interview quotes were collected in 2010 and 2011.

particular role of 'change fatigue'. Regarding these indicators, the case study gives the following results.

Changes in the past have a significant influence on the organisation today

In addition to external turbulence, Klein Zwitserland had to struggle with internal turbulence caused by changes in the past. Interviewees particularly refer to the difficult merger which had a significant impact on current organisational functioning.

"During the last few years, we had to accomplish many change processes including a difficult merger. I think that these changes have a huge impact on the organisation today." (nurse 1)

Whereas the merger was intended to strengthen the position of the newly created organisation, it also was a source of unrest among employees. They were confronted with unpopular measures by the management, such as staffing cuts to improve the organisation's (financial) results. The near-collapse of the organisation caused anxiety and distrust among employees with regard to future changes.

Interviewees also refer to the decentralised way of working in the 1980s and 1990s, which had been gradually replaced by a centralised way of working. The re-introduction of the team-based concept gave them the impression that their management did not sufficiently know what direction to follow.

"In the past, we worked already in a decentralised way. The organisation was based on several self-organising teams. Within the teams, we were responsible for most aspects of homecare provision, even our own planning. Although we all liked this way of working and clients were rather satisfied, we had to make a 180-degree turn several years ago. Everything became more centralised and was determined by the management. Recently, we had to make a 180-degree turn again, back to the former team-based model. I don't know what is happening anymore." (nurse 2)

The influence of changes in the past is perceived as negative

Interviewees suggest a negative influence of past changes on organisational performance. They often perceive these changes as unsuccessful because of an overload of changes which negatively affect their expectations for future changes.

"I think that most changes went too fast without making enough time for actually finishing them." (nurse 3)

"I have the feeling that everything in our organisation is going too fast. It seems that the organisation always takes about only 70% of the time that is actually necessary for accomplishing a change successfully. As a result, changes are usually not completed as they should be. It already started during the preparation of the team-based way of homecare provision. The organisation

decided to start an experiment with the new way of working in a pilot region. In this region, teams started working according to the new decentralised, team-based principles while in the other regions everyone was working 'as usual'. I think the evaluation as the most important part of the pilot project was almost completely forgotten. Consequently, we could hardly learn from 'mistakes' in the pilot region and had to start from scratch in our region. I think this is typical for all changes within our organisation." (junior nurse 1)

Interviewees also mention the top-down character of changes in the past. They perceive these as being pushed through by the management without sufficiently involving the 'bottom' of the organisation. Initiatives to involve professionals are perceived as coming too late or having only an informative function.

"Although we all liked the former way of working in small-scale teams, we had to make a 180-degree turn to a more centralised way of homecare provision. Even the planning which should incorporate specific client information was organised centrally. This major change caused a lot of chaos and anxiety within the organisation and among our clients. Specific client needs could not be met anymore and everything went too fast and too radical. We were all very dissatisfied because the management did not incorporate our opinion sufficiently." (nurse 2)

"I have experienced all changes so far as being initiated mainly from the top of the organisation. I did not feel really involved during the decision-making process on the transition towards self-organising teams. I can understand that they cannot involve everyone, but I think the majority of homecare workers do not feel involved enough. Now it feels too much like doing what they have decided for us. There were some conferences to inform us about the change plans involved. However, I had the feeling that these meetings were organised after decisions had been made, so we could not change things anymore." (nurse 4)

The change process is significantly affected by 'change fatigue'

Change fatigue results from changes in the past which employees consider unsuccessful. After (perceived) unsuccessful changes, many of them have little confidence in future changes, because '*previous changes were unsuccessful too*' or '*there comes yet another change which will be pushed through without finishing the previous ones*'. Observations suggest that change fatigue has a significant negative influence on the functioning of Klein Zwitserland.

5.6.2 Conditions for change

Conditions for change refer to those conditions which are essential to bring about effective change. This study distinguishes between staffing, structural, technological and cultural conditions.

Staffing conditions

Staffing conditions are evaluated by examining (1) the ability and (2) the willingness of individuals to work according to the requirements of the team-based design, and (3) the availability of sufficient employees of all function levels. With regard to these indicators, the case study yields the following results.

Homecare professionals are able to work according to the requirements of the team-based design

The socio-technical type of design requires homecare professionals to act as flexible team players in self-organising teams who can bear additional tasks and responsibilities alongside caring tasks. In general, interviewees suggest that they are able to work according to these requirements. They think that the self-organising team concept fits in well with the characteristics and requirements of homecare provision. However, particularly older employees feel anxiety and uncertainty about their additional responsibilities. They also regularly associate self-organisation with the ability to work with a computer.

"I don't know if I can bear all responsibilities regarding the team-based way of homecare provision. I am not the youngest anymore and I don't know if I can learn to work with a computer." (nurse 5)

Homecare professionals are divided on the willingness to work according to the requirements of the socio-technical type of design

Interviewees suggest that homecare professionals do not agree on the willingness to work in self-organising teams. On the one hand, they emphasise their willingness because of supposed benefits of the team-based concept for clients, employees, the organisation and its key partners:

"I think this new way of working will restore peace among our clients. They will see fewer different faces, which means that continuity of care will improve. This automatically leads to more satisfied informal caregivers, too. Since clients will mostly be cared for by only a few homecare workers, I expect improved relationships between homecare workers and their clients and relatives. Furthermore, it will also improve our working conditions. We will get more freedom to plan and execute our work, which gives me feelings of pride and

recognition. Eventually, I think these improvements will enhance the image of the organisation too. Key partners no longer consider our organisation as a bureaucratic, old-fashioned organisation. Instead, they see that we can meet their expectations by this new and flexible way of working.” (nurse 6)

On the other hand, there are also interviewees who are less optimistic and see downsides to the new way of working. They express fear of an overload of administrative tasks and a disturbed work-life balance due to the feeling of being obliged to be available continuously for the team:

“I think this new way of working has two sides. On the one hand, I like the idea of getting more freedom to plan and organise our own work. However, on the other hand, I am afraid that we will get more administrative tasks at the expense of real homecare provision or, even worse, in addition to the current work. Our workload is already very high. If I get more administrative tasks in addition to my caring tasks, I will get problems with my husband and children at home.” (nurse 7)

Finally, there are interviewees who are not interested at all in working in self-organising teams. They only want to care about their clients and show disinterest, negativism and anxiety with regard to organisational and managerial issues.

“To be honest, I only like visiting my clients and do not want to be introduced to all new working methods and procedures. I am also afraid of losing my job, since my function as a level-2 helper will disappear. All level-2 helpers will have to take a test. People who pass the test will be admitted to an educational programme to become a level-3 nursing aid. People who fail will have to start working as a domestic help. This situation makes me worry.” (level-2 homecare professional 1)

“The change towards the team-based concept means that we need to do more administrative tasks in addition to our caring tasks. These tasks are more or less imposed by the management. Often, there is too little time to execute all tasks properly. Therefore, I usually focus on my caring tasks, since I am a nurse and not an administrative staff member. This means that administrative tasks are not carried out or are carried out too late. However, I do not care and only focus on my clients instead of the managers and planners who always want to do things differently. That’s why I usually do not answer phone calls when I am behind the client’s door.” (nurse 4)

There is (perceived) pressure on highly-educated nurses

Team-based homecare provision requires the availability of all different function levels to enable the team to accomplish complete tasks. Highly-educated (level-5) nurses are particularly important because they often fulfil a key role in the functioning of the team in relation to clients and key partners in the care process. However, interviewees warn

of increasing pressure on nurses, because they are often expected to bear most of the additional responsibilities:

"I think we should be careful with our level-5 nurses in particular. Because they have the highest education, we expect them to bear most of the responsibilities in the self-organising teams. Their workload is already high, so we cannot make them responsible for everything." (manager of self-organising team 1)

Structural conditions

Structural conditions are evaluated by examining (1) team size, (2) team composition and (3) the extent to which regulatory capacity is organised locally. With regard to these indicators, the case study gives the following results.

Self-organising teams exceed the ideal team size, particularly at the start of team-based working, and employees often consider the teams too large

Team size is essential for successfully operating teams (chapter 3). On the one hand, teams should not be too large to encourage the development of an optimal team atmosphere and prevent individuals avoiding responsibilities. On the other hand, they should not be too small to ensure the availability of sufficient team members. Ideally, a team size of about 12 people is recommended. However, at the start of team-based working, more than half of the teams of Klein Zwitserland consisted of at least 20 employees. This number grew even further in the period after 2009. Recently, the organisation has reduced team size to an average of 12-15 people. Employees indicate that teams are often too large, which may have negative consequences for the functioning of teams.

"Although the management intends to reduce the size of the teams, I think the teams are in general too large, which negatively affects the cooperation among team members. Effective communication between team members is sometimes missing and in our large teams it is rather easy to escape responsibilities." (nurse 8)

Team composition may lead to suboptimal team atmosphere and functioning

Another precondition for a successful team is its composition, which is closely correlated with team atmosphere. It is important that all team members fit in with the team and contribute equally to team atmosphere and functioning. We have already explained that not all staffing conditions are fulfilled. For instance, there are employees who mainly see downsides to working in self-organising teams. However, team atmosphere is not only affected by team composition, but also by other aspects such as team size (large teams may cause subgroups to arise within a team) and the attractiveness of the building from which a team operates.

"I think there are quite considerable differences with regard to the composition of teams. There is the problem of subgroups arising within a team, probably because the teams are too large. To encourage team atmosphere, teams should ideally be smaller. The building from which a team operates is crucial as well. It should be an attractive place for employees to work and meet colleagues. They should become intrinsically motivated to visit the building, which would bring life into the building and contribute to the team atmosphere. In addition, the building should be attractive for clients and other stakeholders as well." (nurse 8)

A policy officer of Klein Zwitserland indicates that there is no clear and predefined policy of what to do with poorly functioning teams. Based on observation, practice shows that poor team performance is primarily discussed during a meeting between the cooperative team leader and the team. The regional manager may be involved in the event of lagging team performance on a structural basis. The management emphasises that transferring employees is only considered when it sees no other options, because this measure may cause much unrest among team members.

Planning and scheduling have only partially been decentralised to the teams

The team-based design involves the decentralisation of regulatory capacity to the teams. In addition to caring activities, teams should be responsible for regulatory activities as far as possible within the framework of objectives set by the management. Although planning and scheduling are important elements of the primary process, both activities have only partially been decentralised to the teams. Whereas managers often emphasise (proposed) benefits of central planning, homecare professionals mention its downsides.

"I think planning and scheduling are central issues which should not be decentralised to the teams. Homecare professionals in the teams generally do not have the skills to create their own work planning. Furthermore, decentralisation of planning and scheduling would heavily overload our employees. I think this would lead to several professionals looking for another job." (manager of self-organising team 2)

"I think it is quite cumbersome to initiate our work planning centrally. Usually, the planning does not fit the practice and we have to change it radically to create a workable schedule. This means that we are in fact planning twice, which is far from efficient." (senior male nurse 1)

Technological conditions

As explained in chapter 3, technology plays an important role in the socio-technical provider organisation in supporting the organisation's primary process. Technological conditions are evaluated by examining (1) the use of technology in relation to clients,

(2) the use of technology in relation to employees and (3) the degree of embeddedness of technology use (e.g. training and education). With regard to these indicators, the case study provides the following results.

Employees indicate that the organisation invests sufficiently in technology to improve quality of care for clients

Interviewees mention that their organisation invests in the use of technology to improve the quality of care from the perspective of the client. They refer to e-health initiatives such as the use of iPads to communicate remotely with clients:

"We increasingly communicate with clients in a digital way. For instance, several diabetes clients contact us on a regular basis by making use of iPads. We communicate with them remotely about their current health status as well as insulin injections. E-health is applicable to some types of care needs but will never replace normal home care." (nurse 9)

Employees indicate that the organisation invests sufficiently in technology to improve their quality of work

Interviewees mention that the organisation supports employees by providing PDAs which are used by all employees.³⁴ PDAs play a key role in the communication between homecare professionals, and between professionals and support staff. Interviewees indicate that communication by PDAs has several advantages. PDAs provide access to client and planning information anytime and anywhere. They also provide access to the internet. However, they may also cause problems:

"Initially, there were quite a few problems with the PDA. Its battery went flat quickly and the device lost signal in rural areas. However, after a while, the organisation switched to another type of PDA and mobile provider, which has led to improved communication and a better signal in rural areas. However, from colleagues working in the city, I hear the opposite. They think the new mobile provider has more service disruptions and more frequent losses of mobile signal." (nurse 9)

The level of technology embeddedness depends on the age of technology users and training and education provided

Not surprisingly, interviewees mention that there is sometimes a gap between younger and older employees with regard to technology. They indicate that younger employees are more open to technological advances and internalise technological changes more

³⁴ PDA stands for Personal Digital Assistant. A PDA is a palmtop computer comparable to a smartphone which functions as a personal organiser and also provides email and access to the internet.

easily. However, they also notice that younger employees try to bridge this gap by providing assistance to older employees.

"In general, I notice a gap between the younger and older employees with regard to technology. The younger ones internalise and accept technological changes easily, while the older ones may have real problems. However, I have the feeling that this gap is being bridged, for instance because the younger ones are trying to help older colleagues more often. Generally, I think technological developments such as remote care can lead to better homecare provision."
(nurse 9)

Homecare professionals, the older ones in particular, consider training and education important to internalise technology. However, they think that the internalisation of technology can be improved by reserving more time for tailor-made training and education.

"With regard to training and education, I think the timing is sometimes bad and things are explained too late, too fast or only on paper. I sometimes participate in training sessions organised to explain new ways of working to a large group of employees. I consider such trainings ineffective because there is hardly any possibility to ask questions or practise ourselves. I think trainings should be more small-scale and tailor-made." (nurse 9)

Cultural conditions

Cultural conditions are evaluated by examining (1) the flexible attitude of employees, (2) team atmosphere and (3) the degree of influence of acquired 'vested' rights and habits from the past. With regard to these indicators, the case study yields the following results.

Homecare professionals experience limits to the flexibility required to work in self-organising teams

Working in self-organising teams requires a very flexible attitude on the part of employees. Whereas decentralisation of regulatory potential may increase the freedom of employees working in teams, it also places high demands on flexibility. Employees often feel obliged to be available for the team all the time, which may have consequences for their work-life balance. Interviewees mention that the organisation should accept that there are limits to the required flexibility:

"I think there is a limit to what the organisation can expect from its employees with regard to flexibility. We are already very flexible, because we have accepted all successive changes for years now. Furthermore, we have accepted all new tasks and responsibilities and are willing to work according to new procedures for the umpteenth time. I agree that we were quite spoiled in the past. However,

things have changed now. I would like to go to a concert next month. However, I don't know if I can order tickets because I don't know my definite work schedule. Hopefully, the concert will not be sold out.” (nurse 7)

“I think employees may become less satisfied due to the team-based concept. They are responsible for many administrative and coordinating tasks now in addition to their caring activities. We expect a lot of flexibility of our employees, which often goes too far. For instance, they hardly have any possibility of planning private activities in advance. However, I know that not every manager agrees with me on this.” (manager of self-organising team 3)

The effectiveness of self-organising teams largely depends on team atmosphere

The organisation should develop a team culture that optimises team atmosphere and performance. This means putting the right people together by matching personalities and characters. The organisation must develop a culture of giving and receiving feedback in which all team members are encouraged to make that extra effort to let the team flourish.

“Our team really functions as a self-organising team. We all try to help each other in a proactive way, because this will improve the quality of work for all of us in the team. For instance, last week one of my colleagues noticed on her PDA that my route was heavily delayed due to unforeseen circumstances. Without any hesitation she called me to ask if she could take over some of my clients. We decided that she would visit the last client on my route, which was not only nice for me but also for the client, who could be helped earlier.” (nurse 10)

Acquired ‘vested’ rights and habits from the past have a significant negative influence on the change process

Interviewees mention that some employees were used to having ‘vested’ rights and habits from the past such as fixed days off. They speak of a ‘culture of exemptions’ which means that individuals had their own contractually fixed privileges. A culture of exemptions undermines the flexibility and spirit needed to work in self-organising teams. Although the management aims to break down this culture, interviewees suggest that its influence is still present.

“Employees always got the last word in our organisation. Everyone had her fixed days off and specific desires and needs fulfilled. It was quite easy to become eligible for exemptions, which resulted in a real ‘culture of exemptions’. Individual needs and desires were often formally documented in a contract between the organisation and the employee. I think this was not a good situation, because the same people were always looking for exemptions. This means that the others automatically had to be there for the others. I think we should expect collegiality

and flexibility from everyone in our organisation, especially within the new way of team-based working.” (nurse 11)

In general, the team-based concept requires abandoning the bureaucratic culture and internalising changing roles and relationships. This means that homecare professionals get used to flexible and proactive behaviour in accordance with the requirements of team-based working. They should take up new tasks and responsibilities in addition to their caring tasks. Observations suggest that this may be challenging, because professionals are used to working according to standards and procedures. The team-based concept also requires the management to replace its traditional role of managing and controlling with a supportive function towards the teams. However, managers regularly have difficulties in internalising their supporting role. Furthermore, in the bureaucratic organisation they were used to discussing a wide range of issues at a detailed level. Under the socio-technical type of design they should only set the general framework in which teams should operate.

“I think that we as managers have difficulties in accepting our new roles. We are used to meeting about everything. Whereas we should meet only to determine the general policy framework for the teams, we meet too often to discuss a variety of issues at a very detailed level. I think most of these issues are team issues which should be discussed in the teams. Numerous long meetings are also not effective. After a meeting, I often have the feeling that the managers are going their own way.” (manager of self-organising team 2)

5.6.3 System world versus life world

The *system world versus life world* refers to the context of homecare provision which involves two different domains: a system world and a life world. Chapter 3 explained both domains and concluded that the system world may infiltrate and undermine the life world. The system world versus life world is evaluated by examining (1) the extent to which the system world infiltrates the life world, (2) the response of homecare professionals to the infiltrating system world and (3) the particular role of the informal organisation. With regard to these indicators, the case study gives the following results.

Homecare professionals face a system world which is infiltrating the life world

Interviewees mention that they are increasingly confronted with a system world that infiltrates and undermines their life world. They refer to the multitude of rules and regulations which determine their work nowadays. In the past, they could follow their ‘caring hearts’ better on the basis of professional insight. ‘Hands at the bedside’ dominated over ‘legs under the desk’.

“I notice the increasing influence of rules and regulations infiltrating our work every day. At this moment, I would not say that our work is completely

impoverished by all rules and regulations. However, we don't have the flexibility anymore to plan and organise our work ourselves. Sometimes, this leads to feelings of frustration and unfairness, especially when the prescribed course of action is not congruent with our professional insight. For instance, when I visit a client my 'caring heart' would say that I should straighten the bedding since this only takes one or two minutes. However, according to the current indication rules, this is not allowed. This means that we should accept this and turn our minds off. To some extent, I can understand strict regulations because homecare is a collective service that should also be available for future generations. However, rules and regulations have also made our work less challenging and meaningful." (nurse 12)

Homecare professionals respond to the infiltrating system world by intensifying their relationship with clients while disassociating themselves from the organisation

The interview results suggest that homecare professionals respond to the infiltrating system world by intensifying their relationship with clients while simultaneously disassociating themselves from organisational issues. So, in addition to change fatigue, disinterest in organisational change may also be caused by the infiltrating system world. Interviewees feel a close commitment to their clients and, parallel to this, increasingly disassociate themselves from 'all rules and regulations created by managers'. This dissociation is usually not expressed in terms of active resistance or frustration. More often, employees behave passively towards their managers.

"The change towards the team-based concept means that we need to do more administrative tasks in addition to caring tasks. These tasks are more or less imposed by the management. Often, there is too little time to execute all tasks properly. Therefore, I usually focus on my caring tasks, since I am a nurse and not an administrative staff member. This means that administrative tasks are not carried out or are carried out too late. However, I do not care and learned to focus on my clients instead of the managers and planners who always want to do things differently. That's why I usually do not answer phone calls when I am behind a client's door." (nurse 4)

Homecare professionals increasingly create an informal organisation to prevent the system world from dominating over the life world

The interview results suggest the rise of a substantial informal organisation which often emerges because of management decisions which do not fit in with homecare practice or are perceived to be inappropriate by homecare professionals. Professionals may respond to management decisions by developing their own (informal) policies or adjust the management's policies in such a way that an invisible informal organisation emerges alongside the formal one:

"Each of us receives a weekly schedule containing all clients that should be visited sequentially on one or more days of that particular week. This schedule is prepared centrally and then sent to us by the planners. Usually, it does not fit in well with the practice, either because it leads to unnecessarily high travel times as we have to travel from place A to B and then back to A or because it does not take proper account of client needs. Therefore, I often completely change the schedule in such a way that it fits in better with my clients' needs and leads to shorter travel times. Regarding travel times, I know that a lot of colleagues manipulate the time recording. Although the PDA automatically registers travel times, it is also possible to change them manually. This is what most colleagues do, probably to prevent any comments from their managers." (nurse 12)

5.6.4 External influences

External influences refer to the influence of the external environment on the results of the change. It is evaluated by (1) examining the extent to which the work of homecare professionals is influenced by external influences, (2) investigating the character of external influences (positive or negative) and (3) examining to what extent homecare professionals can anticipate external influences. With regard to these indicators, the case study provides the following results.

Homecare professionals are significantly affected by external influences mainly in terms of interference by the government

Interviewees recognise that home care is heavily affected by external influences such as government measures, new regulations, and so on.

"I think that homecare is currently heavily affected by external influences which are mainly coming from the state. I have been working as a nurse for many years now, but I have never experienced such a big influence from the state. In the news, it's only about how we should organise homecare provision now and in the future. I think the organisation's decision to opt for self-organising teams is a direct result of these external influences." (nurse 8)

The significant influence of external influences is perceived as negative

Interviewees perceive external influences as negative. They refer to uncertainty, chaos and turbulence with regard to how home care will look in the future. They associate the proposed measures mainly with budget cuts in homecare provision which in their view will certainly jeopardise the quality of care and the quality of their work. In general, they also think that the organisation cannot be blamed for its negative results. They see 'The Hague' as the main wrongdoer:

"I think all problems and changes in our organisation should be considered from the perspective of what is happening in The Hague. The current state policies –

and the radical spending cuts in particular – are the main causes of the chaos and turbulence in our organisation nowadays. Besides the fact that these cuts are painful for our homecare system in general, I think the state policies are not consistent at all. The government does not know what to do and is changing all the time. Obviously, this will bring chaos and turbulence in our organisation too. Therefore, we should not only blame the organisation for possible mistakes but address The Hague as the main wrongdoer.” (nurse 8)

Homecare professionals feel unable to anticipate external influences

Interviewees suggest that they hardly have any scope to influence decision-making by the state. Some of them refer to the organisation of mass strikes as a possibility to express their dissatisfaction. However, they realise that mass strikes will harm the position of clients, which is considered undesirable. Therefore, they allow mass strikes as a last resort and only on condition that the continuity of care is not at stake.

“I think it would be a good idea to organise mass strikes among homecare workers. However, everyone is afraid because our clients must not suffer from these actions. I think it would be good if only some of the homecare workers held demonstrations, without leaving clients in the lurch.” (nurse 8)

5.6.5 Synthesis

Figure 5.10 represents the employees’ perception of the reorganisation of Klein Zwitserland. It indicates for each of the four factors whether the influence on the change process was perceived as positive or negative by the employees as well as the strength of the influence. It gives the estimation by the researcher based on the aforementioned observations.

As the figure shows, the results suggest that each factor had a negative influence on the change process. With regard to the history of the case, employees perceive a negative influence of changes in the past. They also indicate the presence of ‘change fatigue’. With regard to conditions for change, employees indicate that the presence of staffing, structural and cultural conditions was not self-evident. Only technological conditions were largely met. With regard to system world versus life world, the results of interviews and observations suggest that Klein Zwitserland faced a significant infiltration of the system world into the life world. External influences in terms of government policies reinforced this critical view. The interviewed employees suggest that government measures had severe consequences for current and future homecare provision.

Figure 5.10 The employees' perception

5.7 Summary

This chapter described the results of the case study of Klein Zwitserland. After an introduction of the case, we discussed the bureaucratic architecture as the point of departure. We explained the organisational complexity of homecare provision in the bureaucratic organisation and the negative results for clients, employees, the organisation and its key partners. We presented the introduction of self-organising teams by the organisation to reduce complexity and improve its results. It was the management's intention to create an organisational structure based on as much local regulatory capacity as possible. However, our results suggest that Klein Zwitserland is only *halfway* along the change trajectory. There is still a gap between objectives and results. Regulatory capacity is only partially located in the teams and people have difficulties in abandoning bureaucratic culture. Furthermore, the assessment of quality of organisation indicates only a small trend towards flexibilisation and the measured quality of work is less than the quality of work aspired to. Our analysis of the change strategy indicates that the management did not specifically take into account the turbulent historical context of Klein Zwitserland, which is remarkable as the turbulent history had a negative influence upon the organisation. Our results also suggest that the reorganisation of Klein Zwitserland neglected important principles of socio-technical redesign. Whereas the management seemed to be inspired by the socio-

technical philosophy with the introduction of self-organising teams, it neglected, for instance, the team size criterion and the assumption that all primary activities should be organised in the teams. Furthermore, its documents hardly contained any socio-technical language. Our reconstruction of the change process also indicates that the management tended to adhere to a top-down approach to realise the change, with little attention devoted to the participation of employees, their preparation for the new way of working and team development. The 'halfway implementation' of the team-based concept is also reflected in the employees' perception of the change process and results. Employees experience a negative influence of the history of Klein Zwitserland. They have feelings of 'change fatigue' and are pessimistic about any future change. They are also critical about the presence of staffing, structural and cultural conditions for change, and they perceive an increasing negative influence of the system world into the life world together with external influences in terms of government measures.

Chapter 6

Case study of Maas & Waal

6. Case study of Maas & Waal

This chapter presents the results of our second case study: Maas & Waal. Figure 6.1 visualises the structure of the chapter, which is similar to the structure of the case study of Klein Zwitserland.

Figure 6.1 Structure of chapter 6: case study of Maas & Waal

6.1 Introduction

Maas & Waal offers a broad spectrum of long-term care and living facilities in the south-eastern part of the Netherlands. In addition to residential care, it provides various (non-residential) homecare services including personal care, nursing care, advice and information, and lending facilities. In 2012, it stopped the provision of domiciliary care because of low prices which made its provision no longer viable. Just as Klein Zwitserland, Maas & Waal operates in a rural area in which only one main city is located. All inhabitants in this area are seen as potential clients.

According to the annual reports, the total revenues of Maas & Waal grew from €121.1 million in 2006 to €144.4 million in 2010 and €153 million in 2012. It should be noted that these numbers also include the intramural care segment, in addition to the broad package of homecare services. The total number of employees of Maas & Waal decreased from 3,557 in 2010 to 2,737 in 2012. Unfortunately, no numbers were found for the period before 2010.

Maas & Waal is the result of a merger between three residential care institutions and two homecare provider organisations in 2000. In 2013, it was organised as illustrated in the organogram in Appendix D. Whereas the organogram represents the overall organisation, this study only includes the so-called “Maas & Waal 3” area (see Appendix D).³⁵ The decision to focus on “Maas & Waal 3” was made because the organisation considers this area to be ‘leading’ in the proposed change from a bureaucratic to a socio-technical type of design. *Although all information in this chapter actually refers to the specific “Maas & Waal 3” area, hereafter we will consistently refer to this area by using the term “Maas & Waal”.*

Figure 6.2 shows the organogram of Maas & Waal in 2013. As the figure highlights, the organisation is directed by a director who is accountable to the Executive Board for the overall organisation. The director is assisted by several lower-level managers operating close to the operating core, which contains two units. The left part represents the residential care unit. Residential care and living facilities are provided at four locations which are either nursing homes or homes for the elderly. The right part of the organogram refers to the non-residential homecare unit. Maas & Waal has organised homecare provision in an ‘area-oriented’ way: it involves four care regions, each of which is managed by a care region manager. Each care region contains self-organising teams to provide personal care and nursing care. It has three types of teams: low-complexity care teams, medium-complexity care teams and high-complexity care teams.

³⁵ Please note that these areas have ‘real’ names in reality. However, to guarantee anonymity, we use the fictitious names “Maas & Waal 1”, “Maas & Waal 2”, “Maas & Waal 3” and so on.

* Please note that these are 'real' names in reality. To guarantee anonymity, we decided to use fictitious names.

Figure 6.2 Organogram of Maas & Waal (in Dutch)

6.2 Point of departure

Around 2006, the management of Maas & Waal mentioned an internal reason for reconsidering its organisational architecture. Following an analysis by an external expert, it concluded that the traditional architecture was complex and mainly focused on quality and efficiency. It lacked incentives for flexibility and innovation, resulting in suboptimal quality of organisation and quality of work. In addition, Maas & Waal had to deal with (1) external developments and (2) a changing strategic direction of the overall organisation. Its bureaucratic architecture involved shortcomings in the handling of these challenges. Client-centeredness was substandard, organisational results were suboptimal and the quality of work was low. Furthermore, the organisation could not sufficiently meet societal requirements.

6.2.1 Bureaucratic architecture

Figure 6.3 gives a stylised overview of the bureaucratic architecture of Maas & Waal. The illustration is taken from a key document of the organisation and builds around the four pillars of the organisational temple (chapter 3).

Figure 6.3 The bureaucratic architecture of Maas & Waal

Documents suggest that the *structure* of the bureaucratic architecture rested upon high division of work. Regulatory capacity was mainly located centrally, which meant that policies were often centrally directed and had to be translated into concrete policies at the local level. However, central regulatory capacity provided little room for adapting policies locally. As a result, professionals at the operating core were responsible for executing detailed centrally directed regulations which did not meet local needs. The bureaucratic structure provided professionals with little freedom to regulate their work and had a strong internal focus. The *culture* of the bureaucratic organisation was internally oriented and left little space for professional autonomy. Professionals operated within a 'world of rules and carefulness'. They worked on the basis of authority and rationality by means of numerous protocols which frustrated proactive and flexible behaviour. The bureaucratic organisation had various *systems* for client administration, client safety, HRM and planning which were considered fragmented, static and cumbersome. The emphasis was on controlling instead of supporting the primary process. The systems could often not deliver usable management information in a timely manner. The management of Maas & Waal also noticed a lack of systems to analyse its wider environment, in particular developments in the client population and the labour market. Finally, the bureaucratic organisation used functionally oriented job *competences* emphasising standardisation instead of flexibility and professional autonomy.

As Figure 6.3 shows, the main focus in the bureaucratic architecture was on quality and efficiency, and not on flexibility and innovation. The management recognised that the bureaucratic features of Maas & Waal prospered in a stable environment, but missed sufficient focus on flexibility and innovation to cope effectively with external developments.

6.2.2 Challenges

As stated earlier, the management of Maas & Waal had to deal with several external developments. It also needed to translate a changing strategic direction of the Executive Board into concrete policies. In its view, a shift from supply-driven to demand-driven care was required.

External developments

One of the external developments concerned the reduction in AWBZ coverage. Initially, the AWBZ paid for the costs of complex and specialised care. Over time, coverage had also been extended to less complex and specialised services. To rein in the growth of healthcare expenditure, the government had taken measures to restrict AWBZ coverage to the most complex and specialised care. Residential care was largely replaced with housing and living facilities only. Another development was that the

national trend of separating care and living facilities meant that people were more than ever stimulated to stay in their own living environment as long as possible. In the view of the management, these developments marked a need for innovative combinations of care and living facilities. It also expected a new method of financing with a focus on output and outcome. In addition to these policy-driven changes, it foresaw an increase of elderly and chronically ill people together with scarcity of healthcare professionals and increasing competition among provider organisations.

A new strategic direction

The management of Maas & Waal also had to implement the strategic redirection of the Executive Board. Every five years, the Executive Board presented its strategic direction in a report with the general objectives for the next period. The strategic report for the period 2008-2012, entitled *“Tussen publiek domein en markt”*, emphasised the importance of (re)positioning the organisation between the public domain and the market. It described the importance of providing an innovative and integrated package of care and living facilities. This package had to be sustainable, competitive and of high quality. The report also mentioned the need for intense collaboration with the organisation’s key partners, including general practitioners, hospitals, municipalities, housing corporations, universities and research institutes.

In addition to the strategic objectives for the period 2008-2012, the Executive Board emphasised individual responsibility of clients for the period 2013-2017. Its strategic report entitled *“Vertrouwen in eigen kunnen”* described a shift in society from a supply-driven to a demand-driven focus of care by means of five transitions (see Figure 6.4). These transitions were considered important leverage points of action for the organisation.

Figure 6.4 From a supply-driven towards a demand-driven focus of care

6.2.3 *Shortcomings and change decision*

The management of Maas & Waal responded to these challenges by seeking a new balance between the external requirements and its internal design. It defined its task as translating the changing 'outside world' into the 'inside world'. Policy documents state that Maas & Waal 'had all the features of a classic long-term care provider' as 'it was mainly organised around its residential care locations and homecare provision was mainly isolated from residential care'. The documents also referred to shortcomings relating to structure, culture, systems and competences. The structure was very bureaucratic, internally oriented and based on centralisation. It did not provide professionals with sufficient regulatory capacity to properly meet local needs. Culture was also bureaucratic and lacked an external orientation. Systems were complex and contained insufficient external information on the (labour) market and new clients. Furthermore, they were oriented excessively towards financial aspects, efficiency and control, instead of supporting the primary process. Finally, there was a lack of competences emphasising a proactive, flexible and externally oriented attitude on the part of professionals.

The management concluded that there was no longer a fit between Maas & Waal and its environment. Consequently, it considered a change to a socio-technical type of design necessary to realign the organisation with its environment and to guarantee the provision of an integrated package of care and living facilities together with its key partners. In deciding to initiate a change to a new design, the management intended to be better able to deal with its changing environment.

6.3 A socio-technical design as objective

The objective of Maas & Waal is a socio-technical type of design which rests upon self-organising teams and is based on principles opposite to the bureaucratic design. The new design is expected to meet performance requirements in terms of clients, employees, society and the organisation.

A socio-technical type of design is assumed to have advantages for **clients**. It is expected to improve information and communication between Maas & Waal and its clients. The organisation should be easily accessible for clients, have a friendly and attentive attitude towards them and employ professionals who are recognisable. Furthermore, clients should be satisfied about the services provided by the organisation in terms of freedom of choice and the availability of innovative services for competitive prices. **Employees** are also assumed to benefit from the new design. It is expected to enhance the attractiveness of Maas & Waal as an employer and increase the scope for professional autonomy. Employees should be satisfied about their organisation and assess it as a learning environment. The socio-technical architecture is also expected to

improve the attractiveness and reliability of Maas & Waal towards key partners in **society**. The new design offers sufficient innovative services to meet market demands with a flexible attitude towards a wide range of stakeholders. Finally, the **organisation** of Maas & Waal will benefit from the socio-technical type of design. In its documents, the management emphasises that the alternative design must include processes in accordance with market demands and client needs. Because performance requirements may change over time, it will continuously monitor its environment to adapt in a timely manner.

Figure 6.5 visualises the new socio-technical type of design of Maas & Waal. The figure is taken from a key document of the organisation and illustrates the *socio-technical language* used by the management. The design is based upon the vision, mission and leadership of the organisation as described in the strategic reports “*Tussen publiek domein en markt*” and “*Vertrouwen in eigen kunnen*”. The management expects that fundamental interventions in each of the four pillars (structure, culture, systems and competences) will significantly improve the organisation’s performance in a turbulent environment.

Figure 6.5 The socio-technical type of design of Maas & Waal

Documents state that the *structure* of the new design should rest upon the integration of tasks and local regulatory capacity. Regulatory tasks and responsibilities should primarily lie in the hands of the people in the primary process. These are the homecare professionals working in small self-organising teams. The ‘world of rules and carefulness’ should be replaced with a *culture* based on professional autonomy. This culture should be externally oriented and involve proactive and result-oriented behaviour based upon core values defined by the management: client-centeredness, professionalism, entrepreneurship, confidence, responsibility, cooperation and ambassadorship. The term ‘ambassadorship’ refers to the objective that employees should become the most important marketing messengers for the organisation.

The new design is also intended to simplify and integrate *systems* which should be flexible and contain information on performance indicators based on predefined performance requirements. With a focus on process and performance instead of pure control, they should support the primary process by delivering management information in a timely way. As for *competences*, the management’s objective is to encourage flexible, proactive and responsible behaviour on the part of its employees. It distinguishes several competences to be developed including client-centeredness, integrity, entrepreneurship, cooperation, vision, ability to learn, result-driven orientation, coaching and flexibility.

Team-based concept

The socio-technical type of design gains a practical dimension in the team-based concept. The management of Maas & Waal intends to introduce self-organising teams with the purpose of organising regulatory capacity locally. Each team should consist of at least five homecare professionals with a maximum team size of 20 employees. A team size of eight to 12 employees is considered ideal. Observations by the researcher confirm that all teams meet this criterion.

Each team is linked to a group of clients within a particular zip code area. Clients are not only the users of home care, but also the team’s key partners, such as GPs, the hospital and welfare organisations. Teams should develop short and direct lines with their key partners to be able to respond to client needs in a flexible way and become the primary point of contact in the neighbourhood.

Teams should possess regulatory capacity to bear their tasks and responsibilities. They work on the basis of the so-called ‘star role model’ containing five ‘areas of

responsibility' or 'star roles'.³⁶ Five star roles are distinguished: (1) planning and productivity, (2) scheduling, (3) quality, (4) team affairs and (5) external relations and PR. As Figure 6.6 highlights, each star role contains various regulatory tasks or team responsibilities. It is assigned to a specific team member who monitors team performance on the particular star role. However, a team member fulfils a star role *on behalf of* the team, which means that the team and not the individual team member is responsible. The implementation of the star role model involves a team development process. Teams should develop at least two star roles during the first six months of team-based working. One year after the start, they should be able to perform at least four star roles and they should grow further to be able to take on all five star roles after one and a half years. Based on observations, practice shows that the majority of teams have developed the star role model in accordance with this planning. At the end of 2013, most teams took responsibility for all regulatory tasks and responsibilities as defined in Figure 6.6. The implementation of the star role model suggests that planning and scheduling lie in the hands of the teams, since the management of Maas & Waal considers these activities essential elements of the primary process. However, observations indicate that the 'planning and productivity' and 'scheduling' star roles are often combined in the teams.

The teams must operate in a result-oriented way on the basis of clear goals defined by the management. For each star role, performance requirements are defined and presented to the teams by means of cockpit gauges. These gauges provide simple information on team performance by using the colours green (performance in accordance with norm), red (performance not in accordance with norm) and yellow (performance in the danger zone). They are to a large extent based upon the input of team members themselves. For the star role 'planning and productivity', the cockpit gives productivity numbers and data on absenteeism and client satisfaction. With regard to 'scheduling', it gives information on the hours of leave of employees and their satisfaction about the schedule. For the star role 'team affairs', information is provided on team atmosphere, compliance with team agreements and the perceived quality of team meetings. With regard to 'quality', the cockpit shows the number and nature of complaints, incidents and medical errors together with information on client satisfaction. Finally, with regard to 'external relations and PR', it provides information on the satisfaction of key partners (e.g. hospitals).

The management clearly defines *which objectives* teams should achieve, but gives a great deal of freedom on *how* to achieve these objectives. Thus teams are primarily

³⁶ The 'star role model' was developed by the management of Maas & Waal in close cooperation with the ST group, which is a Dutch consulting group specialised in facilitating, consulting and training of organisations in change.

responsible for improving their performance, if they do not meet the objectives. Teams should make proposals for realising continuous improvements in each of the five star roles. They may contact a support team to encourage team development. The support team consists of team coaches providing assistance on various fields of expertise, including team development and affairs, financial issues, and PR and marketing. It also assists teams in creating and evaluating the team development plan.

* defined by Maas & Waal as a 'highly frequent' task or responsibility to be accomplished on a daily/weekly basis

** defined by Maas & Waal as a 'frequent' task or responsibility to be accomplished on a weekly/monthly basis

*** defined by Maas & Waal as an 'incidental' task or responsibility to be accomplished 1 or 2 times per year

Figure 6.6 The star role model of Maas & Waal

6.4 Results

Up to this point, we have introduced Maas & Waal and explored its bureaucratic architecture at the point of departure of organisational change. We have also described the socio-technical type of design as an objective and its assumed benefits for clients, employees, society and the organisation. This section addresses the results of the reorganisation.

6.4.1 Objectives versus results

As stated earlier, the documents of Maas & Waal describe the management's efforts to realise fundamental improvements in each of the four pillars of the organisational temple following the principles of socio-technical redesign. The primary objective is to create an organisational structure based upon as much local regulatory capacity as possible. Observations and interviews by the researcher at the end of 2013 indicate that most of the primary activities indeed lie in the hands of the professionals in the self-organising teams. Employees say they are well prepared for the variety of tasks to be accomplished and used to the principle that a team member accomplishes a star role on behalf of the team, which means that the team and not individual team members are responsible.

With the reorganisation of Maas & Waal, the management intends to develop a culture in which professional autonomy flourishes to encourage flexible, proactive and responsible behaviour on the part of professionals based on several competences, including client-centeredness, professionalism and entrepreneurship. Our results indicate that employees have become aware of these competences and seek to apply them in practice. As we will discuss, the management invested in a one-year programme to prepare the employees of Maas & Waal for their new role in the team-based design (see section 6.5)

So, to conclude, our results suggest that Maas & Waal is on track with the change to the socio-technical type of design aspired to. However, the documents are rather silent on the realisation of less complex systems with the purpose of supporting the primary process instead of pure control. As we will see, employees suggest that the management invests insufficiently in technology to support their work. They are also less motivated to participate in the change process due to the large number of changes in the past and the high pace of introducing them. Furthermore, they dislike the high workload involved with team-based working and the negative influence of (external) regulations (see section 6.6).

6.4.2 Quality of organisation

The socio-technical architecture is assumed to optimise quality of organisation, quality of work and quality of working relations.³⁷ As outlined in chapter 4, quality of organisation is investigated by examining the degree to which the organisational architecture is characterised by (1) centralisation, (2) hierarchisation, (3) formalisation, (4) standardisation and (5) specialisation from t^0 to t^{now} , where t^{now} represents the situation at the end of 2013. Figure 6.7 visualises the evaluation of these five aspects

³⁷ As discussed in chapter 4, quality of working relations is not evaluated in this study.

for Maas & Waal. The results represent the researcher's assessment. To empirically validate this estimation, the management of Maas & Waal was requested to confirm the scoring.

Figure 6.7 Quality of organisation within Maas & Waal

Centralisation refers to the extent to which decision-making is concentrated in one particular location or part of the organisation. The degree of centralisation was investigated by (1) studying the formal structure of the organisation to identify where in the organisation decisions are taken on major issues (e.g. personnel, investments, budgets, new products and services, working procedures), (2) examining power relations between several groups of employees, and (3) identifying the perception of employees on centralisation. As Figure 6.7 shows, centralisation is assessed as "decreased" in the period from t^0 to t^{now} . This conclusion is based on the observation that regulatory capacity primarily lies in the hands of self-organising teams. Teams have become responsible for many regulatory tasks and responsibilities regarding planning and productivity, scheduling, quality, team affairs, and external relations and PR. However, decisions on how to respond to external developments and translate government measures into concrete policies for the teams are made centrally.

Hierarchisation refers to the process of vertical structuring in which one or more positions within the organisation are vertically linked to superior positions. The degree of hierarchisation was investigated by (1) studying the verticality of the organisational structure, (2) examining the development of span of control as well as (3) the ratio between management & support staff and executive employees. Based on these criteria, hierarchisation is assessed as "highly decreased". This conclusion is based on

the observation that the span of control doubled from about 40-45 employees per manager under the bureaucratic design to about 100 employees per manager. Furthermore, the ratio between management & support staff and executive employees changed from 1 : 5.5 in 2012 to 1 : 9.3 in 2013.³⁸ Finally, the organisational structure flattened due to the removal of a management layer after the reorganisation.

Formalisation involves the extent to which actions, decisions and rules are formally documented. The more actions, decisions and rules are formally documented, the higher the level of formalisation. The degree of formalisation was evaluated by (1) examining the extent to which employees must document their performance for control, (2) evaluating the extent to which primary processes are based upon predefined standards, guidelines and protocols, and (3) investigating the extent to which documents of the organisation (e.g. policy documents, minutes, memos) are formalised. As Figure 6.7 shows, formalisation is given a score of 0 and assessed as relatively “*unchanged*” in the period from t^0 to t^{now} . This conclusion is based on observation and interviews which suggest no significant changes in formalisation. The work of homecare professionals is still highly regulated by formally documented rules, regulations and protocols.

Standardisation refers to the extent to which work is based upon standards and routines. It is closely related to formalisation. Whereas formalisation involves the formal documentation of standards and routines, standardisation refers to the standards and routines themselves. The degree of standardisation was investigated by (1) examining the level of routinisation in terms of repetitiveness of tasks, (2) identifying the strictness of the rules and procedures, and (3) evaluating the employees’ perception of standardisation. As Figure 6.7 shows, standardisation is assessed as “*decreased*”. Our observations indicate that employees experience more variety in their work and lower task repetitiveness after the reorganisation. No major changes were found regarding the strictness to which rules and procedures must be followed. The general impression is that homecare provision is still highly standardised by means of regulations.

Specialisation refers to the division of tasks into sub-tasks and the coupling of tasks to different job functions on the basis of the workers’ knowledge and expertise. The degree of specialisation was investigated by (1) examining completeness and the integrated character of job content, (2) studying the functional departmental structure of the organisation by examining the types and amount of departments of the organisation, and (3) investigating the level of multi-employability within the

³⁸ The calculation of span of control and the ratio between management & support staff and executive employees was made in close collaboration with a policy officer of Maas & Waal.

organisation. As Figure 6.7 shows, specialisation is assessed as “*decreased*”. Our observations indicate that homecare professionals have become responsible for a multitude of regulatory tasks in addition to their caring tasks. Whereas no significant changes were found with regard to multi-employability, it is expected that multi-employability of employees increased because teams are carefully prepared for and supported in accomplishing their new tasks. No significant changes were found in types and amount of departments.

To *conclude*, the estimation of quality of organisation indicates a trend towards flexibilisation and an increase in quality of organisation. Except for the neutral score on formalisation, all characteristics were assessed as “*decreased*” and hierarchisation as “*highly decreased*”.

6.4.3 Quality of work

The NOVA-WEBA survey was used to determine quality of work (see Appendix A). Just as for Klein Zwitserland and in accordance with the NOVA-WEBA user manual (Kraan et al., 2011), the general version of the questionnaire was changed somewhat to make it applicable to Maas & Waal. Appendix E includes the final version of the questionnaire. Appendix F contains the cover letter used to recruit participants for the survey.

Table 6.1 describes the group of respondents. 224 employees of Maas & Waal completed the questionnaire, of which the vast majority (n=212) were employees with executive functions. 99.1% of all respondents were female employees with an average age of 48 and a relatively long history of working in the organisation (13 years and 6 months) and working in the current function/job (14 years and 5 months).

Table 6.1 Characteristics of the NOVA-WEBA respondents of Maas & Waal

number of respondents	n=224
with executive functions	n=212
with managerial functions	n=8
with supporting functions	n=4
average period working within the organisation	13 years and 6 months
average period working in current function/job	14 years and 5 months
% of respondents executing (hierarchical) managerial activities	3.8% (96.2% not)
% of female respondents	99.1% (0.9% are male respondents)
average age of respondents	48 years

Table 6.2 includes the NOVA-WEBA results for the 13 dimensions of quality of work (see Appendix A). Just as for Klein Zwitserland, the results are compared with a reference file and checked for significance. The scores are statistically significant ($p < 0.05$). As stated earlier, the NOVA-WEBA survey produces scores which vary between 0 and 1. A

score of 0 means no risks to well-being related to the organisation of work (hence optimal quality of work); a score of 1 means risks to well-being related to the organisation of work (hence suboptimal quality of work).

Table 6.2 NOVA-WEBA results of Maas & Waal

Dimension	Reference file (mean)	Reference file (SD)	Maas & Waal (mean)	Maas & Waal (SD)
Completeness of work	0.53	0.22	0.36	0.19
Skills capabilities	0.14	0.23	0.03	0.10
Qualification	0.23	0.42	0.14	0.26
Short-cycled tasks	0.10	0.30	0.26	0.16
Degree of difficulty	0.76	0.26	0.83	0.22
Level of autonomy	0.27	0.26	0.53	0.26
Organisational tasks	0.31	0.31	0.11	0.18
Provision of information	0.28	0.24	0.28	0.16
Job demands	0.43	0.35	0.66	0.32
Regulatory problems	0.44	0.30	0.65	0.31
Emotional burden	0.18	0.21	0.78	0.15
Payment and job security	0.11	0.24	0.48	0.24
Time autonomy	0.47	0.32	0.61	0.29

The NOVA-WEBA results show a *mixed* and *negative* picture, because the measured quality of work is less than the quality of work aspired to. Maas & Waal scores ‘better’ than the reference file on four dimensions: completeness of work, skills capabilities, qualification and organisational tasks. However, it scores ‘worse’ on eight aspects: short-cycled tasks, degree of difficulty, level of autonomy, job demands, regulatory problems, emotional burden, payment and job security, and time autonomy. The mean score on ‘provision of information’ is equal to the score of the reference file. Respondents logically experience their work as emotionally demanding (emotional burden). They are also critical about payment and job security. The NOVA-WEBA results are *remarkable*. Despite the observation that quality of organisation increased, respondents are still critical about the level of autonomy and the existence of short-cycled tasks. Furthermore, they experience a high degree of difficulty, high job demands and regulatory problems or disturbances. However, as discussed in chapter 5, several aspects may have biased the results.

6.5 Change strategy

The decision to start a change towards a socio-technical type of design was followed by various change actions classified in an incubation, preparation, start-up and consolidation phase (chapter 3). Figure 6.8 contains an outline of the main change actions of Maas & Waal, based upon the researcher’s interpretation of document study, observations and interviewing, which was confirmed by the management of Maas & Waal.

Figure 6.8 Historical reconstruction of the reorganisation of Maas & Waal

The **incubation phase** started around 2006 when the management of Maas & Waal consulted an external expert to conduct an analysis of the organisation's architecture. The expert found that Maas & Waal was complex and mainly focused on quality and efficiency. He furthermore concluded that the bureaucratic organisation could no longer meet external requirements. Its turbulent environment required an architecture which not only featured quality and efficiency, but also encouraged innovation and flexibility. As stated earlier, the Executive Board of the overall organisation presented its changing strategic direction for the period 2008-2012 in the report "*Tussen publiek domein en markt*". Another report, entitled "*Beweging naar de toekomst*", analysed the environment of Maas & Waal and evaluated its point of departure. It also included an overview of the socio-technical type of design.

The **preparation and start-up phase** started in 2007 with an intensive leadership reinforcement programme with the purpose of teaching the employees about the principles of the socio-technical design. This programme was developed by the management to create awareness among employees about the socio-technical 'philosophy' and to reinforce their skills and motivation to participate in the process of team development. It consisted of six meetings over 2007, in which employees worked on various themes including team development, personal development and coaching. These meetings were guided by an external consultant and representatives of the management team. The programme was practically oriented: employees immediately applied their acquired skills and competences to their everyday work. Furthermore, it emphasised the close involvement of employees in the change process. The management considered their participation indispensable for an effective change. The composition of teams was therefore also part of the programme.

In 2008, the management of Maas & Waal published the report "*Beweging naar de toekomst*". Whereas the strategic report "*Tussen publiek domein en markt*" did not use explicitly socio-technical language, the document "*Beweging naar de toekomst*" was written from a socio-technical perspective. However, it did not contain much information on how to move towards the socio-technical type of design. It only described the change process as a developmental process which could only be broadly defined beforehand and required an organic approach. The management of Maas & Waal adhered to an approach based on designing the 'rough structure', thereby taking into account the organisation as a whole. Following a bottom-up approach, this rough structure was further developed into a 'fine structure'.

The management of Maas & Waal distinguished four guiding principles for the change process. The first principle was to clearly communicate with employees on the necessity and consequences of the change, and the way in which the reorganisation could be accomplished. Both written and oral communication was used in a formal and

informal way. Interviewees indicated that the star role model played an important role in the communication between the management and the teams (see also section 6.6). Second, the management sought to encourage the employees of Maas & Waal to participate in the change process. It also aimed to carefully inform its clients about the envisaged change actions. A third principle was to create an environment in which the employees could learn by changing. The importance of 'changing together' and learning by doing was emphasised all the time. Finally, it was the management's intention to continuously set and evaluate objectives on the basis of pre-set performance requirements.

After preparing its employees, the management considered the introduction of self-organising teams the essential next step. The team-based concept was introduced in three phases representing three different situations (Figure 6.9). The reason for this gradual approach was a step-by-step reduction of complexity by parallelisation. The objective was to homogenise input flows of the primary process by categorising various client needs (input) and to organise input variety in different input flows. In addition, the management decided to parallelise input flows for two other reasons. First, it sought to improve the efficiency of low-complexity care provision which was expected to increase the financial result of the overall organisation by €1.1 million. Second, it took measures to prevent employees with lower qualifications from being 'disturbed' or overloaded with high-complexity care issues which can only be dealt with by professionals with higher qualifications.

The introduction of self-organising teams for low-complexity, medium-complexity and high-complexity care started in 2008. This is the left-hand model in Figure 6.9, which refers to the team-based concept before parallelisation. As the figure shows, only a single type of team was responsible for the provision of low-complexity, medium-complexity and high-complexity care for all different types of clients. Each team consisted of professionals of all function levels to address all different care needs.

However, this type of team appeared too complex. Therefore, it was decided in 2010 to separate the teams into (1) teams for low-complexity care provision and (2) teams for medium-complexity and high-complexity care provision (see the model in the middle of Figure 6.9). The objective of splitting of teams was to simplify the team-based structure and reduce internal complexity. In the view of the management low-complexity care needs were significantly different from medium-complexity and high-complexity care needs. By separating care flows, it sought to minimise disturbances originating in one care flow and affecting the other.

In 2011 there was a further parallelisation of order flows: the teams for medium-complexity and high-complexity care were split into three types of teams: (1) teams for

low-complexity care, (2) teams for medium-complexity care and (3) teams for high-complexity care (see the right-hand model in Figure 6.9). The management’s objective was to reinforce the position of nurses by this step. Documents show that nurses were not sufficiently able to accomplish their key role in the initial team-based concept, because they were unnecessarily burdened with disturbances related to lower-complexity care. A consequence of the reduction of complexity by parallelisation was that clients who needed each of type of care could be visited by three different teams. To avoid this adverse consequence, it was the organisation’s policy to bring these clients under the responsibility of a high-complexity care team only.

Figure 6.9 Reducing complexity within the Maas & Waal area by parallelisation

The *consolidation phase* started around 2013 with the publication of the Executive Board’s new strategic report, entitled “*Vertrouwen in eigen kunnen*”. To encourage the provision of demand-driven care in co-creation with the key partners, the team-based concept was further refined. Policy documents describe the gradual transition from managing the teams to supporting them. At the start of the transition, the management was still responsible for regulatory tasks which could not yet be

accomplished by the teams. However, teams had gradually become responsible for the regulatory tasks categorised under the five star roles.

Based on our reconstruction of the change process, we draw the following conclusions regarding the change strategy of Maas & Waal. First, the results suggest that the management intended to proactively anticipate its changing environment, rather than reactively correcting for negative events in the past. No indications were found of a turbulent historical context as the initiator of the decision to change (as was the case in Klein Zwitserland). Instead, the management's objective was to prepare the organisation for the future. Second, the management seemed to be aware of the socio-technical principles underlying the change to the team-based design. For instance, the document "*Beweging naar de toekomst*" contained a lot of socio-technical language. The management was also aware of essential socio-technical principles such as the required team size of 8-12 people and the assumption that all activities related to the primary process must be performed as locally as possible. The step-by-step reduction of complexity by parallelisation also meets the principles of socio-technical redesign. Third, the management invested significantly in the participation of employees, particularly during the preparation and start-up phase of the change process. It considered the involvement of employees indispensable for realising an effective change and invested in team development by means of the star role model. For this purpose, the management invested in a one-year programme to prepare the employees for their new roles and responsibilities. The focus was on learning by doing to convince the employees of the need for change and get their commitment.

6.6 The employees' perception

The employees' perception is evaluated in terms of four factors: history of the case, conditions for change, system world versus life world and external influences. These factors not only give an indication of how employees perceive the change process and its results, but can also be seen as factors influencing both the change strategy and its results (see chapter 3). Our observations are mainly based on interview quotes.

6.6.1 History of the case

History of the case refers to the role of organisational history in relation to its current and future functioning. The case study gives the following results.

The history of Maas & Waal does not have a negative influence on the organisation today

Documents of Maas & Waal do not contain any information on turbulent periods in the past such as periods of inadequate management or financial trouble. Nor do they speak

of a difficult merger process (Maas & Waal is the result of a merger between three residential care organisations and two homecare organisations in 2000). Interviewees give a similar picture. They indicate that the organisation faced numerous changes in the past. However, they do not report any significant negative influence of these changes on current organisational functioning.

"I have been working in the organisation for almost seven years now. Looking back on these years, I remember several past changes and developments. At the start of my career we worked with planning boards on the wall and we were in another building. We only had a few teams covering the whole region. Later on, teams were assigned to several subareas and the planning became digital. Recently, teams have been organised on the basis of the function levels of the employees, which means that we have three types of teams now. Although the changes were numerous, I think not all changes were negative and positive changes can surely be noticed too." (level-3IG homecare professional 1)

"I have been working in the organisation for several years now. In general, I think there were quite a lot of changes. The initial phase of a change often involved quite some unrest, which I also experienced myself. However, for the majority of changes, I could see the benefits after the initial phase was over." (nurse 1)

Nor does the history of Maas & Waal have a positive influence on the organisation today

Although employees suggest that past changes do not have a negative influence on the organisation today, nor do they indicate a positive influence. Interestingly, when asked about the influence of history, employees often raise *other* aspects such as their private situation, age and computer skills.

"During the past ten years, we faced numerous changes. I think not every change was a bad change, despite some less successful changes. I think the strength of our organisation is that it always tries to become better off by changes. In doing so, it depends significantly on people's openness and willingness to change. Coping with all the changes was not that difficult for me. However, there were employees who thought differently, but I think the group of people who were reluctant to change represented a small minority. We should not forget that the private situation could play a role too, as well as the fact that we have quite of large group of older employees and people who are afraid of working with computers." (level-3IG homecare professional 1)

The change process is affected by 'change fatigue'

Change fatigue originates from past changes which employees consider unsuccessful. Although employees do not speak about unsuccessful changes, they refer to '*the large*

number of changes' and 'the high pace of implementing these changes'. They often experience difficulties in discussing and processing the changes in their teams, because this usually takes place after dealing with care-related issues.

"I think 'change fatigue' has played an important role during the years I have been working in the organisation. I think this is not only my personal opinion, but also reflects the view of my team members and colleagues from other teams. We face a large number of changes and developments which should be discussed and processed. I think most of these changes are not bad in themselves, but the way in which they are dealt with is often ineffective. Usually, we discuss and process all changes during team meetings. However, since we already have to address so many client-related issues during these meetings, in-depth discussions about changes and their possible consequences often do not take place." (nurse 1)

6.6.2 Conditions for change

Conditions for change refer to those conditions which are essential to realise effective change. A distinction is made between staffing, structural, technological and cultural conditions.

Staffing conditions

With regard to staffing conditions, the case study yields the following results.

Homecare professionals are able to work according to the requirements of the team-based design

The team-based design requires employees who are able to perform a variety of tasks and responsibilities in addition to their caring tasks. Furthermore, employees must have a flexible attitude. The interviewed employees of Maas & Waal do not indicate any significant problems regarding the ability to work in self-organising teams. They argue that self-organising teams are a better alternative in home care than the traditional way of organising. They also refer to investments by their management to enhance employee participation and team development. Interestingly, however, some employees relate the ability to work in self-organising teams to team size and warn about the vulnerability of small teams.

"I think the majority of caregivers are able to work in self-organising teams. Professionals like the small-scale character of the team-based design, because we are now better able to listen to our clients and anticipate their wishes. I think the management of our organisation invested a lot in the participation of employees and the development of teams, which prepared us for working in teams. However, the present situation in which my team has quite a few absentees and a lack of flexi workers makes us vulnerable. Particularly with the

spring and summer holidays coming, I expect problems regarding staffing. Having only a few people in the team means that we should all be very flexible. This is often not possible for a long period, because people have the right to go on holiday and even need to do so to stay healthy. However, I don't think increasing the size of our team is a good idea, because it will cause other problems. Perhaps a better idea would be to increase the number of flexi workers." (nurse 2)

Many employees seem to be willing to work in self-organising teams and convince others of the benefits of the team-based concept

Employees suggest that there are sufficient proponents of team-based working within Maas & Waal who see the benefits of it and are motivated to convince others of the necessity of changing towards self-organising teams. They indicate that people are in general willing to work in teams. By willingness, they refer to the extent to which employees prefer team-based working over the traditional way.

"I think the number of employees who are willing to work in self-organising teams is sufficient in our organisation. Furthermore, I think there is a good balance between highly and less educated professionals. In my opinion, there are sufficient highly educated colleagues to take the lead and support us." (level-3IG homecare professional 1)

"I think there are enough colleagues who try to convince others about the benefits of all changes. They try to prevent less convinced people from thinking in a negative, vicious circle. These positive thinkers are not necessarily people in a star role. I also have colleagues who do not officially fulfil a star role, but are trying to push the change through. At the same time, I also see colleagues in star roles who could make a little bit more effort to spread the necessity of changing." (nurse 1)

There tends to be no relation between the level of education of employees and their ability and willingness to work in self-organising teams

Interestingly, the interviewed employees indicate that more highly educated employees are not more able and more willing to work in self-organising teams than employees with lower education. Instead, they assume that other aspects are more important, such as personality, character, their private situation and general commitment to work.

"I think the ability and willingness to work in self-organising teams is not necessarily higher for more highly educated professionals. For instance, in our team I work with an older level-3 colleague who is perfectly able to bear the responsibilities of even level-4 and level-5 professionals. I think this has mainly to do with personality and character." (nurse 1)

"Nowadays, we have three types of self-organising teams. Although I regularly see that the low-complexity care teams need to be assisted more often, I do not think only highly-educated people are able to work in self-organising teams. My experience is that other aspects may be much more important, such as the private situation of an employee, which should enable her to be flexible. Furthermore, someone's character and commitment to work are important." (nurse 2)

Structural conditions

With regard to structural conditions, the case study provides the following results.

The teams of Maas & Waal meet the ideal team size of 8-12 people and employees mostly consider this a good team size

A team size of 8-12 people is recommended for effective self-organising teams (chapter 3). Whereas the teams of Maas & Waal meet the ideal team size, employees stress their vulnerability when employees go on holiday or drop out due to illness. They suggest that the teams are primarily responsible for dealing with these circumstances. Only when colleagues fall ill for a long time can teams receive support from flexi workers.

"I think the teams have a good size given the areas in which we operate and the number of clients. However, among the eight professionals in my team we currently have three who are chronically ill. This puts a great deal of pressure on the team, since we primarily have to fix the absence of colleagues ourselves. Fortunately, we sometimes get support from flexi workers who work on the basis of a zero hours contract. Despite the pressing situation in my team, I don't think the teams are too small. I actually think the situation in our team is quite exceptional." (nurse 1)

"My team consists of eight people, which is sometimes undesirable. For instance, when a colleague goes on holiday and another one falls ill, we have serious problems in ensuring continuity of care for our clients. In my team, there are only two colleagues with a 24-hour contract. I think we would be unable to guarantee continuity of care if both colleagues were to drop out simultaneously. Nevertheless, the small team size also has advantages. Clients can be served by only a few professionals. Furthermore, everyone in the team is encouraged to take responsibility for the team and a small team enables short lines and good communication between colleagues." (level-3IG homecare professional 1)

The composition of the teams of Maas & Waal has a positive influence on team atmosphere, but the separation of high-complexity from medium-complexity care provision is often not preferred by professionals

Interviews and observations suggest that most teams have an effective team atmosphere which is encouraged by people who are used to giving and receiving feedback openly and speak openly with colleagues about their thoughts and opinions. Furthermore, employees indicate that the teams in general have enough people who want to make that extra effort necessary to optimise team atmosphere. However, they also suggest that the heavy workload and flexibility requirements under the team-based design may influence team atmosphere in a negative way.

"In general, we have a good team atmosphere and everyone is willing to make that extra effort to let the team flourish. In the past, team atmosphere was negatively affected by the heavy workload which caused everyone to run out of steam. The heavy workload was mainly the result of all the changes we had to get used to. Fortunately, we talked about it openly, which was very beneficial for the team atmosphere." (nurse 1)

The team-based concept in Maas & Waal distinguishes three types of teams: low-complexity, medium-complexity and high-complexity care teams (see section 6.5). Employees from medium-complexity care teams dislike the fact that high-complexity care has been fully transferred to high-complexity care teams. They indicate that transferring high-complexity care means that they could no longer perform high-complexity care interventions, while they say they are sufficiently qualified to provide these interventions. Furthermore, they argue that the separation of teams increases the need for communication and coordination between teams, which increases complexity instead of reducing it. Finally, they assume disadvantages for clients, because clients may have to switch between different types of teams due to changing care needs.

"I think the separation of high-complexity care teams from medium-complexity care teams is not successful for three reasons. First, I notice that with the separation of level-4 and level-5 nurses into high-complexity care teams the majority of complex care is delegated to high-complexity care teams. As a level-3 professional working in a medium-complexity care team, I can no longer perform high-complexity care interventions, because these are all provided by the high-complexity care teams. Second, I notice that the separation increases the need for communication between teams because we often have to discuss care-related issues with nurses who are no longer part of our own team. Third, clients sometimes switch between different teams, especially when they are in need of all different types of care. This involves an increased administrative burden and negatively affects continuity of care." (level-3IG homecare professional 1)

Teams have a high level of regulatory capacity but the star role 'external relations and PR' is sometimes neglected

Self-organising teams have received sufficient regulatory capacity with the development of the star role model. Employees suggest that the teams have indeed become responsible for most tasks and responsibilities indicated by this model. However, they also argue that the star role 'external relations and PR' is somewhat neglected:

"I have never heard about five or six star roles. As far as I know, most teams in practice only have three star roles: 'team affairs', 'quality' and 'planning and scheduling'. Right from the start of team-based working, my team has worked on the basis of these three star roles and we have never had a star role in 'external relations and PR'." (informal conversation with a level-3IG homecare professional)

Technological conditions

Technology is important in the socio-technical design to support the organisation's primary process (chapter 3). The case study gives the following results.

Employees indicate that the organisation invests sufficiently in technology to improve quality of care for clients

Interviews suggest that the management of Maas & Waal invests in technological devices to improve quality of care for its clients. Documents also describe several technological innovations such as communicating with clients remotely by using iPads. Furthermore, Maas & Waal established a department for technology in 2006 to integrate technology within care and living facilities to enable clients to stay in their own environment as long as possible.

"The computer has become increasingly important and I cannot imagine homecare provision without a computer anymore. Currently, we even provide patient care digitally by giving clients an iPad which is used for the provision of e-health. For instance, several diabetes clients who regularly have to inject insulin receive care remotely, which means that we digitally check if a particular client injects the right amount of insulin at the right time. When we started e-health, I was afraid of losing my job. However, now I mainly see advantages, not only for the organisation in terms of cost savings, but also for our clients who are discovering a whole new digital world!" (nurse 1)

Employees suggest that the organisation invests insufficiently in technology to improve their quality of work

Employees indicate that the management of Maas & Waal prefers the use of technology to improve quality of care for its clients over the provision of technological devices for its employees. In their view Maas & Waal seems to value its clients more than its employees. Clients receive iPads for e-health, while they still have to go on the road with their private phones. Furthermore, they refer to an insufficient number of computers at the district office and difficulties regarding working from home.

"It is very unfortunate that the organisation does not provide us with smartphones. The organisation invests large sums in technology to improve the quality of care for clients. However, we still have to go on the road with our private telephones. This sometimes leads to suboptimal situations, because not every colleague has a smartphone available. I always need to write down the planning in advance, which is not really an issue. However, when something changes in the planning I usually need to go back to the district office to check the new schedule. Furthermore, the completion of registration activities would be much easier if we had a smartphone." (informal conversation with a homecare professional)

"I think the number of computers at the district office is insufficient. That's why we recently started a pilot to experiment with working from home. Although I believe in working from home and the pilot is still in the preliminary phase, it should be noted that working from home is not that easy. We should have access to the G-drive from home in order to accomplish administrative tasks. However, the organisation does not allow this, to ensure the privacy of our clients. So actually I can only read and answer emails from home, and for client-related issues I still need to be at the office. Consequently, I often have to fight for a computer. Especially on Tuesdays and Thursdays it is very busy and most computers are occupied. That's why I try to do my administrative tasks on Wednesday and Friday as much as possible." (nurse 1)

The level of technology embeddedness depends on the age of technology users and the provision of training and education

Interviewees experience a gap between younger and older employees regarding technology. They indicate that younger employees have fewer difficulties in internalising technological changes and are often more open to technological innovations. However, they also argue that this gap is increasingly being bridged by younger professionals who assist older colleagues. Furthermore, they emphasise the importance of training and education to internalise technology.

"With regard to technology, I notice a gap between younger and older workers. The younger ones internalise and accept technology more easily and the older ones sometimes experience real problems. However, I have the feeling that this gap is already being bridged because younger colleagues are trying to help the older ones." (nurse 1)

"I have quite a few older colleagues who are not really used to working with computers and smartphones. This means that only providing devices will not be enough. In addition, the organisation should provide effective and tailor-made training programmes especially for older employees." (informal conversation with a homecare professional).

Cultural conditions

With regard to cultural conditions, the results of the case study are as follows:

Employees find that working in self-organising teams requires a high degree of flexibility and involves a high workload

Employees indicate that working in self-organising teams requires a very flexible attitude. Numerous additional tasks and responsibilities have to be accomplished by rather small teams of homecare professionals. Although many employees indicate that they prefer team-based working over traditional homecare provision, they regularly experience a disturbed work-life balance due to increased administrative tasks and the feeling of being obliged to be available for the team at all times. They also argue that not everyone in the team has the same flexible attitude, which may frustrate collaboration among team members and increase pressure on others.

"Although I think we should be flexible nowadays, not every colleague has the same flexible attitude. However, I agree that it is also important to have a good work-life balance. In my situation it is perhaps not that difficult to achieve a good work-life balance, since my husband is unemployed and mainly takes responsibility for housekeeping. Although I know that not every colleague is in such a position, I think we will not get far by having an inflexible attitude. Ideally, working in self-organising teams requires all colleagues to be as flexible as possible without jeopardising their work-life balance. This would make our work pleasant for everyone and prevent crooked faces." (nurse 1)

"Working in teams requires us to be very flexible. Since I only have a 20-hour contract, I frequently have to work for six days in a row because homecare provision is usually concentrated at specific hours of the day. In addition, I am busy reading and answering emails from home and doing administrative tasks. I know that my work requires flexibility anyway, but it gets too much sometimes." (level-3IG homecare professional 1)

Employees indicate that team-based working involves a high workload. They appreciate the increased autonomy of working in teams. However, they argue at the same time that the high workload is often not in accordance with their contract hours and may even have negative consequences for the quality of care for clients.

“Working in self-organising teams involves a high workload and puts real pressure on me. Despite my 15-hour contract, I fulfil the ‘team affairs’ star role, which means that I feel responsible for keeping the team together and taking the lead in dealing with all team-related issues. This is quite a challenging task and means that I usually have to work for more than 15 hours a week. Furthermore, there is the risk of administrative tasks being accomplished at the expense of care provision for our clients.” (informal conversation with a homecare professional)

Employees consider team atmosphere a precondition for effective self-organising teams

Employees suggest that team atmosphere is very important to be successful as a self-organising team. They indicate the importance of putting the right people together on the basis of their personalities and characters. Teams are primarily responsible for team atmosphere and transferring employees to other teams is only considered when there are no options left, because it might create much unrest among team members. Observations suggest that an optimal team atmosphere requires team members who have similar and compatible views on self-organisation and simultaneously bring in enough diversity to accomplish the variety of tasks and responsibilities.

“Team atmosphere is crucial. In the past, I had two colleagues who were talking all the time during team meetings and did not leave any room for others to talk and bring in important issues. The dominance of the two people negatively affected team atmosphere and even caused tensions among team members. Fortunately, both people are not working in my team anymore and since they left the team atmosphere has significantly improved. I think it is a real challenge to put the right people together given different personalities and characters. Furthermore, I think that team atmosphere also requires an intensive process of team development.” (nurse 2)

“Team atmosphere is very important for being successful as a self-organising team. I think a good team atmosphere means that there is enough space for giving and receiving feedback openly. Everyone in the team should be honest and behave in an open way. It should also be possible to speak to colleagues about their actions and thoughts without any barrier. A team sometimes contains one or two people who are rather negative and frustrated. These people may cause a lot of unrest in the team, which negatively affects team atmosphere.” (nurse 1)

The functioning of Maas & Waal seems not to be hindered by acquired ‘vested rights’ and habits from the past

Employees indicate that acquired ‘vested rights’ and habits from the past do not cause any problems. They argue that it is still possible to have fixed days off after the introduction of self-organising teams, because the small teams involve good relationships between team members and team members have a lot of influence on scheduling. The collegiality and cooperation between team members make it possible to create a schedule that meets everyone’s needs and desires. However, employees in a team with relatively few clients sometimes face difficulties in scheduling, because they have to work for shorter times but with more shifts to accomplish their contract hours.

“In our team, it is still possible to have fixed days off regardless of the flexibility required to work in self-organising teams. We have quite a lot of influence on our schedule, which makes it easier to create a schedule that meets all needs and desires without neglecting the interests of the team. However, at this moment, it is quite a challenge to create the optimal schedule, because we only have a few clients to care for. This means that we have shorter but more frequent shifts, making it more difficult to keep free days off.” (level-3IG homecare professional 1)

6.6.3 System world versus life world

The *system world versus life world* refers to the extent to which the system world infiltrates and undermines the life world (see chapter 3). The case study provides the following results.

Homecare professionals increasingly face a system world infiltrating the life world

The results of interviews and observations suggest that homecare professionals are increasingly confronted with (external) rules and regulations determining their work. Whereas home care was initially provided on the basis of professional expertise, it is increasingly determined by ‘hard’ system aspects (e.g. regulations, guidelines, protocols) in uniform homecare provision. Employees agree that the infiltration of the system world makes their work less challenging and meaningful. They also emphasise that each client situation is unique, which actually contradicts standardisation.

“When I started working as a nurse, homecare provision had a small-scale character and was based on the insight and autonomy of professionals. However, over the years the homecare sector has grown bigger and has become highly standardised due to numerous protocols and regulations. I think all the rules and regulations severely diminish the meaningfulness and quality of our work. Whereas I welcome the team-based concept to revalue the autonomy of

professionals by means of self-organisation, I do not think it will become like the old times again.” (informal conversation with a homecare professional)

Homecare professionals respond to the infiltrating system world by defending the interests of clients without ignoring the fact that homecare is a public service

Employees tend to respond to the infiltrating system world by defending the interests of their clients, but without ignoring the fact that home care should be available to those people who are in need of it. No significant indications were found of employees disassociating themselves from their organisation.

“We have a client who has suffered from rheumatism for several years now. She lives in one of the upper floors of a building which has all mailboxes on the ground floor. In the past, we picked up the newspaper from her mailbox every day, because she cannot open the mailbox herself anymore. However, for some time now, we have decided not to pick up her newspaper anymore, because her allocation has been tightened and there is no time left for emptying her mailbox. Her first reaction was one of frustration and anger, because she considered our decision unacceptable. However, we made our decision very carefully and our most important argument was that she still has a social network available while other clients do not have social contacts anymore and are more in need of home care.” (nurse 1)

Homecare professionals sometimes create an informal organisation to defend the interests of their clients

Employees may create an information organisation to circumvent rules and regulations in favour of their clients and to respond to the dominance of the system world. On the basis of their professional insight, they develop their own informal policies in accordance with client needs:

“In principle, we are expected to provide homecare according to the allocation decisions as determined by the CIZ. The allocation decision prescribes the services that should be provided as well as the time involved for providing them. However, allocation decisions often do not match reality, which means some clients actually get more time than allocated, while others receive less care than they need. I think this is unfair. Therefore, in our team we try to be flexible with regard to allocation decisions in favour of clients with a tight allocation. This may involve ‘stealing’ time from clients with a broader indication, which I think is acceptable as long as clients do not have to pay out of their own pocket and their quality of care is not negatively affected. Eventually, I think everyone will benefit from our ‘illegal’ decision, which means that our goal has been reached by letting our caring heart prevail over the multitude of rules and regulations.” (nurse 1)

6.6.4 External influences

External influences refer to the extent to which the external environment influences homecare provision. The case study gives the following results.

Employees perceive a strong influence from the external environment mainly in terms of government interference

Interviews and observations suggest that employees increasingly have to deal with external influences such as a large number of rules and regulations, standardised needs assessment procedures, ever more bureaucracy, budget cuts and so on. These influences signify the increasing dominance of the system world over the life world. Employees consider the team-based concept as an attempt by Maas & Waal to deal with these developments.

“The homecare sector is highly affected by external influences. For instance, I think the separation of high-complexity care teams from medium-complexity care teams is a direct result of government regulations regarding the AWBZ. I think the organisation aims to anticipate these regulations by separating the teams. In general, external developments have a huge impact on our work, because they involve a lot of uncertainty, particularly because they are continuously changing.” (informal conversation with a homecare professional)

The significant influence of government regulations is perceived as negative by the employees

Employees associate increasing government influence with negative consequences for homecare provision. They mainly refer to budget cuts which negatively affect the quality of home care and the quality of their work.

“I think most external developments and regulations jeopardise the quality of homecare provision and the quality of our work. We are required to provide the same care in less time and with less money, which I consider unacceptable. Since a few years ago, the indications have been tightened, which means we have to do the same, or even more, with less. If this development continues, which I do expect, the quality of home care will decrease to a level which is no longer acceptable.” (informal conversation with a homecare professional)

Homecare professionals feel unable to anticipate external influences, but must increasingly explain the consequences of government regulations to clients

Employees indicate that the management is aware of major external developments and regularly informs the employees of their consequences. They have confidence in their management and expect managers to make the right choices in responding to external

influences. Employees say they have hardly any possibility to deal with external developments.

"I think the organisation is aware of major developments in its environment. I remember a large meeting with the overall director of the organisation almost a year ago in which the most important developments and their implications for our work were explained clearly. I consider such meetings really valuable because it helps me to understand the consequences of external developments and it strengthens my confidence that the management is doing the right things."
(nurse 1)

6.6.5 Synthesis

Figure 6.10 represents the employees’ perception of the reorganisation of Maas & Waal. It indicates for each of the four factors whether the influence on the change process and results was perceived as positive or negative by the employees as well as the strength of the influence. It gives the estimation by the researcher based on the aforementioned observations.

Figure 6.10 The employees’ perception

As Figure 6.10 highlights, our results suggest that the history of the case had a slight negative influence on the change process and results of the change. Although no indications were found of a turbulent historical context of Maas & Waal, employees expressed feelings of change fatigue because of the large number of changes and the high pace of implementing them. The results indicate that the conditions for change were largely present with the exception of the use of technology, which has lagged

behind. They also disliked the splitting of teams and experienced a very high level of flexibility and workload required to work in self-organising teams. As for system world versus life world, the results of interviews and observations indicate that Maas & Waal struggled with a significant infiltration of the system world into the life world. External influences in terms of government measures reinforced this infiltration. The employees suggest that these measures had severe consequences for their work and the future of home care.

6.7 Summary

This chapter contained the results of the case study of Maas & Waal. After an introduction to the case, we described the bureaucratic architecture at the point of departure of organisational change. We explained that the bureaucratic organisation involved shortcomings in dealing with external developments and a changing strategic direction of the Executive Board. It lacked client-centeredness and produced suboptimal organisational results. Next, we explored the socio-technical design as an objective to realign the internal design of Maas & Waal with its external environment. The management's objective was to create a structure based on local regulatory capacity and a culture that leaves sufficient room for professional autonomy. This objective gained a practical dimension in the team-based concept. On the basis of the star role model, self-organising teams were introduced and developed, which have become responsible for all activities of the primary process. Our observations suggest no significant discrepancy between the management's objectives and the results of the change. Furthermore, the estimation of quality of organisation indicates a trend towards flexibilisation. However, the results for quality of work show a negative picture, as the measured quality of work is less than the intended quality of work. The management of Maas & Waal adhered to a change strategy in accordance with the socio-technical principles and with a lot of attention devoted to the participation of employees. We explored the introduction of self-organising teams which followed three phases of parallelisation. The final part of the chapter evaluated the employees' perception of the change process and results, based on interviews supplemented with observations and document study. Employees expressed some feelings of change fatigue as a consequence of a multitude of changes in the past. They furthermore indicated that the conditions for change were largely present, except for the use of technology in their work, but emphasised that the team-based concept involved a heavy workload with high expectations in terms of flexibility. Finally, they argue that their work is increasingly confronted with a system world infiltrating the life world, and external influences mainly in terms of government policies. They refer to severe consequences of these developments for their work and homecare provision in future.

Chapter 7

Comparative analysis

7. Comparative analysis

This chapter presents a comparative analysis of the case studies of Klein Zwitserland and Maas & Waal. It focuses on internal factors, which are those factors that are specific to Klein Zwitserland and Maas & Waal respectively (chapter 1). The first part compares the results of the reorganisations of both cases, thereby focusing on objectives versus results, quality of organisation and quality of work. It also includes the employees' perception of the changes. The second part aims to explain differences in the results by concentrating on the change strategy of both organisations. Our focus on internal factors in this chapter does not mean that external factors are not important. As we will argue in chapter 8, provider organisations are squeezed by their bureaucratic external environment which hinders them in breaking their vicious circle of bureaucracy.

7.1 Results of the change: differences and similarities

The case studies of Klein Zwitserland and Maas & Waal suggest that Maas & Waal has come closer to the socio-technical type of design than Klein Zwitserland. They indicate differences between the two organisations in terms of the discrepancy between objectives and results, quality of organisation and quality of work. The employees' perception of the changes, which is also assumed to influence the change results, also suggests that Maas & Waal has come closer to the socio-technical type of design aspired to.

Objectives versus results

Both Klein Zwitserland and Maas & Waal intended to change to a socio-technical type of design, which involved interventions in the four pillars of the organisational temple: structure, culture, systems and people. We examined for both cases to what extent the management's objectives were in accordance with the actual results. Whereas our observations suggest a significant discrepancy between objectives and results in Klein Zwitserland, no indications of a significant discrepancy were found in Maas & Waal. As for *structure*, Klein Zwitserland had the intention to organise as many activities as possible locally based on the maximisation of regulatory capacity in self-organising teams. However, our results suggest that the main activities (planning and scheduling, monitoring of clients' indications, recruitment of new team members) were not organised locally in spite of the organisation's original intention. Maas & Waal also proposed to create an organisational structure based on as much local regulatory capacity as possible. Unlike Klein Zwitserland, our observations indicate that the aforementioned activities in Maas & Waal were indeed organised locally and employees said they were well prepared to accomplish these activities. With regard to *culture* and *people*, both Klein Zwitserland and Maas & Waal opted for an open and

flexible culture in which professional autonomy flourishes. Our observations suggest that the employees of Maas & Waal have been prepared for this new culture based upon an intensive one-year programme. They said they were aware of their new role in the team-based design. By contrast, Klein Zwitserland had great difficulty in abandoning bureaucratic cultures and internalising new roles and relationships. Also, no indications were found of an intense programme to prepare the employees for their new role. As for *systems*, the objective of Klein Zwitserland and Maas & Waal was to develop systems with the purpose of supporting the primary process. Whereas the documents of Maas & Waal were rather silent on the realisation of such systems, our results suggest that the systems within Klein Zwitserland still had a central orientation, with a regular focus on control.

Quality of organisation

Figure 7.1 compares Klein Zwitserland and Maas & Waal in terms of quality of organisation. It shows that Maas & Waal realised a stronger trend towards flexibilisation and so a stronger increase in quality of organisation. Our results suggest that centralisation, formalisation, standardisation and specialisation decreased within Maas & Waal, which indicates flexibilisation. Hierarchisation was assessed as highly decreased. Whereas the results for Klein Zwitserland also suggest a decrease in centralisation, standardisation and specialisation, formalisation was assessed as ‘unchanged’ and hierarchisation as ‘increased’. The neutral score for formalisation and the increase in hierarchisation indicate bureaucratisation instead of flexibilisation.

Figure 7.1 Comparing Klein Zwitserland and Maas & Waal in terms of quality of organisation

Quality of work

Table 7.1 compares Klein Zwitserland and Maas & Waal in terms of quality of work. In contrast to quality of organisation, it suggests a negative picture for both cases, with a small advantage for Klein Zwitserland. In both cases, the measured quality of work is less than the intended quality of work. Whereas Klein Zwitserland scores ‘better’ than the reference file in five dimensions (completeness of work, skills capabilities, qualification, organisational tasks and provision of information), Maas & Waal scores

‘better’ than the reference file in four dimensions (completeness of work, skills capabilities, qualification and organisational tasks). As for the other dimensions, both organisations have lower scores than the reference file. The scores which are ‘better’ than the reference file are similar for both cases, with the exception of provision of information. Furthermore, contrary to our expectations and other research findings, Klein Zwitserland in some respects scores better than Maas & Waal.

Table 7.1 Comparing Klein Zwitserland and Maas & Waal in terms of quality of work

Dimension	Reference file (mean)	Reference file (SD)	KZ (mean)	KZ (SD)	MW (mean)	MW (SD)
Completeness of work	0.53	0.22	0.30	0.20	0.36	0.19
Skills capabilities	0.14	0.23	0.03	0.09	0.03	0.10
Qualification	0.23	0.42	0.11	0.23	0.14	0.26
Short-cycled tasks	0.10	0.30	0.23	0.18	0.26	0.16
Degree of difficulty	0.76	0.26	0.78	0.25	0.83	0.22
Level of autonomy	0.27	0.26	0.41	0.28	0.53	0.26
Organisational tasks	0.31	0.31	0.07	0.14	0.11	0.18
Provision of information	0.28	0.24	0.20	0.14	0.28	0.16
Job demands	0.43	0.35	0.68	0.29	0.66	0.32
Regulatory problems	0.44	0.30	0.57	0.34	0.65	0.31
Emotional burden	0.18	0.21	0.77	0.17	0.78	0.15
Payment and job security	0.11	0.24	0.43	0.21	0.48	0.24
Time autonomy	0.47	0.32	0.57	0.35	0.61	0.29

There is no simple explanation for the NOVA-WEBA results. As outlined in chapter 5, several factors may have biased the NOVA-WEBA results. We must take into account that preferences of respondents may shift in the course of time. Respondents may become more critical and set higher standards as their organisation moves forward in the change process. Their perception may also be influenced by the turbulent historical context of the change process. As the NOVA-WEBA questionnaire was completed only once at one particular moment in time, we could not properly correct for these factors. Furthermore, although the questionnaire was adapted for use in accordance with the NOVA-WEBA user manual, respondents commented that questions were difficult to understand and often did not fit the context of home care.

The employees' perception

As explained in chapter 3, organisational change comprises an interconnectedness between the change strategy and the employees' perception of it. The change strategy followed by the management has consequences for the employees' perception of the change. However, the view and attitude of employees also has consequences for the change strategy. Furthermore, there is an important relationship between the change results and the employees' perception of the change. The perception of employees tells us something about the change results. At the same time, however, their perception is also an important factor in the change process itself. If employees are positive about

the change, their ‘positivism’ is expected to increase the probability of effective change. On the other hand, if they are negative, their ‘negativism’ will influence the change negatively.

Figure 7.2 compares Klein Zwitserland and Maas & Waal in terms of the employees’ perception of the change. It indicates for each of the four factors whether the influence on the change process and results was perceived as positive or negative as well as the strength of the influence.

Figure 7.2 Comparing Klein Zwitserland and Maas & Waal in terms of the employees’ perception of the change

In the view of the employees of Klein Zwitserland, the *history of the case* had a negative influence on the change process and its results. The influence of the historical context within Klein Zwitserland was profound: it caused structural distrust among employees. Fundamental change initiatives always cause distrust in organisations and employees may have negative experiences with changes in the past. A situation of structural distrust exists when the majority of employees do not see the benefits of any future change, which makes fundamental change difficult (Kuipers et al., 2010). The starting point of Klein Zwitserland was unfavourable. It almost went bankrupt and to secure its survival the management had to propose numerous unpopular measures including financial and staffing cuts. Although the organisation eventually survived, the difficult merger lowered the confidence of employees in their management. What is more, it

dented the breeding ground for fundamental change as employees expressed feelings of change fatigue and negativism about organisational decision-making. Change fatigue and negativism were dominant themes throughout the whole period of case study research. They reinforced the gap between the employees and the management, encouraged employees to do their own thing irrespective of management decision-making (informal organisation) and made fundamental organisational change more challenging. No such indications of a difficult merger or severe financial situation were found for Maas & Waal. Its employees only complained about the large number of changes in the past and the high pace of implementing them.

Our results also suggest differences with regard to the *conditions for change* (staffing, structural, technological and cultural conditions). Figure 7.2 shows that the results suggest a negative influence of these conditions in Klein Zwitserland, whereas they indicate a positive influence within Maas & Waal. Staffing conditions were sufficient within Maas & Waal. Employees indicated that they were able and willing to work in self-organising teams and support the socio-technical concept. Employees of Klein Zwitserland were more divided on the willingness to work in self-organising teams. As for structural conditions, both cases differ with regard to team size. Whereas the teams of Maas & Waal met the ideal team size of 8-12 people, the teams of Klein Zwitserland were larger, particularly at the start of team-based working. Furthermore, both organisations differ with regard to the extent to which teams have regulatory capacity. Whereas Maas & Waal assumed that all activities relating to the primary process must be performed as locally as possible, Klein Zwitserland only partially decentralised planning and scheduling as crucial elements of the primary process to the teams. With regard to technological conditions, employees of both organisations mentioned that their management invested sufficiently in the use of technology to improve quality of care for clients. However, employees of Maas & Waal stated their opinion that investments to encourage the use of technology by employees lagged behind. As for cultural conditions, employees of both organisations pointed to the high degree of flexibility required to work in teams. They stated that the required flexibility could disturb their work-life balance. Furthermore, they felt obliged to be available for the team at all times. Whereas acquired 'vested' rights (e.g. culture of exemptions, fixed days off, contractually fixed privileges) had a negative influence on the change process of Klein Zwitserland, we found no such indications in Maas & Waal.

Apart from differences there are similarities. As stated earlier, the assessment of quality of work indicates a negative picture for both cases. Furthermore, employees of both organisations experienced negative consequences of the infiltrating system world (see Figure 7.2). In this respect, they referred to external influences (e.g. a large number of rules and regulations, standardised needs assessment procedures, ever more bureaucracy, budget cuts) affecting their work negatively.

7.2 Towards an explanation

The differences in the change results of Klein Zwitserland and Maas & Waal will be explained by comparing the point of departure, the objective and change process of both cases. Our case studies indicate that the point of departure was similar for Klein Zwitserland and Maas & Waal, with the exception of the turbulent historical context of Klein Zwitserland. Both organisations had developed an architecture according to the principles of the bureaucratic design. Our results also suggest similarities in terms of the socio-technical type of design as the objective. Both Klein Zwitserland and Maas & Waal intended to introduce an architecture based on self-organising teams with the purpose of maximising local regulatory capacity and reducing complexity. As the point of departure and objective are in many respects similar for both organisations, explanations for the different results must be sought in the way in which both organisations intended to achieve the design they aspired to: the change process. As stated earlier, the way employees perceive the change tells us something about the change results. At the same time, however, their perception is also an important factor in the change process itself. If employees are positive about the change, their 'positivism' will increase the probability of successful change. By contrast, if they are 'negative', their 'negativism' is likely to influence the change negatively. The differences between Klein Zwitserland and Maas & Waal in employees' perception may be an explanation for the differences in the change results. Whereas the employees of both organisations were negative about the infiltrating system world and external influences in particular, the employees of Klein Zwitserland were more critical about the internal conditions for change including staffing, structural and cultural conditions. In addition, they were pessimistic about the probability of successful change due to the turbulent historical context of Klein Zwitserland. By contrast, no indications were found of such 'negativism' in Maas & Waal.

An important difference refers to the time perspective of the change process. Whereas the change process of Klein Zwitserland actually started around 2009, the change trajectory of Maas & Waal had already started in 2006, when the management consulted an external expert to conduct an analysis of the organisation's architecture. For this reason, Maas & Waal had more time to internalise changes.

Another difference between Klein Zwitserland and Maas & Waal relates to the change strategy followed by the management to bring about the intended change. As explained in chapter 3, the management is responsible for placing the change on the agenda and fulfilling a leading and inspiring role. It is also its responsibility to keep the change on track and, if necessary, take the right actions to redirect the change trajectory. However, organisational change should not be planned as a top-down exercise. It also requires the active participation of employees to get their commitment and fulfil the organisation's aspiration. In this respect, our results indicate differences

between the two organisations. Whereas the management of Maas & Waal invested a lot in the involvement of employees, particularly during the preparation and start-up phase of the change process, the management of Klein Zwitserland paid less attention to the participation of employees. The management of Maas & Waal seemed to be aware that its change strategy should embrace the involvement of its employees to build support for it. It considered the preparation of the employees for the team-based design and their new roles and responsibilities a necessity. For this purpose, the first year of the change process was entirely devoted to an intensive programme to convince the employees of the necessity to change, prepare them for team-based working and build their commitment to the change process. After the introduction of teams, the management also invested in team development by means of the star role model (chapter 6). It adhered to a bottom-up approach as much as possible, thereby focusing on learning by doing and assigning the employees the role of disseminating the change.

The management of Klein Zwitserland tended to adhere to a more top-down approach rather than a bottom-up approach to realise the change. In a multitude of documents, it gave a detailed description of a step-by-step implementation of the change. Unlike at Maas & Waal, no indications were found of an intensive programme to prepare the employees for the team-based concept and enhance their commitment to the change actions. Although employees said that newsletters and informative meetings were used to inform them about the change, they felt they were not really participating in the change process. In their view, informative meetings were often organised too late and with the purpose of informing the employees after decisions had already been taken. Furthermore, whereas Maas & Waal followed a learning approach by actively involving its employees in the change process, no indications were found of such an approach within Klein Zwitserland.

Our results also suggest a design-technical difference between Klein Zwitserland and Maas & Waal with regard to the extent of adherence to the principles underlying the socio-technical type of design. As explained in chapter 6, the management of Maas & Waal seemed to be very aware of the socio-technical principles and its documents contained much socio-technical language. It sought to apply essential socio-technical principles, including team size and the assumption that all activities related to the primary process must be performed as locally as possible. The step-by-step reduction of complexity by parallelisation was also in accordance with the socio-technical design philosophy. Whereas the management of Klein Zwitserland also considered the socio-technical principles a source of inspiration, it adhered much less strictly to these principles. Nor did its documents speak much socio-technical language. The management made the decision to introduce self-organising teams, but it did not respect the assumption that all activities related to the primary process should be

organised locally where possible. Furthermore, it neglected the importance of a proper team size: although it was scaled down in the course of time, teams continued to be larger than the ideal team size.

In addition to essential requirements with regard to team size and local regulatory capacity, socio-technical (re)design also assumes that a particular design sequence will be met. As explained in chapter 3, this design sequence involves a series of design steps to be followed in the right order to realise a socio-technical type of design. Whereas our results suggest that Maas & Waal designed its new architecture in accordance with this design sequence, Klein Zwitserland followed a different approach. Figure 7.3 visualises the design sequence of both organisations. As it shows, the management of Maas & Waal started the reorganisation with the design of the production structure from a macro perspective, which was followed by the design of the control structure in relation to the production structure. It started by homogenising order flows by parallelisation. It differentiated three types of order flows – low-complexity, medium-complexity and high-complexity care – and linked each type of order flow to a different type of team (chapter 6). The management also invested in the design of self-organising teams, thereby assuming that regulatory capacity must be located in the teams as much as possible to deal with all activities and disturbances related to the primary process. After the designing of teams, it allocated inter-local regulatory capacity to create alignment between teams, for instance with regard to the deployment of flexi workers. It also allocated global regulatory capacity to create uniformity on overall performance requirements.

Figure 7.3 Design sequence of Klein Zwitserland and Maas & Waal

The management of Klein Zwitserland did not adhere to the socio-technical design sequence. On the contrary, as Figure 7.3 highlights, it started from the perspective of the control structure, which violates the socio-technical principles and design sequence. It actually did not start from the perspective of the primary process. On the contrary, it decentralised or 'gave' some regulatory tasks to the teams by transferring them from the top of the organisation to the teams without creating a production structure first, followed by a control structure in relation to this production structure. Instead of assuming that *all* activities relating to the primary process should in principle be organised as locally as possible, it only made the teams responsible for part of the primary activities. For instance, planning and scheduling as crucial activities of the primary process were only partially delegated to the local level and the organisation continued to decide centrally on the monitoring of client indications.

In our view, the design-technical difference between Klein Zwitserland and Maas & Waal is a core explanation of our finding that Maas & Waal has come closer to the socio-technical type of design than Klein Zwitserland. The change towards a socio-technical type of design requires awareness of and adherence to the principles underlying it. The introduction of teams without following socio-technical design principles inevitably increases the risk of implementation failure. Furthermore, a socio-technical type of design requires a fundamental reconsideration of the organisation's entire architecture and cannot simply be realised by decentralising or 'giving' some regulatory capacity to the teams.

7.3 Summary

This chapter contained a comparative analysis of Klein Zwitserland and Maas & Waal. It started with a comparison of the change results in terms of the distance between objectives and results, quality of organisation and quality of work. Based on our results, we concluded that a discrepancy exists between the objectives and results in Klein Zwitserland. No indications were found of such a discrepancy in Maas & Waal. As for quality of organisation, we noticed that Maas & Waal realised a stronger trend towards flexibilisation and so a stronger increase in quality of organisation than Klein Zwitserland. Remarkably, the measured quality of work is less than the intended quality of work in both cases. Both Klein Zwitserland and Maas & Waal have lower scores than the reference file for most dimensions. With regard to the employees' perception of the change, we concluded that the respondents of Klein Zwitserland were much more critical of the history of the case and most of the conditions for change. Respondents in both cases were negative about the infiltrating system world and external influences.

The second part of the chapter was spent on finding explanations for the different change results. We concluded that explanations had to be sought in the change process

of both organisations, because their point of departure and objective were in many respects equal. We referred to a different time perspective of the change process, as the change trajectory of Maas & Waal had started much earlier. We also explored important differences in the change strategy: whereas the management of Maas & Waal invested in the participation of employees and team development, the management of Klein Zwitserland followed a more top-down approach. We finally addressed a fundamental design-technical difference between both organisations. Whereas Maas & Waal adhered to the principles underlying the socio-technical design, Klein Zwitserland only respected some of these principles and followed a managerial approach.

Chapter 8

The impact of the external world

8. The impact of the external world

The results of our case studies suggest that the external world heavily affects Klein Zwitserland and Maas & Waal in their change from a bureaucratic to a socio-technical type of organisation. Professionals face a system world that is infiltrating their life world. They are also increasingly confronted with external influences (e.g. a large number of rules and regulations, standardised needs assessment procedures, budget cuts) which they perceive as negative. The existence of external influences indicates *tensions*: whereas provider organisations take initiatives to change from a bureaucratic to a socio-technical type of design to better adapt to their external world, the influence of this world actually hinders their change to the alternative design.

This chapter discusses the influence of the external world upon the ability of provider organisations to accomplish the change to a socio-technical type of design. The assumption is that Klein Zwitserland and Maas & Waal are confronted with the same external influences, such as government-induced regulations, political influences and budget cuts. For this reason, we argue that external factors cannot explain the differences in the research findings. However, we realise that this is a simplification, because external contexts are never entirely similar. Both organisations have relations with different municipalities and care offices, and there may be differences in the local and regional care market, for instance with regard to the intensity of competition.

Our findings indicate that Maas & Waal has come closer to the socio-technical type of design than Klein Zwitserland (chapter 7), despite increasing external influences which are perceived as negative by its employees. At the same time, however, we argue that even Maas & Waal faces the risk of becoming locked in a *'double hold'*. They intend to break their internal vicious circle of bureaucracy while struggling with an environment also featuring the characteristics of a vicious circle of bureaucracy. The socio-technical design offers the principles for provider organisations to break the internal vicious circle of bureaucracy. However, we postulate that provider organisations can change to a 'full' socio-technical type of design on the condition that their environment provides them with sufficient room for manoeuvre and the flexibility required to realise such a change. Our claim is that the external world is based on the opposite principles. It contains more and more bureaucratic mechanisms for accountability to control the provision and funding of home care. These mechanisms are often the result of the government's tendency to interfere in home care with the purpose of preserving its public character. This tendency results in ever more accountability and control mechanisms and triggers an external vicious circle of bureaucracy in addition to the internal vicious circle of bureaucracy.

8.1 The public character of home care

In the Netherlands, home care is provided by private not-for-profit provider organisations (chapter 2). However, it has a public character and is associated with the public domain. Provider organisations are publicly funded and policy decisions on home care are taken in the public domain to safeguard its core values such as quality, accessibility and affordability. We argue that bureaucratisation of the homecare environment is rooted in the public character of home care. The public sector contains various characteristics differing from the private sector situation which elicit a control-based approach by the government.

An important difference concerns the existence of ‘automatic feedback mechanisms’ in the private sector which do not exist in the public sector. In the private sector the direct interplay between supply and demand determines the viability of organisations, as they are only viable if there is sufficient demand for their products and services and consumers are willing to pay for these at the market price. Organisations in the private sector are automatically rewarded for products and services of high quality offered at favourable market prices, and ‘punished’ if there is insufficient demand, if prices are too high or if services are of suboptimal quality. Lack of demand may eventually lead to their bankruptcy. In the public sector, there is no direct relation between supply and demand and automatic feedback mechanisms are lacking. A third party (e.g. health insurer, care office, municipality) pays the provider organisation for the services delivered. As a consequence, there is no direct relationship between consumption and payment and, therefore, no automatic feedback mechanism as exists in the market. The government seeks to monitor the performance of public sector organisations and to intervene when performance is substandard. It defines performance indicators to monitor performance of organisations and realise accountability for their actions (De Bruijn, 2007; Pollitt et al., 2008). Provider organisations in the Netherlands have been confronted with numerous performance indicators over time putting high pressure on them. For instance, they are obliged to participate in the Consumer Quality Index (CQ-index), which is an instrument of periodically measuring the quality of care from the clients’ perspective. They are also requested to conduct employee satisfaction surveys (e.g. *MedewerkerMonitor*) to show the satisfaction of their employees. Furthermore, they are encouraged to show their quality of care to the care offices which intend to reward those provider organisations that improve their quality of care in a transparent way. In addition, there are also numerous internal indicators in place regarding productivity, continuity of care, travel times, absenteeism, overhead, the number of protocols used and so on. According to Pollitt et al. (2008), the introduction of performance indicators is associated with a ‘logic of escalation’: the number of indicators multiplies, there is a shift from formative to summative indicators and funding is made dependent on performance indicators.

A related difference refers to the institutional environment which plays a more important role in the public sector than in the private sector. The government-induced measures to correct for the absence of automatic feedback mechanisms leads to an extensive institutional environment in the public sector. Kramer (2014) provides an interesting theoretical framework and explains that the environment of organisations can be divided into the institutional environment and the task environment (Meyer & Rowan, 1977; Tolbert & Zucker, 1983; Scott, 1987; Oliver, 1991; 1997). This is a relevant distinction, because the institutional environment contains the mechanisms to deal with the absence of automatic feedback mechanisms in the public sector. The *institutional environment* rests upon insights from the new institutionalism in organisational science (e.g. DiMaggio & Powell, 1983; Scott, 1987; 1995).³⁹ It involves the wider institutional context in which organisational behaviour is embedded and comprises the regulative framework within which organisations must operate. Organisations must comply with rules and regulations and deal with inspection from state agencies and supervisory bodies. Regulations must be internalised by organisations, even when they fit poorly in primary organisational activities (Meyer & Rowan, 1977; DiMaggio & Powell, 1983). Conformity to their institutional environment is crucial for organisations to survive, because the institutional environment provides them with essential resources such as funding, information and contacts (see next section). The *task environment* refers to the market where suppliers meet consumers and organisations compete with each other. It involves the effective and efficient control of organisations over their primary processes. Whereas adaptation to rules and regulations is crucial for survival in the institutional environment, survival in the task environment depends on the ability of organisations to allocate resources and to be one step ahead of their competitors (Oliver, 1997).

While organisations cope with both environments, Oliver (1997) claims that in most cases either the institutional or the task environment dominates, because organisations usually depend on either institutional relationships or task relationships. The interesting question is which environment dominates in care. Kramer concludes that the institutional environment dominates in health care, 'because organisations are largely dependent on laws, regulation, inspection and funding from government institutions. Of course healthcare providers are dependent on clients and need to manage their resources efficiently, but the task environment is less dominant than in commercial sectors' (Kramer, 2014, p. 119). Although we agree with Kramer's view, it should be noted that provider organisations also struggle with a task environment which has become more strenuous. They face the entry of new providers (chapter 2), because the assets for starting a provider organisation are low compared with complex

³⁹ Institutional theory focuses on the role of social influence and pressures on organisational behaviour and adaptation to the environment (DiMaggio & Powell, 1983; Scott, 1987; 1995).

care sectors such as hospital care. Consequently, they may experience fierce competition and many market changes. They must also take into account many other organisations, including other homecare provider organisations, care offices, health insurers, general practitioners and hospitals. In this complex network of actors each organisation also faces the influence of the institutional environment and may set its own requirements for other organisations.

Although home care is increasingly positioned in the market, we conclude that there are major differences with a 'real' market. To safeguard core values such as quality, accessibility and affordability, home care is surrounded by an extensive institutional environment. Provider organisations must consequently deal with many accountability and control mechanisms which create an ideal breeding ground for bureaucratisation.

8.2 Provider organisations in a 'double hold'

The socio-technical type of design offers the principles for provider organisations to break their internal vicious circle of bureaucracy. However, as stated earlier, they can break their vicious circle of bureaucracy when their environment does not impede them from doing so. Based on our results, we argue that the institutional homecare environment does not provide sufficient room for manoeuvre and flexibility to do so. On the contrary, it contains ever more bureaucratic mechanisms indicating that the environment is also in a vicious circle of bureaucracy. Provider organisations are consequently locked in a 'double hold': in addition to their internal vicious circle of bureaucracy, they are locked in an external vicious circle of bureaucracy.

Figure 8.1 highlights the external vicious circle of bureaucracy. To safeguard the public character of home care, the government tends to regulate and control the homecare system by initiating control mechanisms including laws and regulations, performance measurement and supervision and control. These control mechanisms put high pressure on provider organisations. They reinforce their internal vicious circle of bureaucracy, because provider organisations feel (and actually are) obliged to translate these external control requirements into internal control mechanisms. In this respect, they tend to intensify their focus on control by means of a further division and coordination of work. Eventually, they become structurally 'out-of-control', which increases the risk of problems and incidents in the limelight of public attention. These problems and incidents increase the need for interventions to prevent similar incidents in future. This almost naturally leads to a further intensification of control by the government in terms of extra regulations and accountability requirements. The external vicious circle of bureaucracy has started a new loop.

Figure 8.1 The external vicious circle of bureaucracy

The external vicious circle of bureaucracy produces numerous external influences affecting provider organisations. Figure 8.2 shows ‘the squeezing fist’ to visualise the influence of these external influences upon a provider organisation. Based on the perception of homecare professionals and our own observations, the hand symbolises the institutional environment which squeezes the provider organisation and limits its freedom to act. The figure distinguishes five types of external influences corresponding with the five fingers of the hand. These are: accountability, laws and regulations, politics, social perceptions and (restricted) budgets. Based on the results of our study, we argue that these are five common types of external influences affecting provider organisations. Although Figure 8.2 visualises a provider organisation being locked in its institutional environment, we assume that other actors in the field of homecare provision (e.g. municipalities, care offices, health insurers, general practitioners and hospitals) are similarly squeezed by their institutional environment.

Figure 8.2 “The squeezing fist”

As stated earlier, a provider organisation must deal with multiple performance measurement requirements and inspection and supervision to realise **accountability**. Accountability is based on the assumption that an organisation can show its performance by making its activities transparent (De Bruijn, 2007). It is expected to enhance the effectiveness, efficiency and legitimacy of its actions and involves the deep penetration of management techniques from industry into the public sector

organisation. It assumes that, like private enterprises, organisations in the public sector provide products and services and that their performance can be assessed. Accountability requires performance measurement by provider organisations and inspection and supervision by the government (or agencies that act on behalf of the government). Provider organisations must deal with numerous external performance indicators regarding quality of care, client satisfaction, absenteeism and so on. These indicators are supplemented with internal performance indicators selected by the provider organisation itself. Performance measurement is assumed to create transparency with regard to activities, results and costs. Proponents of performance measurement argue that it enhances the effectiveness, efficiency and transparency of public spending. Opponents, however, state that it neglects the nature of activities performed by organisations in the public sector (De Bruijn, 2007). For instance, whereas organisations in the public sector often provide services which are the result of co-production between several actors, performance measurement often reduces this complexity to a single dimension. It is also associated with increased bureaucracy in creating and maintaining a performance measurement system and coping with mechanisms for inspection and supervision (De Bruijn, 2007).⁴⁰

To stay viable, a provider organisation must take into account an increasing number of **laws and regulations**, for instance with regard to the financing and provision of home care. The development of the homecare system was accompanied by increased government interference in terms of laws and regulations to emphasise the public character of home care and safeguard its core values such as quality and solidarity (see chapter 2). Home care had become a right enshrined in legislation and therefore claimable. The government decided to replace the rights-based structure of home care provision with a provision-based approach in the Wmo (2007) (chapter 2). However, this decision has not resulted in fewer regulations and provider organisations have had to adapt to various new policies and regulations, including the recent introduction of the Long-Term Care Act (*Wet langdurige zorg – Wlz*). They have also had to internalise revisions of existing legislation, in particular the revision of the Wmo into the new Wmo 2015. By means of laws and regulations, the state sets the legislative framework within which provider organisations must operate. The implementation of legislation is left to the municipalities and health insurers (Van der Aa, Evers, Klosse & Maarse, 2014). The decentralisation of tasks and responsibilities has made municipalities responsible for various homecare services and the contracting of provider organisations to accomplish the provision of these services (chapter 2). Municipalities have a high degree of policy discretion on how to make this obligation concrete. They are free to determine their own criteria for needs assessment and care provision. Whereas some municipalities may develop a rather generous model, others may choose a restrictive model. As of

⁴⁰ For an extensive overview of the pros and cons of performance measurement see De Bruijn (2007).

2015, the coverage of services under the Zvw, in particular home nursing and personal care, involves a devolution of tasks and responsibilities to the health insurers. As the following example illustrates, new laws and regulations and revisions of existing legislation create much *uncertainty* for the actors in the field.

Long-term care reform goes too fast and creates too much uncertainty

Several actors in the healthcare sector, including municipalities, civil society organisations and scientific institutions, are concerned about the pace of current long-term care reforms. They expressed their concerns during a hearing in the Dutch Parliament. Representatives of the municipalities were divided on the decentralisation of tasks to the municipalities. Whereas they agreed on the idea behind the decentralisation of tasks to the local level, particularly small municipalities are concerned about the pace of change and major budget cuts in the short term. Employers' organisations and civil society organisations express major uncertainties on the effects of long-term care reform. Scientific institutions, such as the Netherlands Bureau for Economic Policy Analysis (Centraal Planbureau, CPB), could not predict the consequences of long-term care reform. The director of the CPB could only emphasise that long-term care provision under the AWBZ is complex.

Source: retrieved and freely translated from Zorgvisie Nederland (21 May 2013)

Provider organisations also face increasing influence of **politics**. In chapter 2, we explained that home care has gradually become part of the political domain. The political system has the tendency to focus on a malleable society in which failure is not tolerated (e.g. Frissen, 2013). The focus on this malleability elicits 'agitated' political behaviour: almost each incident prompts a political debate resulting in a further intensification of control to prevent similar incidents in future. Provider organisations are increasingly aware of the incident-driven character of politics and realise that any misstep may become a big political issue. Furthermore, incident-driven politics may lead to increased inspection and supervision. In addition to all this, provider organisations see themselves confronted with local politics and its inherent uncertainties (chapter 2).

Provider organisations must also deal with **social perceptions** on the part of 'the public'. They are often associated with large bureaucracies unable to meet the needs of their clients and regularly accused of providing poor-quality care. As the following example illustrates, the management of a provider organisation faces the risk of slipping on a banana skin all the time because any misstep may reach the media.

Almere provider organisation disregards the rules on quality of care

The Dutch provider organisation TCC Zorg in Almere (The Netherlands) has been ordered to stop the provision of home care. After reports from former employees, the Dutch Healthcare Inspectorate concluded that the organisation employs people who are not authorised and competent to provide homecare services. According to the Inspectorate, TCC Zorg does not meet any of the quality requirements. A report by the Inspectorate states that employees without any medical background give injections, help to flush out the bladder and give enemas. According to the Inspectorate, TCC Zorg also employs student nurses to carry out these risky activities, putting the lives of clients at risk. The Inspectorate furthermore concludes that the director of the organisation pretends to be a nurse, whereas he has no degree in nursing and is not registered as a nurse. The director denies that TCC Zorg provides care to clients. "We do not treat patients so whose lives are put at risk? We only provide medication." The Inspectorate has ordered the organisation to transfer its clients to other provider organisations in the region.

Source: retrieved and freely translated from Dutch Broadcast Foundation (NOS) (29 January 2015)

Finally, provider organisations are confronted with restricted **budgets**. As explained in chapter 2, the policy agenda with regard to long-term care has changed rapidly in the Netherlands. Whereas the government increased healthcare spending to reduce waiting lists around the year 2000, it nowadays proposes a reform of long-term care to safeguard its sustainability. Where possible, home care should replace expensive residential care. Whereas one would expect an increase in the capacity of home care organisations, the government is implementing significant expenditure cuts, many of which are targeted at home care (chapter 2).

To conclude, the squeezing fist shows that provider organisations are increasingly constrained by rules and regulations, political influences, negative social perceptions and budget cuts which are replacing the traditional values focused on confidence in and autonomy of professionals (e.g. Benson, 1973; Davies, 1983; Los, 1997). Or, according to the theory of Habermas (1981) as explored in chapter 3, the life world of professionals is increasingly being replaced by the system world as illustrated by the fingers of the squeezing fist. In our view, this is a worrying development, because a socio-technical type of design rests upon the autonomy of and confidence in professionals.

If we take a closer look into the homecare system, we get the impression of a system that is in a 'chaotic' state. The multitude of accountability requirements, rules and regulations, political influences, negative social perceptions and budget cuts suggests that the current system is no longer viable. The traditional way of homecare provision and financing has reached its growth limits. In the government's view the availability of a broad range of publicly funded services in its current form is no longer self-evident. As an alternative, society could consider adopting new ways of homecare provision and

financing with an emphasis on individual and social responsibility. According to chaordic systems thinking (see box below), the complex homecare system has reached a point of bifurcation at which it oscillates between old and new ways of thinking and doing. This point of bifurcation involves a turbulent period of confusions, contradictions and uncertainty which might precede the rise of a 'new' system (if possible at all) or 'death'.

8.3 How to get out of the ‘double hold’?

Up to this point, we have discussed how provider organisations are squeezed by their ‘chaotic’ environment which keeps them in a double hold. How could they get out of this double hold? On the basis of the results of our study, we conclude that neither Klein Zwitserland nor Maas & Waal accomplished the change to a ‘full’ socio-technical type of design. Even Maas & Waal, which largely met the internal conditions for organisational change (see chapter 7), has not (yet) achieved its objective. This conclusion may suggest that it is pointless for provider organisations to start a change at all, because the external vicious circle of bureaucracy makes it impossible to accomplish the change. However, we do not recommend the scenario of ‘doing nothing’, because any initiative to realise flexibilisation is a better alternative within a turbulent environment than maintaining the bureaucratic architecture. Provider organisations might increase their chances of survival by embracing ambidexterity, which refers to exploiting their current way of homecare provision while simultaneously exploring new ways of ‘doing business’ (see box below). In exploring new ways of homecare provision they should try to circumvent external influences as much as possible to avoid becoming locked in the external vicious circle of bureaucracy.

The concept of ambidexterity

Ambidexterity is presented in the literature as a mechanism that may help organisations to prevent their business from decline by choosing a new business model in a timely way while exploiting the existing one (Duncan, 1976; March, 1991; O’Reilly & Tushman, 2004; Gupta, Smith & Shalley, 2006; O’Reilly & Tushman, 2008). According to March (1991, p. 105), ‘the basic problem confronting an organisation is to engage in sufficient exploitation to ensure its current viability and, at the same time, to devote enough energy to exploration to ensure its future viability’. Ambidexterity thus entails two core mechanisms – exploitation and exploration – which should be pursued simultaneously by organisations operating in rapidly changing and turbulent environments (Tushman & O’Reilly, 1997). Exploitation essentially involves exploiting the current way of ‘doing business’, for instance in terms of increasing efficiency. Exploration entails organisational activities to explore new future opportunities, for instance in terms of searching for new markets and stimulating creative thinking and innovation. Ambidexterity is about doing both. The literature does not provide clear information on how to realise exploitation and exploration. Teece (2006) gives a threefold classification into sensing, seizing and reconfiguring. Sensing involves the identification of exploratory opportunities and threats in the organisation’s environment. Seizing is about translating exploratory opportunities in a clear vision and strategy, and considering organisational activities and resources required to realise them. Reconfiguring involves the reallocation of resources away from mature and declining businesses towards new ways of doing business. Ambidexterity is challenging for most organisations, because there is often a tension between exploitation and exploration as both concepts are in themselves polar extremes. Whereas exploitation is about generating short-term results, exploration focuses on the long term. March (2003, p. 14) states that ‘established organisations will always specialise in exploitation, in becoming more efficient in using what they already know. Such organisations will become dominant in the short run, but will gradually become obsolescent and fail’. By contrast, exploration involves uncertainty, generates effects only in the long term and may change the status quo, which means organisations are often less effective at it and become vulnerable to environmental turbulence (e.g. Siggelkow, 2001). Efforts to balance the tension between exploitation and exploration are difficult and often tilted towards exploitation (Benner & Tushman, 2003; Gupta et al., 2006).

How could provider organisations deal with exploitation and exploration? We assume that the answer to this question requires a study in itself. Nevertheless, we brainstorm on some ideas for potential directions. Provider organisations may further explore the potential of technology. Various telecare and e-health projects have been set up indicating the potential of technology in home care (e.g. Dohmen, 2013). The results of our study indicate that provider organisations are investing in technology (chapter 5 and 6). However, they also suggest that technology could play a more important role in future. It is interesting for provider organisations to investigate to what extent technology could further enhance the quality, effectiveness and efficiency of homecare provision. Particularly with the emergence of smartphones, tablets and smartwatches at home, technology is more accessible than ever before, indicating its potential to physically, psychologically and even emotionally support the process of homecare provision.

It will be a challenging task to follow the exploitative and explorative route simultaneously, in particular for provider organisations operating in the bureaucratic public sector. Nevertheless, we intend to address how the exploitative and explorative routes may look. The *exploitative route* assumes that provider organisations focus upon improving their current way of homecare provision within the external world in which they operate. Their main focus stays on the provision of traditional homecare services (domiciliary care, personal care and nursing care) to traditional homecare clients. Provider organisations are aware of the influence of their bureaucratic environment and their objective is to operate as efficiently and effectively as possible within it. They take their environment as a given. While they may consider a change to an alternative organisational design, they opt for such a change with the aim of improving their current way of homecare provision instead of fundamentally renewing it. How could they realise this while operating in a bureaucratic environment that instigates bureaucratisation? We argue that provider organisations could seek ways to dampen the impact of external control mechanisms. In other words, they should find buffers to 'protect' their internal processes against external influences. They may consider the separation of all external accountability efforts from their primary activities. By doing so, they actually create two separate 'organisations': one 'organisation' to accomplish the primary processes and one 'organisation' to deal with external control.

Provider organisations could also follow an *explorative route* to explore new 'business models'. As a first option, they might explore potential groups of clients in the private market. This route could be particularly interesting to avoid bureaucratisation rooted in the public sector. It is also relevant now that the government is reducing the public funding of formal homecare services, creating room for private initiatives. Provider organisations may investigate whether they could focus upon clients who still prefer formal care over informal care and who are able and willing to pay for it out of their

own pocket. Several indications support the exploration of this trajectory for the group of elderly in the Netherlands. Whereas the government is reducing the availability of a broad range of publicly funded services, the demand for these services is not necessarily decreasing among the elderly and they may still prefer professional home care over informal care (Castelijns, Van Kollenburg & Te Meerman, 2013). The study of Castelijns et al. (2013) also suggests that elderly people are willing to make out-of-pocket payments to maintain professional home care. However, the problem with this strategy is that only the upper class benefits from it. It is unachievable for many people in the middle class.

Up to this point, we argued that provider organisations might pursue exploratory opportunities in addition to the exploitation of their current way of homecare provision. However, in the literature on ambidexterity there is a debate on whether exploration and exploitation should be pursued simultaneously or not. Several authors argue that both should be addressed simultaneously, because of the complexity and pace of environmental changes and the time required to create new products and services (e.g. Tushman & O'Reilly, 1997). Others are less optimistic about the potential of mature organisations to both explore and exploit simultaneously and argue that a separate organisation is needed to realise exploration (e.g. Christensen & Bower, 1996; Ebben & Johnson, 2005). In their view, organisations are unable to explore and exploit simultaneously and must develop a single focused strategy to spin out exploratory opportunities. Translated to the context of home care, these insights suggest that provider organisations should primarily seek new initiatives and no longer 'worry' about their current way of homecare provision. Instead, they should invest in an *entrepreneurial route* in terms of exploring unique 'business' opportunities and translate them into a new 'business' model. They might draw inspiration from *Buurtzorg Nederland*, which started the entrepreneurial route a few years ago (chapter 2). Despite some criticism from established organisations, *Buurtzorg Nederland* still has highly satisfied clients and professionals together with positive organisational results. Several news stories indicate that the government is embracing the innovative approach of *Buurtzorg Nederland*, which suggests that the organisation has found a strategy to avoid becoming locked in a double hold.

The elaboration of the aforementioned routes is beyond the scope of this study; it actually requires a study in itself. However, we assume that these routes are worth exploring for provider organisations as a potential to get out of the double hold. The chances of success will depend on the ability of provider organisations to develop an out-of-the-box attitude which may be particularly challenging for bureaucratic organisations. Furthermore, it remains to be seen whether the external world will provide sufficient room for provider organisations to translate exploratory

opportunities into effective new 'business' models with an underlying socio-technical type of design.

Chapter 9

Epilogue

9. Epilogue

This study examined the extent to which the socio-technical view of provider organisations is a viable alternative to the bureaucratic view, given the turbulence in the homecare environment. The final chapter of this dissertation presents the main conclusions of the study and explores some methodological and theoretical considerations and limitations.

9.1 Conclusions

As outlined in chapter 1, the purpose of our study was to investigate the effectiveness of the attempt of Klein Zwitserland and Maas & Waal to move their organisation from a bureaucratic to a socio-technical type of design. In addition, we discussed the question of whether such a change can be effective, given their turbulent external world. We formulated the following research question:

To what extent did Klein Zwitserland and Maas & Waal effectively change from a bureaucratic to a socio-technical type of design and what are the explanations for the results achieved?

With regard to this research question, we draw the following conclusions. Both Klein Zwitserland and Maas & Waal featured a bureaucratic architecture at the point of departure of organisational change. Both organisations were highly functionally differentiated, rested upon central regulatory capacity and featured a high division of work. Their complex architecture provided professionals with little autonomy to regulate their work and respond to clients' needs properly. Consequently, Klein Zwitserland and Maas & Waal experienced many shortcomings of their traditional design for clients (e.g. poor quality of care, too many professionals involved, insufficient participation), employees (e.g. task fragmentation, simplification of tasks, hollowing out of work) and the organisation (e.g. low productivity). Furthermore, their bureaucratic architecture hindered the collaboration with their key partners, including general practitioners, hospitals and municipalities.

The management of Klein Zwitserland and Maas & Waal considered a socio-technical type of design with the purpose of improving performance and creating a sustainable organisation. In their documents, the management of both organisations described their intentions to develop self-organising teams with high regulatory capacity to accomplish primary activities locally. However, we conclude that there are some important differences between the two organisations. First, the primary objective of organisational change in Maas & Waal was to proactively respond to its changing environment, while Klein Zwitserland considered the change more as the last phase of

recovery after turbulent years. Second, the management of Maas & Waal outlined its new design in accordance with socio-technical principles and requirements. Although the management of Klein Zwitserland was also inspired by the socio-technical principles, it did not draw on all the consequences of the socio-technical approach to design and develop its new architecture.

Based on our findings, we conclude that Maas & Waal has come closer to the socio-technical type of design than Klein Zwitserland. Our results indicate that Maas & Waal achieved a stronger increase in quality of organisation. Furthermore, whereas the management of Klein Zwitserland struggled with a discrepancy between its objectives and results (see chapter 5), no indications were found of such a discrepancy in Maas & Waal (see chapter 6). In addition, the employees of Klein Zwitserland were critical of the turbulent historical context of their organisation and the conditions for change. In their view, the turbulent history of Klein Zwitserland and the lack of essential conditions for change had a negative impact on the change process and results. The employees of Maas & Waal were more positive on the internal conditions for change. Furthermore, they did not complain about serious turbulence in the past.

The results of the comparative analysis (see chapter 7) justify our conclusion that explanations for the differences in change results must be primarily sought in the way in which both organisations intended to achieve their new design: the change process. With regard to the change process, we found several differences between the two cases underpinning our conclusion that Maas & Waal has come closer to its required design than Klein Zwitserland. First, Maas & Waal had more time to internalise changes. Its change trajectory had already started in 2006, whereas the change process of Klein Zwitserland started around 2009. Second, given its turbulent historical context with a difficult merger and a period of negative financial results, the point of departure of Klein Zwitserland was much more unfavourable than the start of Maas & Waal. The unfavourable point of departure of Klein Zwitserland had a negative influence on the change process. Also, the employees of Klein Zwitserland were rather negative about the envisaged reform and its required conditions.

Third, the change strategy of Maas & Waal was more in accordance with the prerequisites of socio-technical redesign than that of Klein Zwitserland. The management of Maas & Waal invested a lot in the participation of employees and considered the preparation of the employees for the team-based design a necessity. For this reason, the first year of the change process was spent entirely on an intensive programme to prepare the employees for their new roles and responsibilities in the self-organising teams. Where possible, the management followed a bottom-up approach, thereby involving the employees in important activities of the change trajectory such as the composition of the teams. Furthermore, a great deal of attention

was devoted to team development. By contrast, the management of Klein Zwitserland adhered more to a top-down approach. Less attention was paid to the participation of employees and no indications were found of an intensive programme to prepare them for the new way of working.

In addition, our results support the conclusion that the change trajectory of Maas & Waal was in accordance with the principles of socio-technical redesign, whereas the change process of Klein Zwitserland featured a managerial or bureaucratic approach (see chapter 7). The management of Maas & Waal started the reorganisation with the design of the production structure followed by the design of the control structure in relation to this production structure. Furthermore, it adhered to the socio-technical principles including team size and local regulatory capacity. By contrast, the reorganisation of Klein Zwitserland did not start from the perspective of the production structure. Furthermore, it ignored the importance of a proper team size and did not allocate any crucial activities of the primary process (planning, scheduling and the monitoring of client indications) to the teams.

Based on the aforementioned findings, our overall conclusion is that the *internal* conditions for change were largely present in Maas & Waal, while their presence was not self-evident in Klein Zwitserland.

Our study also examined the effectiveness of the reorganisations in relation to the turbulent external environment of both provider organisations. We draw the following conclusions with regard to the impact of the external world upon the ability of provider organisations to change to a socio-technical type of design.

First, the external world has a great impact upon Klein Zwitserland and Maas & Waal in their attempt to move in the direction of a socio-technical type of design. Homecare provision is increasingly influenced by external factors including regulatory changes and expenditure cuts. The impact of the external world indicates a paradox: whereas provider organisations seek to change to a new architecture to better adapt to their external world, the external world actually severely hinders them in achieving the design aspired to.

Second, the strong impact of external influences seems to be rooted in the public character of homecare provision. Provider organisations are publicly funded and decision-making on home care is part of the public domain. In chapter 8, we argued that the public sector has several characteristics that differ from the private sector which initiate a state-led control approach. Consequently, provider organisations function in an institutional environment containing mechanisms to correct for the absence of 'automatic feedback mechanisms' of the private sector. This institutional

environment consists of several types of external influences (accountability, laws and regulations, politics, social perceptions and (restricted) budgets) which limit their room for manoeuvre.

Third, we conclude that provider organisations struggle with an external vicious circle of bureaucracy in addition to the internal vicious circle of bureaucracy. Both circles are closely interwoven. External control mechanisms elicit internal control, which increases the risk of internal bureaucratisation. There is a permanent risk of problems and incidents getting public attention, which is responded to by intensifying (external) control. The existence of these vicious circles of bureaucracy indicates that provider organisations see themselves locked in a 'double hold': they struggle to break their internal vicious circle of bureaucracy while being locked in an external world which also features the characteristics of a vicious circle of bureaucracy.

Fourth, our findings justify the conclusion that it is not sufficient for provider organisations to focus on breaking the internal vicious circle of bureaucracy to ensure their viability. In addition, they must find new ways to cope with external bureaucratisation, or, in other words, they must explore ways to get out of the double hold. We argued that 'doing nothing' is no option, because any initiative to become more flexible as an organisation is a better alternative within a turbulent environment than keeping the bureaucratic architecture. Provider organisations may enhance their chances of survival by seeking ways to dampen the impact of the external world or by exploring the potential of new ways of 'doing business'. However, the elaboration of these scenarios is beyond the scope of our study as it requires a study in itself.

9.2 Considerations and limitations

As each study involves (potential) limitations, this study also requires some considerations to be taken into account. This section describes the most important considerations in no particular order.

A first methodological consideration refers to the use of the NOVA-WEBBA survey to assess quality of work in Klein Zwitserland and Maas & Waal. Several issues were discussed which may have biased the results. We pointed to the fact that quality of work is a dynamic concept which means that the employees' perception of it may change over time. For instance, respondents may become more critical and set higher standards as their organisation moves forward in the direction of a socio-technical type of design (preference drift). Furthermore, the employees' perception of their quality of work may be influenced by their appreciation of the history of their organisation. If employees are negative about the past, it is likely that their negativism will influence the organisation today and hence their perception of quality of work. In this respect,

we also referred to the fact that the employees' perception could be affected by 'issues of the day' or private circumstances. Although the questionnaire was adapted for use in accordance with the requirements in the user manual, employees often commented that questions were difficult to understand and formulated in accordance with manufacturing work instead of homecare provision. They also said they missed the 'sometimes' option and suggested that their work was not as black or white as the answer options 'yes' or 'no' indicate. Another potential limitation involves the different response rates between Klein Zwitserland and Maas & Waal. Whereas 224 respondents completed the questionnaire in Maas & Waal, only 72 people did so in Klein Zwitserland. Although an identical approach was followed, the different response rates may be explained by the fact that the respondents of Klein Zwitserland had completed several other surveys in the same period. A final consideration concerns the reference file used to compare the scores of Klein Zwitserland and Maas & Waal. Although this file included the scores of over 10,000 people as a representation of the Dutch labour force, it was not possible to investigate how the file was actually composed.

Various authors point to potential limitations of observations, interviewing and document study as the main research methods used in this study (e.g. Bogdan & Biklen, 1992; Merriam, 1998; Creswell, 2009; Yin, 2009). As for *observations*, the presence of the researcher may have affected the behaviour of the people under observation with the consequence that the results do not represent the 'natural' behaviour of these people. In the literature this is referred to as the 'Hawthorne effect' or 'observer effect' involving the possibility for individuals to improve or modify their behaviour in response to their awareness of being observed (Landsberger, 1958). The researcher assumed the most neutral role possible to reduce the risk of this type of bias. Another possibility is that the researcher's role was considered intrusive by the people under observation, as the researcher infiltrated their working domain and the private home situation of their clients. Although no signs of intrusiveness were noticed, the people under observation may have experienced intrusiveness. To prevent feelings of intrusiveness, the researcher visited clients only when their state of health permitted and observed people only when informed consent was given. A final comment involves the possibility of selectivity, because the researcher observed the practical setting from his own framework of reference and prior knowledge. This type of bias was dealt with by taking an open attitude and asking representatives of Klein Zwitserland and Maas & Waal to confirm the researcher's interpretations.

With regard to *interviewing*, interviews only provided indirect information filtered through the views of the interviewees. The quality and usability of interview data depend upon the accuracy and articulateness of the interviewees. The results could be affected by 'issues of the day' or private circumstances of the interviewees. Several other types of bias may have influenced the results, including memory bias, moderator

acceptance bias and sensitivity bias. Interviewees may have had difficulties in remembering past events (memory bias). Furthermore, they may have given answers to please the interviewer (moderator acceptance bias) or answers in the hope of bringing about improvements in their organisation. It is also possible that the interviewer addressed sensitive subjects about which interviewees were not willing to talk and consequently gave false answers. In addition, not all interviews were conducted in the natural field setting of the interviewees, as a consequence of which interviewees may not have given 'natural' answers. As a final consideration, most interview quotes in Klein Zwitserland were collected in 2010 and 2011. It was not possible to conduct the interviews at a later stage for practical reasons.

As for *document study*, the results could be affected by several types of bias. A first potential limitation involves the fact that the documents were written for some specific purpose other than the objective of the case study. Most documents of Klein Zwitserland and Maas & Waal were visionary documents outlining the future direction of the organisation. They were written from the management perspective and most of the time did not contain retrospective information. Furthermore, most documents under study were accessible only after they were made available by the management of both organisations. Consequently, the researcher could not check the provided documents for completeness, authenticity and accuracy. Just as with observation, the results of document study may be influenced by selectivity, because the researcher as the only observer examined all documents and extracted the 'general picture' from these documents. The probability of selectivity was reduced by asking representatives of both cases to confirm the researcher's interpretations.

Another methodological consideration is the possibility of subjectivity due to the researcher's key role in analysing the data. Several elements of the case studies, such as the assessment of quality of organisation, were only based upon the researcher's estimation of these elements. As we will explain, this approach is common within the socio-technical strand, because of the lack of an integral and objective model to operationalise all elements of socio-technical redesign. As explained in chapter 4, subjectivity was dealt with by following a research approach that was comprehensive, confirmed and structured.

We should also address some considerations with regard to the procedure of our case studies. First, Klein Zwitserland was studied for a longer period of time than Maas & Waal. The researcher started conducting practice-driven research within Klein Zwitserland in 2009, which consisted of several small-scale studies on continuity of care, client and employee satisfaction, and productivity and efficiency. The purpose of these studies was to support decision-making by the management of Klein Zwitserland. Whereas these studies yielded important information on Klein Zwitserland, such

studies were not conducted in Maas & Waal. As stated earlier, Maas & Waal was selected as an additional case to enable comparison with Klein Zwitserland. The different time perspective may have affected the evaluation results, as the researcher had more time in Klein Zwitserland to build up contacts and observations.

Second, whereas the objective of case study research is to include all issues in relation to the case under study, the possibility of selectivity should be taken into account. Selectivity occurs when some important aspects have received more attention than others. In our study, we explored in detail the point of departure and the objective of Klein Zwitserland and Maas & Waal. We also analysed the change process of both cases and its results, focusing on the employees' perspective in particular. Although we assume that leadership may also play an important role in the change from a bureaucratic to a socio-technical type of design, we did not pay much attention to it. In our study, the role of leadership in the change process was analysed only indirectly, because our main focus was on the perception of the employees as the people who were actually undergoing the change.

Also we did not take into account the impact of the specific external environments of Klein Zwitserland and Maas & Waal. The assumption was that both organisations were confronted with the same external influences. However, this was a simplification, because external environments are never fully equal (see chapter 7).

Third, the employees' perception of the change was evaluated on the basis of a model consisting of four factors: history of the case, conditions for change, system world versus life world and external influences. The presentation of this model (chapter 3) may suggest that this model was developed before the start of the first case study (Klein Zwitserland). However, this was not the case. As explained in chapter 3, we carried out an inductive analysis of Klein Zwitserland which yielded the four factors to analyse the employees' perception in Klein Zwitserland. In the literature, these factors were only addressed separately and not presented as an integral model. However, as we found them relevant together, we presented them as a model to study Maas & Waal as the second case. With regard to the employees' perception of the change, we should also mention that most interviews were conducted with homecare professionals and less with representatives of the organisations' management and support staff. Consequently, the employees' perception mostly reflects the view of homecare professionals. With regard to the interviews to analyse the employees' perception, it should be noted that there was a significant difference between the two cases in the number of (formal) interviews conducted. As explained in chapter 4, we interviewed over forty employees in Klein Zwitserland, whereas we could conduct only three in-depth interviews in Maas & Waal. However, we had numerous informal conversations during observations to compensate for this.

A final methodological consideration involves the discussion as to whether our results provide sufficient basis for *scientific generalisation*, as our conclusions were based on only two cases. Although the inclusion of multiple cases may be preferred over a double-case study (e.g. Herriott & Firestone, 1983; Yin, 2009), it was practically impossible to include more than two cases. Given the time and resources available, an in-depth examination of more than two cases was beyond the range of options. Nevertheless, there were good reasons to include only two cases, assuming that the analytic benefits of having two cases instead of one were substantial (Yin, 2009). First, it was considered justified to include only two cases, because both cases were unique. Whereas Klein Zwitserland and Maas & Waal both aimed to change from a bureaucratic to a socio-technical type of design, they contained numerous unique elements including their historical context and operating area. Second, our case studies had an in-depth and long-term character with an intensity that could not have been achieved if more cases had been included.

The work of Patton (1978) suggests that generalisation within the qualitative research paradigm has a different meaning than generalisation in the traditional, experimental setting which he calls the 'hypothetico-deductive paradigm'. According to Patton (1978, p. 231), the 'hypothetico-deductive paradigm is thus directed at producing generalisations. The assumption that this is the goal of science is so deeply ingrained that it is virtually true by definition. Science is the search for generalisations'. Although qualitative research also seeks generalisations, its main objective is not to deduce results from a sample and generalise it to a population (statistical generalisation). Instead, the researcher shows how the case study findings rest upon a particular theory, theoretical construct or sequence of events, and how the same theory can be applied to similar situations or phenomena. According to Yin (2010), this is called 'analytic generalisation'. In our study, we also seek analytic generalisation rather than statistical generalisation. Although our cases contained various unique elements, we claim that the theory underpinning our study, and the model and procedure of our analysis, may be useful in other studies on organisational (re)design.

Besides methodological considerations, this study also requires a few theoretical considerations to be taken into account. An initial theoretical consideration involves the operationalisation of the three core outcomes or 'qualities' of the socio-technical design approach: quality of organisation, quality of work and quality of working relations. In this study, quality of organisation was operationalised by evaluating the degree of organisational flexibilisation based on the work of Zuurmond (1994). Quality of work was operationalised by means of the NOVA-WEB survey and quality of working relations was not evaluated because of the lack of a validated model. Although the socio-technical design approach assumes an integral improvement in the three

qualities, our study indicated that a scientifically validated model to evaluate them in an integral way does not exist yet.

A final consideration refers to the scope of the socio-technical design approach. Although the socio-technical design has proved to offer the principles for breaking the internal vicious circle of bureaucracy, it does not provide specific answers to organisations struggling with an external vicious circle of bureaucracy. Future research might focus on the ability of the socio-technical design to contribute to breaking the external vicious circle of bureaucracy.

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Appendices

Appendix A: NOVA-WEBA survey

The NOVA-WEBA (*TNO Arbeid OnderzoeksVragenlijst Arbeidsinhoud - Welzijn Bij Arbeid*) method establishes risks of well-being related to the organisation of work by investigating stress-related risks and employees' learning opportunities (Vaas et al., 1995; Kraan et al., 2011). It concerns the conducting of a survey among employees within an organisation (both executive and regulatory functions). The NOVA-WEBA survey is based on the principles of the broader, more extensive WEBA (*Welzijn Bij Arbeid*) method. It is proven to be a valid and reliable method and generates results more quickly than the WEBA method. Furthermore, it generates results which can be reported to the respondents directly, whereas the WEBA method offers 'job descriptions' which must be interpreted by the researcher. Finally, the NOVA-WEBA method is considered much cheaper than the WEBA-method (Dhondt & Houtman, 1996).

The NOVA-WEBA method strongly relates to Karasek's balance between 'Job Demands' and 'Job Decision Latitude' (see figure below) (Karasek, 1979). Job demands represent the control need that is determined by problems or disturbances that might occur in the work. Job decision latitude involves the possibilities of employees to deal with these problems or disturbances. Based on these two dimensions, Karasek distinguishes four job categories with varying levels of stressfulness. The 'Passive Job' is characterised by low job demands and low job decision latitude. It involves low control need over problems or disturbances as well as few possibilities to deal with them. The 'Active Job' involves high job demands and high job decision latitude. It involves high control need over problems or disturbances and many possibilities to deal with them. The 'Low Strain Job' and 'High Strain Job' are in between and refer to low job demands and high job decision latitude, and high job demands and low job decision latitude respectively.

The WEBA method combines Karasek's dimensions in seven characteristics of 'good jobs' that minimise stress-related risks to well-being and maximise employees' learning opportunities (Vaas et al., 1995; Schouteten & Benders, 2004; Kraan et al., 2011):

1. **Completeness of work:** in addition to executive tasks and activities, a job must contain preparatory and support tasks.
2. **Difficulty of work:** a job must contain a variety of difficult and easy tasks. The criterion for difficulty is the variety and level of mental processing required to accomplish the job. The level of education is not important.
3. **Monotony of work:** the job should contain non-monotonous tasks. Monotonous tasks are defined as short-cyclical tasks that repeat themselves within 90 seconds and make up the great majority of 'daily activities'.
4. **Workplace autonomy:** the worker must be able to decide autonomously on work pace, order and methods.
5. **Interaction potential at work:** the worker should be able to ask direct colleagues for help and advice on problems that might occur.
6. **Presence of organising tasks:** the worker should be able to consult superiors and/or other departments for assistance in dealing with problems.
7. **Information provision:** the worker must receive sufficient information about the work that needs to be done. This information should be complete, reliable and on time.

The presence of the above characteristics represents a high quality of work within the organisation. They can be operationalised by asking employees (in both executive and regulatory functions) to complete the NOVA-WEBA questionnaire. The NOVA-WEBA survey uses similar aspects of quality of work:

1. **Completeness of work (*functievoldigheid*)**: involves the extent to which a job contains preparatory and support tasks in addition to executive tasks. According to Kraan et al. (2011), a score of 0 refers to work that does not include preparatory and support tasks. A score of 1 refers to work that optimally combines executive, preparatory and support tasks.
2. **Skills capabilities (*vaardigheidsmogelijkheden*)**: refer to the extent to which a job is varied, requires creativity and provides the ability to develop and learn skills. A score of 0 refers to work without skills capabilities; a score of 1 refers to work with perfect skills capabilities.
3. **Qualification (*kwalificatiegebruik*)**: reflects the level of education and work experience in relation to work. It addresses the question of whether someone's level of education and experience fits his or her job (or not). A score of 0 refers to a level of education and experience which does not fit someone's work; a score of 1 means a level of education and experience that perfectly fits someone's work.
4. **Short-cycled tasks (*kortcyclische arbeid*)**: refer to the extent to which work is monotonous, requires repetitive, short-cycled activities and has a routine-based character. A score of 0 refers to work activities which are monotonous, highly repetitive and short-cycled, and have a routine-based character; a score of 1 reflects the opposite.
5. **Degree of difficulty (*moeilijkheidsgraad*)**: refers to the mental efforts in relation to work and refers to the extent to which an employee should be able to perceive, remember and process information. A score of 0 refers to non-difficult work; a score of 1 means work with a high degree of difficulty.
6. **Level of autonomy (*autonomie*)**: refers to the extent to which an employee has regulatory potential or capacity to plan and execute work activities. A score of 0 refers to suboptimal regulatory potential and a score of 1 means the opposite.
7. **Organisational tasks (*organiserende taken*)**: refer to the extent to which an employee is supported by colleagues, has the ability to communicate with colleagues and has the potential to affect and participate in the organisation of work. A score of 0 refers to suboptimal support and communication with colleagues, and suboptimal participation in the organisation of work; a score of 1 means the opposite.
8. **Provision of information (*informatievoorziening*)**: refers to the extent to which an employee receives adequate and timely information to execute work activities. It also concerns information on the quality of the work (provided by a supervisor or

- colleagues) and general information on organisational performance. A score of 0 refers to suboptimal information provision; a score of 1 means the opposite.
9. **Job demands (*taakeisen*)**: refer to job requirements with respect to the amount of work that should be done, as well as the time spent on accomplishing the work. A score of 0 means suboptimal job demands; a score of 1 means the opposite.
 10. **Regulatory problems (*regelproblemen*)**: refer to the extent to which an employee faces problems or disturbances in the execution of work. A score of 0 means no regulatory problems; a score of 1 means a large number of regulatory problems.
 11. **Emotional burden (*emotionele belasting*)**: involves the extent to which work is characterised by human death, illness or other forms of human suffering. It also refers to the extent to which an employee is exposed to discrimination, dangerous situations and aggressive clients. A score of 0 means no emotional burden; a score of 1 involves high emotional burden.
 12. **Payment and job security (*beloning en werkzekerheid*)**: involves the extent to which work is compensated for by an appropriate salary, future possibilities and a low risk of becoming unemployed. A score of 0 means inappropriate salary and job security; a score of 1 means the opposite.
 13. **Time autonomy (*tijdsautonomie*)**: involves the extent to which an employee can influence the time aspect within work. It may refer to the influence on working hours and breaks as well as taking days of leave. A score of 0 means no influence on the time aspect; a score of 1 means high influence on the time aspect.

The above aspects are operationalised by Kraan et al. (2011). Analysing the data should result in a score between 0 and 1. A score of 0 means no risks to well-being related to the organisation of work; a score of 1 means risks of well-being related to the organisation of work. The organisation-specific scores can be compared to a reference file containing the scores of over 10,000 people who are a reflection of the overall Dutch labour force (Houtman, Bloemhoff, Dhondt & Terwee, 1994; Kraan et al., 2011).

Appendix B: NOVA-WEBA questionnaire adapted for use in the Klein Zwitserland case (in Dutch)

Instructie voor het invullen van de vragenlijst:

Dit is de NOVA-WEBA vragenlijst (TNO OnderzoeksVragenlijst Arbeidsinhoud – Welzijn Bij Arbeid). Deze vragenlijst beoogt de arbeidsinhoud en het welzijn bij arbeid te bepalen en is opgesteld door TNO Arbeid.

Het beantwoorden van de vragenlijst neemt ongeveer 20 minuten in beslag.

De meeste vragen kunt u eenvoudig met 'ja' of 'nee' beantwoorden. Het gaat er bij het invullen om, dat u de knelpunten van uw werk **zoals u die zelf ziet** zo goed mogelijk naar voren laat komen. Het is de bedoeling dat u de vragen **zonder lang nadenken** beantwoordt; uw eerste reactie op een vraag is vaak het beste antwoord. We verzoeken u de vragen zelf, dus zonder overleg met anderen, te beantwoorden.

Kruis slechts één antwoord aan, ook al vindt u de keuze tussen de antwoordmogelijkheden misschien moeilijk. Kies dan het antwoord dat naar uw mening het beste past bij uw werkbeleving. Probeer alle vragen te beantwoorden en doe dat volgens onderstaand voorbeeld.

VOORBEELD:

Bespreekt u het werk vaak met collega's?	☐ nee	☒ ja
Zo ja, leveren deze werkbesprekingen u iets op?	☒ nee	☐ ja

Als u vaak of zeer veel werk met uw collega's bespreekt, dan kruist u het vakje aan zoals in dit voorbeeld aangegeven en beantwoordt u ook de vervolgvraag. Als u nooit, zelden of niet vaak uw werk met uw collega's bespreekt, kruis dan 'nee' aan, waarna u de vervolgvraag kunt overslaan.

Twijfelt u, probeer dan toch te kiezen voor die mogelijkheid die het dichtst bij de werkelijkheid komt. Kruis nooit zowel 'ja' als 'nee' aan of iets ertussen in; uw antwoord kan dan niet meer verwerkt worden!

Indien u zich vergist bij het aankruisen van een hokje, kunt u dit corrigeren door dat hokje zwart te maken en het juiste antwoord aan te kruisen.

Als volgt: ☒ nee ☒ ja

De beantwoording van de vragenlijst is **anoniem**. Niemand van uw organisatie krijgt de ingevulde vragenlijsten onder ogen. Alleen de onderzoeker heeft inzage in de ingevulde vragenlijsten. Er zal alleen gerapporteerd worden over groepen medewerkers. Individuele medewerkers zullen nooit herkenbaar zijn in de rapportage.

Ieders deelname is zeer belangrijk voor het slagen van het onderzoek.

Hartelijk dank voor uw inbreng en medewerking!

Informatie over de vragenlijst is te verkrijgen bij dhr. T. Peeters (Universiteit Maastricht):

E-mail: t.peeters@maastrichtuniversity.nl

Telefoon: +31 X XXXXXXXX

A. Algemeen

1. Kunt u hieronder aangeven in welke categorie uw functie valt?

- ☐ Verzorgende B / Helpende
- ☐ Verzorgende C
- ☐ Verzorgende IG
- ☐ Verzorgende D
- ☐ Verpleegkundige in de Wijk (niveau 4)
- ☐ Wijkverpleegkundige (niveau 5)
- ☐ Administratief medewerker
- ☐ Ondersteunend medewerker (ICT, P&O, financiën etc.)
- ☐ (Zorgregio) Manager/leidinggevende

2. Kunt u hieronder **zo precies mogelijk** aangeven op welke **afdeling/unit** of in welk **team** u werkzaam bent?

.....

3. Hoe lang werkt u al in deze organisatie?

jaar maanden

4. Hoe lang werkt u al in uw huidige functie?

jaar maanden

5. Geeft u leiding aan mensen (*hiërarchische leiding*)? ☐ nee ☐ ja

Toelichting: Om na te gaan in hoeverre de terug te ontvangen vragenlijsten een goede afspiegeling vormen van de organisatie als geheel, is het van belang dat u onderstaande vragen ook invult. Deze gegevens worden alleen voor dat doel gebruikt.

6. Bent u man of vrouw? ☐ man ☐ vrouw

7. Wat is uw geboortjaar? 19

8. Hoeveel uren werkt u per week?
- ☐ 35 uur of meer per week (fulltime)
 - ☐ 20 – 34 uur per week
 - ☐ 12 – 19 uur per week
 - ☐ minder dan 12 uur per week
9. Wat is de hoogste opleiding die u heeft afgemaakt?
- ☐ geen
 - ☐ lagere school
 - ☐ lager algemeen vormend of lager beroepsonderwijs
 - ☐ middelbaar onderwijs of middelbaar beroepsonderwijs
 - ☐ hoger beroepsonderwijs
 - ☐ (post-)academisch onderwijs
 - ☐ andere opleiding

B. Arbeidsinhoud

Functievolledigheid

1. Bepaalt u vooraf de volgorde van hoe u het werk gaat uitvoeren? ☐ nee ☐ ja
2. De verschillende (*hulp*)*middelen** waarmee u werkt
 - stelt u deze zelf in? ☐ nee ☐ ja
 - kunt u zelf kiezen met welke u een taak gaat uitvoeren? ☐ nee ☐ ja
 - kunt u zelf kiezen welke u gebruikt bij uw klanten/cliënten? ☐ nee ☐ ja
 - onderhoudt u deze zelf? ☐ nee ☐ ja
 - kijkt u zelf na of deze in orde zijn? ☐ nee ☐ ja
 - indien deze kapot zijn, herstelt of vervangt u deze zelf? ☐ nee ☐ ja
 - zorgt u zelf voor het op peil houden van voorraad? ☐ nee ☐ ja

**Hulpmiddelen kunnen bijvoorbeeld zijn: een bloedsuikerapparaat, een tillift en aantrek-hulpmiddelen voor elastische (steun)kousen. Het kan echter ook gaan om bijvoorbeeld een computer in geval van administratieve en/of ondersteunende activiteiten, of zelfs machines dan wel gereedschappen in geval van technische (ondersteunende) activiteiten.*

3. Houdt u zelf bij *hoeveel informatie* u per dag/week/maand in uw werk nodig heeft? ☐ nee ☐ ja
4. Houdt u zelf bij *hoeveel materiaal* u per dag/week/maand in uw werk nodig heeft? ☐ nee ☐ ja
5. Beoordeelt u zelf de kwaliteit van uw afgeleverde werk? ☐ nee ☐ ja
6. Werkt u wel eens een nieuwe collega in haar/zijn werk in? ☐ nee ☐ ja

In de volgende vragen wordt gevraagd of u een bepaalde taak wel of niet uitvoert. Er wordt daarbij uitgegaan van twee soorten functies:

- functies waarin u vooral omgaat met **informatie** (bijv. een secretaresse die teksten corrigeert of invoert, een planner die verantwoordelijk is voor een adequate planning, etc.)
- functies waarin u vooral met **personen** werkt (bijv. een leraar werkt met leerlingen, een verpleegster verzorgt patiënten, een verkoper werkt met klanten, etc.)

Er zijn functies waarin de werknemer zowel met informatie als met mensen te maken krijgt. Wilt u eerst aanduiden waar u in de eerste plaats in uw werk mee te maken krijgt, en dan de verwijzing naar de juiste vraag volgen?

Waar werkt u voornamelijk mee?

- informatie **ga naar vraag 7**
- personen (cliënten) **ga naar vraag 8**

7. Indien u vooral met *informatie* werkt:

- verzamelt u zelf de informatie die nodig is voor uw werk? ☐ nee ☐ ja
- vraagt u zelf de informatie op of aan die nodig is voor uw werk? ☐ nee ☐ ja
- stelt u zelf een plan op voor de bewerking en verwerking van uw informatie/materiaal? ☐ nee ☐ ja

8. Indien u vooral met *personen* werkt:

- benadert u in eerste instantie zelf deze cliënten? ☐ nee ☐ ja
- bedenkt u doorgaans zelf hoe u deze cliënten gaat bedienen/helpen? ☐ nee ☐ ja
- bepaalt u hoe lang u met een cliënt werkt? ☐ nee ☐ ja

Vaardigheidsmogelijkheden

1. Is voor de uitvoering van uw werk vakbekwaamheid vereist? ☐ nee ☐ ja
2. Is uw werk gevarieerd? ☐ nee ☐ ja
3. Vereist uw baan dat u nieuwe dingen leert? ☐ nee ☐ ja
4. Vereist uw baan creativiteit? ☐ nee ☐ ja
5. Heeft u de gelegenheid om uw vakbekwaamheid te ontwikkelen? ☐ nee ☐ ja

Kwalificatiegebruik

1. Heeft u voor uw werk een te hoge, te lage of juist een goede opleiding?
☐ te hoge opleiding
☐ te lage opleiding
☐ juist een goede opleiding
2. Heeft u voor uw werk te veel, te weinig of juist voldoende werkervaring?
☐ te veel ervaring
☐ te weinig ervaring
☐ juist voldoende ervaring

Kort-cyclische arbeid

1. Is uw werk eentonig? ☐ nee ☐ ja
2. Komen in uw werk steeds dezelfde kortdurende werkzaamheden terug?
☐ nee
☐ ja → Hoe lang duurt dan een herhaling van deze taken?
☐ < 90 seconden
☐ 90 seconden – 5 minuten
☐ 5 minuten – 10 minuten
☐ > 10 minuten

Indien deze kortdurende werkzaamheid minder dan 10 minuten duurt, welk percentage van uw totale dagtaak komen deze kortdurende werkzaamheden voor?

- ☐ bijna de hele tijd
 - ☐ de hele tijd
 - ☐ ongeveer driekwart van de tijd
 - ☐ ongeveer de helft van de tijd
 - ☐ ongeveer een kwart van de tijd
 - ☐ zelden of nooit
3. Kunt u uw werk grotendeels op routine doen? ☐ nee ☐ ja

Moeilijkheidsgraad

1. Vereist uw werk voortdurend intensief nadenken?	☐ nee	☐ ja
2. Moet u veel informatie gedurende lange tijd onthouden?	☐ nee	☐ ja
3. Vergt uw werk dat u er voortdurend uw gedachten bij houdt?	☐ nee	☐ ja
4. Vergt uw werk voortdurend veel aandacht van u?	☐ nee	☐ ja
5. Vergt uw werk voortdurend oplettendheid?	☐ nee	☐ ja
6. Moet u in uw werk veel dingen tegelijk in de gaten houden?	☐ nee	☐ ja

Autonomie

1. Kunt u zelf beslissen hoe u het werk uitvoert/doet?	☐ nee	☐ ja
2. Bepaalt u zelf de volgorde van uw werkzaamheden?	☐ nee	☐ ja
3. Beslist u zelf wanneer u een taak uitvoert?	☐ nee	☐ ja
4. Kunt u makkelijk even weg van de plaats waar u werkt?	☐ nee	☐ ja
5. Kunt u uw werk, als u dat nodig vindt, zelf onderbreken?	☐ nee	☐ ja
6. Kunt u zelf het werktempo regelen?	☐ nee	☐ ja
7. Kunt u, indien nodig, het tijdstip waarop iets klaar moet zijn uitstellen?	☐ nee	☐ ja
8. Wordt uw werkwijze in grote mate voorgeschreven?	☐ nee	☐ ja
9. Kunt u een eigen werkwijze kiezen?	☐ nee	☐ ja

Organiserende taken

*(Nota bene: **leidinggevenden** dienen bij de onderstaande vijf vragen ermee rekening te houden dat het niet over de positie als leidinggevende gaat, maar over de **positie als medewerker**)*

1. Heeft u invloed op de beslissingen van uw team/afdeling?	☐ nee	☐ ja
2. Kunt u bij eventuele problemen mensen uit andere teams/afdelingen inschakelen?	☐ nee	☐ ja
3. Bespreekt u met anderen hoe de taken worden verdeeld?	☐ nee	☐ ja
4. Bespreekt u met anderen hoe de taken gepland moeten worden?	☐ nee	☐ ja
5. Hoe vaak heeft u werkoverleg*?		
☐ eens per week of vaker		
☐ eens per 2 weken		
☐ eens per maand		
☐ eens per 2 maanden of minder vaak		
☐ nooit		

***Werkoverleg** is overleg met uw eigen leidinggevende en collega's waarbij uw eigen werkproblemen aan de orde kunnen komen.

Informatievoorziening

1. Hoort u van uw leidinggevende hoe goed uw dienst is?	☐ nee	☐ ja
2. Hoort u van uw collega's hoe goed uw dienst is?	☐ nee	☐ ja
3. Krijgt u informatie over de prestaties van uw organisatie?	☐ nee	☐ ja
4. Krijgt u voldoende informatie over het doel van uw werk?	☐ nee	☐ ja
5. Krijgt u voldoende informatie om mee te werken?	☐ nee	☐ ja
6. Komt de informatie die u nodig heeft meestal op tijd?	☐ nee	☐ ja
7. Moet u vaak wachten op informatie die u nodig heeft?	☐ nee	☐ ja
8. Krijgt u tegenstrijdige opdrachten in uw werk?	☐ nee	☐ ja
9. Wordt u in uw werk geconfronteerd met tegenstrijdige verwachtingen?	☐ nee	☐ ja
10. Zijn de gegevens die u krijgt meestal juist?	☐ nee	☐ ja
11. Zijn de opdrachten die u krijgt duidelijk?	☐ nee	☐ ja

Taakeisen

1. Moet u erg snel werken?	☐ nee	☐ ja
2. Moet u heel veel werk doen?	☐ nee	☐ ja
3. Moet u extra hard werken?	☐ nee	☐ ja
4. Heeft u over het algemeen genoeg tijd om al uw werk af te krijgen?	☐ nee	☐ ja
5. Is uw werk hectisch/Is het op uw werk een gekkenhuis?	☐ nee	☐ ja

Regelproblemen

1. Vertraagt het wachten op werk van andere mensen of teams/ afdelingen vaak uw eigen werk?	☐ nee	☐ ja
2. Beïnvloedt de snelheid waarmee u werkt het tempo van andermans werk?	☐ nee	☐ ja
3. Loopt het werk vaak anders dan gepland?	☐ nee	☐ ja
4. Heeft u regelmatig met storingen in uw werk te maken?	☐ nee	☐ ja
5. Moet u vaak improviseren om een opdracht uit te voeren?	☐ nee	☐ ja
6. Wordt u op het werk vaak voor onverwachte gebeurtenissen geplaatst?	☐ nee	☐ ja

Emotionele belasting

1. Wordt u beroepshalve geconfronteerd met dood, ziekte of ander menselijk lijden?	☐ nee	☐ ja
2. Wordt er op het werk gediscrimineerd vanwege huidskleur?	☐ nee	☐ ja
3. Wordt er op het werk gediscrimineerd vanwege sekse?	☐ nee	☐ ja
4. Is uw werk gevaarlijk voor uzelf?	☐ nee	☐ ja
5. Moet u voortdurend beducht zijn op gevaarlijke situaties?	☐ nee	☐ ja
6. Moet u veel werken met agressieve cliënten?	☐ nee	☐ ja
7. Zijn uw cliënten lastig?	☐ nee	☐ ja

Beloning en werkzekerheid

1. Is uw salaris/loon voldoende voor het werk dat u doet?	☐ nee	☐ ja
2. Is uw werkzekerheid goed?	☐ nee	☐ ja
3. Verwacht u promotie te maken in de komende vijf jaren?	☐ nee	☐ ja
4. Liep u in het laatste jaar kans om werkloos te worden?	☐ nee	☐ ja
5. Verwacht u uw huidige baan de komende vijf jaar te kunnen behouden?	☐ nee	☐ ja
6. Zullen over vijf jaar uw kennis en vaardigheden nog steeds nuttig zijn voor uw huidige werk?	☐ nee	☐ ja
7. Zullen over vijf jaar uw kennis en vaardigheden nuttig zijn voor andere organisaties?	☐ nee	☐ ja

Tijdsautonomie

1. Kunt u het tijdstip waarop u begint of stopt met werken zelf kiezen?	☐ nee	☐ ja
2. Kunt u zelf kiezen wanneer u pauzeert?	☐ nee	☐ ja
3. Kent u uw werkrooster langer dan één maand van tevoren?	☐ nee	☐ ja
4. Kunt u verlofdagen opnemen wanneer u dat zelf wilt?	☐ nee	☐ ja

C. Overige aspecten van het werk

Beleving en gezondheid

1. Kunt u van de volgende uitspraken aangeven of u het ermee eens of oneens bent:
 - Ik vind het belangrijk dat het werk goed verloopt ☐ mee oneens ☐ mee eens
 - Deze organisatie gaat me echt ter harte ☐ mee oneens ☐ mee eens
 - Ik vind het erg vervelend als er iets fout gaat in het werk, ook als het niet mijn schuld is ☐ mee oneens ☐ mee eens
 - Ik trek het me erg aan als ik merk dat onze organisatie een slechte naam heeft bij anderen ☐ mee oneens ☐ mee eens
 - Mijn werk betekent veel voor me ☐ mee oneens ☐ mee eens
 - Ik voel me uitstekend thuis in deze organisatie ☐ mee oneens ☐ mee eens
 - Het is de moeite waard om te proberen mijn werk zo goed mogelijk te doen ☐ mee oneens ☐ mee eens
 - Vergeleken met de meeste andere organisaties, is het werken bij deze organisatie erg aantrekkelijk ☐ mee oneens ☐ mee eens
2. Heeft u meestal plezier in uw werk? ☐ nee ☐ ja
3. Heeft u er in het afgelopen jaar over nagedacht om ander werk te zoeken dan het werk bij uw huidige werkgever? ☐ nee ☐ ja
4. Heeft u in het afgelopen jaar ook daadwerkelijk iets ondernomen om ander werk te vinden (activiteiten om aan uw huidige baan te komen niet meegerekend)?
☐ nee
☐ ja → kon/kunt u gemakkelijk ander werk vinden? ☐ nee ☐ ja
5. Zou u, als het aan u lag, over 5 jaar nog bij deze organisatie werken? ☐ nee ☐ ja
6. Bent u de laatste 12 maanden wel eens van uw werk thuis gebleven wegens ziekte of ongeval?
☐ nee, **ga verder met vraag 9**
☐ ja → hoe vaak bent u in de afgelopen 12 maanden ziek thuis geweest?
 - ☐ 1 keer
 - ☐ 2 tot 5 keer
 - ☐ meer dan 5 keerhoeveel weken bent u in de afgelopen 12 maanden ongeveer ziek thuis geweest?
 - ☐ minder dan 2 weken
 - ☐ 2 tot 3 weken
 - ☐ meer dan 3 weken

7. Heeft u voor uw ziekte of ongeval een arts bezocht?	☐ nee	☐ ja
8. Hing deze ziekte of dit ongeval samen met uw werk?	☐ nee	☐ deels ☐ ja
9. Voelt u zich mentaal uitgeput door uw werk?	☐ nee	☐ ja
10. Voelt u zich aan het einde van een werkdag leeg?	☐ nee	☐ ja
11. Voelt u zich 's morgens bij het opstaan als er weer een werkdag voor u ligt, vermoeid?	☐ nee	☐ ja
12. Voelt u zich 'opgebrand' door uw werk?	☐ nee	☐ ja
13. Voelt u zich gefrustreerd door uw baan?	☐ nee	☐ ja
14. Denkt u dat u zich teveel inzet voor uw werk?	☐ nee	☐ ja
15. Voelt u zich aan het eind van uw latijn?	☐ nee	☐ ja

Dit is het einde van de vragenlijst.
Heeft u vragen over uw werk gemist?
Zo ja, kunt u hieronder aangeven welke vragen dat zijn?

Hartelijk dank voor uw medewerking!

Appendix C: Cover letter of the NOVA-WEBBA survey in the Klein Zwitserland case (in Dutch)

Geachte medewerker van XXXXXXXXXX,

Een aantal jaren geleden is XXXXXXXXXX gestart met het wijkgericht werken. We hebben inmiddels behoorlijke stappen voorwaarts gemaakt, zoals bijvoorbeeld is gebleken uit de 0- en 1-meting van de enquête “XXXXXXXXXX”.

Bij het verder verbeteren van het wijkgericht werken, staat dit jaar het thema ‘kwaliteit’ centraal. Hiermee bedoelen we niet alleen de kwaliteit van de zorg- en dienstverlening, maar ook de *kwaliteit van arbeid*. Kwaliteit van arbeid gaat over zaken als betrokkenheid bij werk, invloed op werkzaamheden en mogelijkheden om de inhoud van het werk zelfstandig in te vullen. Het achterliggende idee hierbij is dat een hoge kwaliteit van arbeid uiteindelijk niet alleen ten gunste is van de medewerkers, maar ook leidt tot een verbeterde kwaliteit van de algehele organisatie.

Om de kwaliteit van arbeid binnen XXXXXXXXXX te kunnen bepalen, is het noodzakelijk om een hiervoor ontwikkelde vragenlijst af te nemen. Deze vragenlijst zal binnenkort aan u worden voorgelegd. Ik zou u vriendelijk willen vragen om deze vragenlijst nauwkeurig in te vullen. Zodoende kunnen we een goed beeld krijgen van de kwaliteit van arbeid binnen XXXXXXXXXX. Daarnaast biedt dit de mogelijkheid om de kwaliteit van arbeid verder te verbeteren.

Bij de 0- en 1-meting van de enquête “XXXXXXXXXX” hebben jullie gezorgd voor een bijzonder hoge respons, waardoor de resultaten zeer bruikbaar zijn. Hopelijk kunnen we deze hoge respons herhalen of zelfs verbeteren. Mag ik wederom op jullie medewerking rekenen?

Met vriendelijke groet,
Tom Peeters
Universiteit Maastricht

Appendix D: Organogram of Maas & Waal overall

Figure A1 represents the organogram of Maas & Waal overall. Unlike “Klein Zwitserland”, which is organised functionally, Maas & Waal is organised in an ‘area-oriented’ (*gebiedsgebonden*) way. While the organisation operates within all areas depicted in the organogram, this study only includes the “Maas & Waal 3” area.

* Please note that these areas have ‘real’ names in reality. To guarantee anonymity, we use the fictitious names “Maas & Waal 1”, “Maas & Waal 2”, “Maas & Waal 3” etcetera.

Figure A1 Organogram of Maas & Waal overall (in Dutch)

Appendix E: NOVA-WEB questionnaire adapted for use in the Maas & Waal case (in Dutch)

Instructie voor het invullen van de vragenlijst:

Dit is de NOVA-WEB vragenlijst (TNO OnderzoeksVragenlijst Arbeidsinhoud – Welzijn Bij Arbeid). Deze vragenlijst beoogt de arbeidsinhoud en het welzijn bij arbeid te bepalen en is opgesteld door TNO Arbeid.

Het beantwoorden van de vragenlijst neemt ongeveer 20 minuten in beslag.

De meeste vragen kunt u eenvoudig met 'ja' of 'nee' beantwoorden. Het gaat er bij het invullen om, dat u de knelpunten van uw werk **zoals u die zelf ziet** zo goed mogelijk naar voren laat komen. Het is de bedoeling dat u de vragen **zonder lang nadenken** beantwoordt; uw eerste reactie op een vraag is vaak het beste antwoord. We verzoeken u de vragen zelf, dus zonder overleg met anderen, te beantwoorden.

Kruis slechts één antwoord aan, ook al vindt u de keuze tussen de antwoordmogelijkheden misschien moeilijk. Kies dan het antwoord dat naar uw mening het beste past bij uw werkbeleving. Probeer alle vragen te beantwoorden en doe dat volgens onderstaand voorbeeld.

VOORBEELD:

Bespreekt u het werk vaak met collega's? ☐ nee ☒ ja
Zo ja, leveren deze werkbesprekingen u iets op? ☒ nee ☐ ja

Als u vaak of zeer veel werk met uw collega's bespreekt, dan kruist u het vakje aan zoals in dit voorbeeld aangegeven en beantwoordt u ook de vervolgvraag. Als u nooit, zelden of niet vaak uw werk met uw collega's bespreekt, kruis dan 'nee' aan, waarna u de vervolgvraag kunt overslaan.

Twijfelt u, probeer dan toch te kiezen voor die mogelijkheid die het dichtst bij de werkelijkheid komt. Kruis nooit zowel 'ja' als 'nee' aan of iets ertussen in; uw antwoord kan dan niet meer verwerkt worden!

Indien u zich vergist bij het aankruisen van een hokje, kunt u dit corrigeren door dat hokje zwart te maken en het juiste antwoord aan te kruisen. ■

Als volgt: ☐ nee ☒ ja

De beantwoording van de vragenlijst is **anoniem**. Niemand van uw organisatie krijgt de ingevulde vragenlijsten onder ogen. Alleen de onderzoeker heeft inzage in de ingevulde

vragenlijsten. Er zal alleen gerapporteerd worden over groepen medewerkers. Individuele medewerkers zullen nooit herkenbaar zijn in de rapportage.

Ieders deelname is zeer belangrijk voor het slagen van het onderzoek.

Hartelijk dank voor uw inbreng en medewerking!

Informatie over de vragenlijst is te verkrijgen bij dhr. T. Peeters (Universiteit Maastricht):

E-mail: t.peeters@maastrichtuniversity.nl
Telefoon: +31 X XXXXXXXX

A. Algemeen

1. Kunt u hieronder aangeven in welke categorie uw functie valt?
 - ☐ Medewerker Stabiele zorg (niveau 2)
 - ☐ Verzorgende (niveau 3)
 - ☐ Verplegende 3IG
 - ☐ Verpleegkundige (niveau 4)
 - ☐ Wijkverpleegkundige (niveau 5)
 - ☐ Administratief medewerker
 - ☐ Ondersteunend medewerker (ICT, P&O, financiën etc.)
 - ☐ (Zorgregio) Manager/leidinggevende
2. Kunt u hieronder **zo precies mogelijk** aangeven op welke **locatie/thuiszorgregio** of in welk **team** u werkzaam bent?

.....

3. Hoe lang werkt u al in deze organisatie?
 jaar maanden
4. Hoe lang werkt u al in uw huidige functie?
 jaar maanden
5. Geeft u leiding aan mensen (*hiërarchische leiding*)? ☐ nee ☐ ja

Toelichting: Om na te gaan in hoeverre de terug te ontvangen vragenlijsten een goede afspiegeling vormen van de organisatie als geheel, is het van belang dat u onderstaande vragen ook invult. Deze gegevens worden alleen voor dat doel gebruikt.

6. Bent u man of vrouw? ☐ man ☐ vrouw
7. Wat is uw geboortejaar? 19

8. Hoeveel uren werkt u per week?

- ☐ 35 uur of meer per week (fulltime)
☐ 20 – 34 uur per week
☐ 12 – 19 uur per week
☐ minder dan 12 uur per week

9. Wat is de hoogste opleiding die u heeft afgemaakt?

- ☐ geen
☐ lagere school
☐ lager algemeen vormend of lager beroepsonderwijs
☐ middelbaar onderwijs of middelbaar beroepsonderwijs
☐ hoger beroepsonderwijs
☐ (post-)academisch onderwijs
☐ andere opleiding

B. Arbeidsinhoud

Functievoldigheid

1. Bepaalt u vooraf de volgorde van hoe u het werk gaat uitvoeren? ☐ nee ☐ ja
2. De verschillende (hulp)middelen* waarmee u werkt stelt u deze zelf in? ☐ nee ☐ ja
- kunt u zelf kiezen met welke u een taak gaat uitvoeren? ☐ nee ☐ ja
- kunt u zelf kiezen welke u gebruikt bij uw klanten/cliënten? ☐ nee ☐ ja
- onderhoudt u deze zelf? ☐ nee ☐ ja
- kijkt u zelf na of deze in orde zijn? ☐ nee ☐ ja
- indien deze kapot zijn, herstelt of vervangt u deze zelf? ☐ nee ☐ ja
- zorgt u zelf voor het op peil houden van voorraad? ☐ nee ☐ ja

****Hulpmiddelen** kunnen bijvoorbeeld zijn: een bloedsuikerapparaat, een tillift en aantrek-hulpmiddelen voor elastische (steun)kousen. Het kan echter ook gaan om bijvoorbeeld een computer in geval van administratieve en/of ondersteunende activiteiten, of zelfs machines dan wel gereedschappen in geval van technische (ondersteunende) activiteiten.*

3. Houdt u zelf bij hoeveel informatie u per dag/week/maand in uw werk nodig heeft? ☐ nee ☐ ja
4. Houdt u zelf bij hoeveel materiaal u per dag/week/maand in uw werk nodig heeft? ☐ nee ☐ ja
5. Beoordeelt u zelf de kwaliteit van uw afgeleverde werk? ☐ nee ☐ ja
6. Werkt u wel eens een nieuwe collega in haar/zijn werk in? ☐ nee ☐ ja

In de volgende vragen wordt gevraagd of u een bepaalde taak wel of niet uitvoert. Er wordt daarbij uitgegaan van twee soorten functies:

- functies waarin u vooral omgaat met **informatie** (bijv. een secretaresse die teksten corrigeert of invoert, een planner die verantwoordelijk is voor een adequate planning, etc.)
- functies waarin u vooral met **personen** werkt (bijv. een leraar werkt met leerlingen, een verpleegster verzorgt patiënten, een verkoper werkt met klanten, etc.)

Er zijn functies waarin de werknemer zowel met informatie als met mensen te maken krijgt.

Wilt u eerst aangeven waar u in de eerste plaats in uw werk mee te maken krijgt, en dan de verwijzing naar de juiste vraag volgen?

Waar werkt u voornamelijk mee?

informatie

ga naar vraag 7

personen (cliënten)

ga naar vraag 8

7. Indien u vooral met *informatie* werkt:
 - verzamelt u zelf de informatie die nodig is voor uw werk? ☐ nee ☐ ja
 - vraagt u zelf de informatie op of aan die nodig is voor uw werk? ☐ nee ☐ ja
 - stelt u zelf een plan op voor de bewerking en verwerking van uw informatie/materiaal? ☐ nee ☐ ja
8. Indien u vooral met *personen* werkt:
 - benadert u in eerste instantie zelf deze cliënten? ☐ nee ☐ ja
 - bedenkt u doorgaans zelf hoe u deze cliënten gaat bedienen/helpen? ☐ nee ☐ ja
 - bepaalt u hoe lang u met een cliënt werkt? ☐ nee ☐ ja

Vaardigheidsmogelijkheden

1. Is voor de uitvoering van uw werk vakbekwaamheid vereist? ☐ nee ☐ ja
2. Is uw werk gevarieerd? ☐ nee ☐ ja
3. Vereist uw baan dat u nieuwe dingen leert? ☐ nee ☐ ja
4. Vereist uw baan creativiteit? ☐ nee ☐ ja
5. Heeft u de gelegenheid om uw vakbekwaamheid te ontwikkelen? ☐ nee ☐ ja

Kwalificatiegebruik

1. Heeft u voor uw werk een te hoge, te lage of juist een goede opleiding?
☐ te hoge opleiding
☐ te lage opleiding
☐ juist een goede opleiding
2. Heeft u voor uw werk te veel, te weinig of juist voldoende werkervaring?
☐ te veel ervaring
☐ te weinig ervaring
☐ juist voldoende ervaring

Kort-cyclische arbeid

1. Is uw werk eentonig? ☐ nee ☐ ja
2. Komen in uw werk steeds dezelfde kortdurende werkzaamheden terug?
☐ nee
☐ ja → Hoe lang duurt dan een herhaling van deze taken?
☐ < 90 seconden
☐ 90 seconden – 5 minuten
☐ 5 minuten – 10 minuten
☐ > 10 minuten

Indien deze kortdurende werkzaamheid minder dan 10 minuten duurt, welk percentage van uw totale dagtaak komen deze kortdurende werkzaamheden voor?

- ☐ bijna de hele tijd
☐ de hele tijd
☐ ongeveer driekwart van de tijd
☐ ongeveer de helft van de tijd
☐ ongeveer een kwart van de tijd
☐ zelden of nooit
3. Kunt u uw werk grotendeels op routine doen? ☐ nee ☐ ja

Moeilijkheidsgraad

1. Vereist uw werk voortdurend intensief nadenken? ☐ nee ☐ ja
2. Moet u veel informatie gedurende lange tijd onthouden? ☐ nee ☐ ja
3. Vergt uw werk dat u er voortdurend uw gedachten bij houdt? ☐ nee ☐ ja
4. Vergt uw werk voortdurend veel aandacht van u? ☐ nee ☐ ja
5. Vergt uw werk voortdurend oplettendheid? ☐ nee ☐ ja
6. Moet u in uw werk veel dingen tegelijk in de gaten houden? ☐ nee ☐ ja

Autonomie

1. Kunt u zelf beslissen hoe u het werk uitvoert/doet?	☐ nee	☐ ja
2. Bepaalt u zelf de volgorde van uw werkzaamheden?	☐ nee	☐ ja
3. Beslist u zelf wanneer u een taak uitvoert?	☐ nee	☐ ja
4. Kunt u makkelijk even weg van de plaats waar u werkt?	☐ nee	☐ ja
5. Kunt u uw werk, als u dat nodig vindt, zelf onderbreken?	☐ nee	☐ ja
6. Kunt u zelf het werktempo regelen?	☐ nee	☐ ja
7. Kunt u, indien nodig, het tijdstip waarop iets klaar moet zijn uitstellen?	☐ nee	☐ ja
8. Wordt uw werkwijze in grote mate voorgeschreven?	☐ nee	☐ ja
9. Kunt u een eigen werkwijze kiezen?	☐ nee	☐ ja

Organiserende taken

(Nota bene: leidinggevenden dienen bij de onderstaande vijf vragen ermee rekening te houden dat het niet over de positie als leidinggevende gaat, maar over de positie als medewerker)

1. Heeft u invloed op de beslissingen van uw team/afdeling?	☐ nee
☐ ja	
2. Kunt u bij eventuele problemen mensen uit andere teams/afdelingen inschakelen?	☐ nee ☐ ja
3. Bespreekt u met anderen hoe de taken worden verdeeld?	☐ nee ☐ ja
4. Bespreekt u met anderen hoe de taken gepland moeten worden?	☐ nee ☐ ja
5. Hoe vaak heeft u werkoverleg*?	
☐ eens per week of vaker	
☐ eens per 2 weken	
☐ eens per maand	
☐ eens per 2 maanden of minder vaak	
☐ nooit	

***Werkoverleg** is overleg met uw eigen leidinggevende en collega's waarbij uw eigen werkproblemen aan de orde kunnen komen.

Informatievoorziening

1. Hoort u van uw leidinggevende hoe goed uw dienst is?	☐ nee	☐ ja
2. Hoort u van uw collega's hoe goed uw dienst is?	☐ nee	☐ ja
3. Krijgt u informatie over de prestaties van uw organisatie?	☐ nee	☐ ja
4. Krijgt u voldoende informatie over het doel van uw werk?	☐ nee	☐ ja
5. Krijgt u voldoende informatie om mee te werken?	☐ nee	☐ ja
6. Komt de informatie die u nodig heeft meestal op tijd?	☐ nee	☐ ja
7. Moet u vaak wachten op informatie die u nodig heeft?	☐ nee	☐ ja
8. Krijgt u tegenstrijdige opdrachten in uw werk?	☐ nee	☐ ja
9. Wordt u in uw werk geconfronteerd met tegenstrijdige verwachtingen?	☐ nee	☐ ja
10. Zijn de gegevens die u krijgt meestal juist?	☐ nee	☐ ja
11. Zijn de opdrachten die u krijgt duidelijk?	☐ nee	☐ ja

Taakeisen

1. Moet u erg snel werken?	☐ nee	☐ ja
2. Moet u heel veel werk doen?	☐ nee	☐ ja
3. Moet u extra hard werken?	☐ nee	☐ ja
4. Heeft u over het algemeen genoeg tijd om al uw werk af te krijgen?	☐ nee	☐ ja
5. Is uw werk hectisch/Is het op uw werk een gekkenhuis?	☐ nee	☐ ja

Regelproblemen

1. Vertraagt het wachten op werk van andere mensen of teams/afdelingen vaak uw eigen werk?	☐ nee	☐ ja
2. Beïnvloedt de snelheid waarmee u werkt het tempo van andermans werk?	☐ nee	☐ ja
3. Loopt het werk vaak anders dan gepland?	☐ nee	☐ ja
4. Heeft u regelmatig met storingen in uw werk te maken?	☐ nee	☐ ja
5. Moet u vaak improviseren om een opdracht uit te voeren?	☐ nee	☐ ja
6. Wordt u op het werk vaak voor onverwachte gebeurtenissen geplaatst?	☐ nee	☐ ja

Emotionele belasting

1. Wordt u beroepshalve geconfronteerd met dood, ziekte of ander menselijk lijden? ☐ nee ☐ ja
2. Wordt er op het werk gediscrimineerd vanwege huidskleur? ☐ nee ☐ ja
3. Wordt er op het werk gediscrimineerd vanwege sekse? ☐ nee ☐ ja
4. Is uw werk gevaarlijk voor uzelf? ☐ nee ☐ ja
5. Moet u voortdurend beducht zijn op gevaarlijke situaties? ☐ nee ☐ ja
6. Moet u veel werken met agressieve cliënten? ☐ nee ☐ ja
7. Zijn uw cliënten lastig? ☐ nee ☐ ja

Beloning en werkzekerheid

1. Is uw salaris/loon voldoende voor het werk dat u doet? ☐ nee ☐ ja
2. Is uw werkzekerheid goed? ☐ nee ☐ ja
3. Verwacht u promotie te maken in de komende vijf jaren? ☐ nee ☐ ja
4. Liep u in het laatste jaar kans om werkloos te worden? ☐ nee ☐ ja
5. Verwacht u uw huidige baan de komende vijf jaar te kunnen behouden? ☐ nee ☐ ja
6. Zullen over vijf jaar uw kennis en vaardigheden nog steeds nuttig zijn voor uw huidige werk? ☐ nee ☐ ja
7. Zullen over vijf jaar uw kennis en vaardigheden nuttig zijn voor andere organisaties? ☐ nee ☐ ja

Invloed op tijdsindeling

1. Kunt u het tijdstip waarop u begint of stopt met werken zelf kiezen? ☐ nee ☐ ja
2. Kunt u zelf kiezen wanneer u pauzeert? ☐ nee ☐ ja
3. Kent u uw werkrooster langer dan één maand van tevoren? ☐ nee ☐ ja
4. Kunt u verlofdagen opnemen wanneer u dat zelf wilt? ☐ nee ☐ ja

C. Overige aspecten van het werk

Beleving en gezondheid

1. Kunt u van de volgende uitspraken aangeven of u het ermee eens of oneens bent:
 - Ik vind het belangrijk dat het werk goed verloopt ☐ mee oneens ☐ mee eens
 - Deze organisatie gaat me echt ter harte ☐ mee oneens ☐ mee eens
 - Ik vind het erg vervelend als er iets fout gaat in het werk, ook als het niet mijn schuld is ☐ mee oneens ☐ mee eens
 - Ik trek het me erg aan als ik merk dat onze organisatie een slechte naam heeft bij anderen ☐ mee oneens ☐ mee eens
 - Mijn werk betekent veel voor me ☐ mee oneens ☐ mee eens
 - Ik voel me uitstekend thuis in deze organisatie ☐ mee oneens ☐ mee eens
 - Het is de moeite waard om te proberen mijn werk zo goed mogelijk te doen ☐ mee oneens ☐ mee eens
 - Vergeleken met de meeste andere organisaties, is het werken bij deze organisatie erg aantrekkelijk ☐ mee oneens ☐ mee eens
2. Heeft u meestal plezier in uw werk? ☐ nee ☐ ja
3. Heeft u er in het afgelopen jaar over nagedacht om ander werk te zoeken dan het werk bij uw huidige werkgever? ☐ nee ☐ ja
4. Heeft u in het afgelopen jaar ook daadwerkelijk iets ondernomen om ander werk te vinden (activiteiten om aan uw huidige baan te komen niet meegerekend)?
 - ☐ nee
 - ☐ ja → kon/kunt u gemakkelijk ander werk vinden? ☐ nee ☐ ja
5. Zou u, als het aan u lag, over 5 jaar nog bij deze organisatie werken? ☐ nee ☐ ja
6. Bent u de laatste 12 maanden wel eens van uw werk thuis gebleven wegens ziekte of ongeval?
 - ☐ nee, **ga verder met vraag 9**
 - ☐ ja → hoe vaak bent u in de afgelopen 12 maanden ziek thuis geweest?
 - ☐ 1 keer
 - ☐ 2 tot 5 keer
 - ☐ meer dan 5 keer

hoeveel weken bent u in de afgelopen 12 maanden ongeveer ziek thuis geweest?

☐ minder dan 2 weken

☐ 2 tot 3 weken

☐ meer dan 3 weken

7. Heeft u voor uw ziekte of ongeval een arts bezocht?	☐ nee	☐ ja
8. Hing deze ziekte of dit ongeval samen met uw werk?	☐ nee	☐ deels ☐ ja
9. Voelt u zich mentaal uitgeput door uw werk?	☐ nee	☐ ja
10. Voelt u zich aan het einde van een werkdag leeg?	☐ nee	☐ ja
11. Voelt u zich 's morgens bij het opstaan als er weer een werkdag voor u ligt, vermoeid?	☐ nee	☐ ja
12. Voelt u zich 'opgebrand' door uw werk?	☐ nee	☐ ja
13. Voelt u zich gefrustreerd door uw baan?	☐ nee	☐ ja
14. Denkt u dat u zich teveel inzet voor uw werk?	☐ nee	☐ ja
15. Voelt u zich aan het eind van uw latijn?	☐ nee	☐ ja

Dit is het einde van de vragenlijst.

Heeft u vragen over uw werk gemist?

Zo ja, kunt u hieronder aangeven welke vragen dat zijn?

Hartelijk dank voor uw medewerking!

Appendix F: Cover letter of the NOVA-WEBA survey in the Maas & Waal case (in Dutch)

Aan: alle medewerkers van zorgregio XXXXXXXXXX

Onderwerp: stand van zaken kwaliteit van arbeid in de zelfsturende teams

Geachte medewerker,

Een aantal jaren geleden is er binnen jullie zorgregio XXXXXXXXXX gestart met het werken in zelfsturende teams. Samen met collega's ben je al tot mooie resultaten gekomen voor de cliënten en de organisatie.

Kwaliteit van arbeid:

Het thema kwaliteit is een belangrijk onderwerp bij het werken in zelfsturende teams. Met kwaliteit bedoelen we niet alleen de kwaliteit van de zorg- en dienstverlening, maar ook de *kwaliteit van arbeid*. Kwaliteit van arbeid gaat over zaken als betrokkenheid bij het werk, het invloed hebben op de wijze waarop werkzaamheden kunnen worden uitgevoerd en de mogelijkheden hebben om de inhoud van het werk zelfstandig in te vullen. De achterliggende visie hierbij is dat een (hoge) kwaliteit van arbeid niet alleen goed is voor de medewerkers, maar ook leidt tot een algemeen verbeterde kwaliteit van de zorg- en dienstverlening aan de cliënt en de kwaliteit van de organisatie.

Onderzoek:

Om samen (medewerkers, teams, Ondernemingsraad (OR) en Managementteam (MT)) verder inzicht te krijgen in de kwaliteit van arbeid binnen jullie zorgregio XXXXXXXXXX gaan we eenmalig meedoen aan een wetenschappelijk onderzoek. Dit onderzoek is in nauw overleg tussen het MT en de OR van ZZG zorggroep gebied Wijchen en Maas en Waal tot stand gekomen.

Het onderzoek zal zowel voor jullie persoonlijk als voor jullie teams, de OR en het MT inzicht geven in de (on)mogelijkheden om zelf invloed te hebben op de inhoud van jullie werk.

Het onderzoek zal plaatsvinden aan de hand van een vragenlijst. Dit onderzoek is gepland voor de 2^e helft van 2013 en is een eenmalige invulling van de Brown Paper

Session (BPS). Het invullen van deze vragenlijst zal dus tijdens de eerstvolgende BPS bijeenkomst centraal staan.

Tom Peeters (de onderzoeker) zal dan de BPS (het invullen van de vragenlijst) begeleiden en hij zal, daar waar nodig is, ondersteunen bij het invullen van de vragenlijst. De ingevulde persoonlijke gegevens zullen nooit worden gebruikt in de terugkoppeling naar de teams, de OR en het MT.

Vervolg:

Zoals altijd zal er, in overleg met jullie, een BPS bijeenkomst worden gepland.

Gezien het onderzoek zal de planning liggen tussen september en begin december 2013. Ook zullen we kijken of we zo efficiënt mogelijk de BPS kunnen inplannen (als het kan per regio en meerdere teams op een dagdeel). Met de sterrolhouders teamzaken zal dit worden overlegd. Het is dus gewenst dat de sterrolhouders teamzaken van de diverse teams per zorgregio in juni vanuit een gezamenlijke afstemming met datavoorstellen komen. Deze datavoorstellen kunnen dan rechtsreeks per e-mail (t.peeters@maastrichtuniversity.nl) worden doorgegeven aan de onderzoeker, dhr. Tom Peeters.

De resultaten zullen zo spoedig mogelijk door dhr. Tom Peeters aan jullie worden teruggekoppeld, zodat ook jullie deze resultaten kunnen gebruiken bij jullie teamontwikkeling.

Bij voorbaat hartelijk dank voor uw medewerking.

Met vriendelijke groet,

Tom Peeters
Universiteit Maastricht

Valorisation

Valorisation

This thesis describes the effectiveness of initiatives of Dutch homecare provider organisations to change their organisation from a bureaucratic to a socio-technical type of organisation. It also addresses the wider question of whether the intended change can be successful at all in the turbulent environment provider organisations must respond to. In this addendum we briefly indicate how this study could be beneficial for society by exploring its social value.

We address the social relevance of the most important research findings and argue why they are of interest to policymakers within and outside provider organisations. We focus on the strategic management of provider organisations, because they hold the key to effective organisational change. If they succeed in bringing about the conditions for effective change, homecare clients, professionals and the society as a whole will benefit in terms of improvements in the quality and efficiency of the care provided, the clients' appreciation of the care and the quality of the work carried out by care professionals.

The results of our study justify the conclusion that provider organisations see themselves locked in a 'double hold': they struggle with a self-reinforcing internal vicious circle of bureaucracy while being squeezed by an external world also featuring the characteristics of a similar vicious circle of bureaucracy. In addition to internal bureaucratic mechanisms, homecare provision is increasingly affected by external factors including accountability mechanisms, regulatory changes and expenditure cuts. The impact of the external world indicates an interesting situation: whereas their turbulent environment necessitates provider organisations to change to a socio-technical type of design, a change to a 'full' socio-technical design requires the condition that the environment is not 'too turbulent'. However, our findings suggest that the current homecare environment is turbulent, which makes that the external world severely hinders provider organisations in achieving a socio-technical type of design.

The situation of the double hold has several implications for policy officers *within* provider organisations. It requires them to find ways to break the internal vicious circle of bureaucracy while simultaneously exploring new ways to cope with external bureaucratisation. With regard to breaking the internal vicious circle of bureaucracy, our study yields several recommendations regarding the actions that could be taken. First, policy officers should not underestimate the importance of a change strategy in accordance with the socio-technical principles. The results of our study suggest that an effective change from a bureaucratic to a socio-technical type of design requires a change strategy which follows the socio-technical design principles, embraces the

preparation and involvement of employees, and invests in team development. In addition, policy officers should not underestimate the influence of the organisation's historical context. An unfavourable point of departure, for instance in terms of a difficult merger or negative financial results in the past, may have a persistent negative influence on the change process. Policy officers must find ways to deal with a turbulent historical context, confronting them with a dilemma: their organisation must change to respond to a changing environment, but actually suffers from change fatigue hindering effective change.

Second, policy officers must understand that a change from a bureaucratic to a socio-technical type of design can only succeed if they are willing to consider the necessary reorganisation from an integral perspective. Partial improvements do not work. By following the socio-technical design sequence, they should outline a new architecture which entails optimal regulatory capacity at the level of teams. It is not sufficient and even ineffective to make the teams responsible for only part of the primary activities.

Third, with regard to the influence of the external world, policy officers must realise that an effective change to a socio-technical type of design requires that the change process is not considered solely from the internal, organisational perspective. To enhance the effectiveness of change, policy officers must be aware of the strong influence of the external environment on it. They should realise that their organisation is squeezed by the external world, which hinders them in achieving the design aspired to. As a consequence, they must find ways to get out of the double hold, thereby acknowledging that any initiative to realise flexibilisation is a better alternative in a turbulent environment than maintaining a bureaucratic architecture. As explained in chapter 8, policy officers may explore an exploitative route, which assumes that provider organisations focus on improving their current way of homecare provision within the external world in which they operate. They take their bureaucratic environment as a given and could seek ways to dampen the impact of external influences. Policy officers may also follow an explorative route to explore new 'business models' in addition to their current way of homecare provision. For instance, they might think of potential groups of clients in the private market to avoid bureaucratisation in the public sector. This route is also relevant now that the government is reducing the public funding of formal homecare services, creating room for private initiatives. The situation of the double hold also necessitates more radical trajectories to be explored. As a third option, policy officers may follow an entrepreneurial route of investing in new 'business' opportunities while leaving the current way of homecare provision. As stated in chapter 8, they might draw inspiration from *Buurtzorg Nederland*, which started the entrepreneurial route a few years ago. There are several news stories suggesting that the government is encouraging the new organisation's innovative approach, which suggests that the organisation has found a

way to stay out of the double hold. However, it takes courage to stray off the beaten track and develop an out-of-the-box attitude.

Policy officers within provider organisations must critically consider the aforementioned recommendations before initiating a change to a socio-technical type of design. There is always the risk of starting a reorganisation without sufficiently considering the conditions required to accomplish an effective change. This may lead to a halfway implementation of the new design without achieving its proposed benefits.

Our study also includes some recommendations regarding the actions that could be taken by policymakers *outside* provider organisations. Policymakers in the field of homecare should become more aware of the implications of their policies for provider organisations. They must learn to understand that their attitude is to respond on problems and challenges in a bureaucratic way, by introducing more and more accountability mechanisms, performance indicators and regulations. They should set a step aside and think about ways to create more flexibility instead of complexity. In other words, they must consider on how to break the external vicious circle of bureaucracy. Just as provider organisations have started to consider their traditional type of design, policymakers in the homecare environment must explore ways to reduce complexity. However, it remains to be seen if policymakers can fundamentally change the system into a flexible system which does no longer lock provider organisations in a double hold. News stories on the current reform of long-term care do not speak of decreasing complexity. On the contrary, they suggest even more complexity and uncertainty. However, ever more bureaucratic responses from the homecare environment will inevitably lead to a system that becomes overly complex and, as a consequence, structurally 'out-of-control'.

Nederlandse samenvatting

Nederlandse samenvatting

Dit proefschrift beoogt op basis van twee case studies – “Klein Zwitserland” en “Maas & Waal” – de effectiviteit in kaart te brengen van de verandering van een bureaucratische organisatievorm naar een organisatie-inrichting gebaseerd op de socio-technische ontwerpprincipes. Vanuit wetenschappelijk oogpunt borduurt het onderzoek voort op studies voorafgaand aan de introductie van de Wet maatschappelijke ondersteuning (Wmo). Het onderzoek besteedt tevens expliciet aandacht aan de relatie tussen organisatieverandering en de externe omgeving. Vanuit maatschappelijk oogpunt beoogt de studie een bijdrage te leveren aan de zoektocht naar waarborging van een duurzaam stelsel van langdurige zorg. Initiatieven rond socio-technische organisatieverandering passen binnen deze zoektocht en worden gestimuleerd door de overheid. De studie bestaat uit vier delen. De hoofdstukken 1 tot en met 3 omvatten het exploratieve deel van het proefschrift, gevolgd door de methodologische verantwoording in hoofdstuk 4. De hoofdstukken 5 en 6 behelzen het evaluatieve deel van de studie en geven een weergave van beide case studies. De hoofdstukken 7 tot en met 9 omvatten het reflectieve deel van het proefschrift.

Hoofdstuk 1 geeft een introductie van het onderwerp en beschrijft de relevantie van de studie. Thuiszorgorganisaties worden geconfronteerd met een toenemende omgevingsturbulentie als gevolg van talrijke veranderingen waaronder hervormingen in de langdurige zorg. Zij moeten onder meer omgaan met nieuwe wet- en regelgeving en een decentralisatie van verantwoordelijkheden naar de gemeenten. Tevens worden er hogere eisen gesteld aan hun dienstverlening vanuit het perspectief van cliënten en medewerkers. Omgevingsturbulentie wordt in deze studie gedefinieerd als het samenspel tussen complexiteit, dynamiek en onvoorspelbaarheid. Complexiteit betreft het aantal heterogene actoren in de omgeving en de verwevenheid tussen deze actoren. Dynamiek verwijst naar de frequentie en intensiteit van veranderingen in de omgeving. Onvoorspelbaarheid heeft betrekking op de beschikbaarheid van informatie over de toekomstige omgeving. Onze veronderstelling is dat de thuiszorgomgeving turbulent mag worden genoemd, omdat deze wordt gekenmerkt door talrijke met elkaar verbonden actoren (complexiteit), vele veranderingen met een grote impact (dynamiek) en onzekerheden ten aanzien van de effecten van deze veranderingen (onvoorspelbaarheid). Thuiszorgorganisaties zijn zich er in toenemende mate van bewust dat een bureaucratische organisatiearchitectuur de flexibiliteit ontbeert om in te kunnen spelen op deze omgevingsturbulentie. Zij beogen daarom een organisatieverandering te realiseren naar een socio-technische organisatiearchitectuur. Deze studie beoogt de effectiviteit van een dergelijke verandering in kaart te brengen aan de hand van de volgende vraagstelling:

In hoeverre hebben Klein Zwitserland en Maas & Waal een effectieve organisatieverandering gerealiseerd van een bureaucratisch naar een socio-technisch georiënteerde organisatie-inrichting en hoe kunnen de behaalde resultaten worden verklaard?

De analyse van de behaalde resultaten is gericht op zowel interne als externe factoren. Onder interne factoren worden die factoren verstaan die specifiek zijn voor Klein Zwitserland en Maas & Waal. Externe factoren verwijzen naar factoren in de omgeving van beide organisaties.

Hoofdstuk 2 omvat een verkenning van thuiszorgverlening in zijn context. Het hoofdstuk start met het definiëren van het elastische begrip ‘thuiszorg’. Er wordt onderscheid gemaakt tussen formele en informele vormen van thuiszorg. In dit proefschrift wordt enkel aandacht besteed aan de drie belangrijkste typen van formele thuiszorgverlening: huishoudelijke hulp, persoonlijke verzorging en verpleging. Het hoofdstuk wordt vervolgd met een historische reconstructie van de ontwikkeling van het Nederlandse thuiszorgsysteem. Deze ontwikkeling wordt gekenmerkt door de groei van kleinschalige, private initiatieven van thuiszorgverlening in de negentiende eeuw tot het huidige sterk gedifferentieerde, gereguleerde en gebureaucratiseerde thuiszorgsysteem. Tot 2015 vormden twee publieke regelingen het fundament onder het stelsel van langdurige zorg: de Wmo en de Algemene Wet Bijzondere Ziektekosten (AWBZ). Vanaf 2015 is de langdurige zorg onderhevig aan omvangrijke institutionele veranderingen. De belangrijkste hervormingen betreffen de introductie van de Wet langdurige zorg (Wlz) ter vervanging van de AWBZ, de herziening van de Wmo in de nieuwe Wmo 2015 en de overheveling van de wijkverpleging naar de Zorgverzekeringswet (Zvw). Na een beschrijving van de belangrijkste gebruikers en aanbieders van thuiszorg wordt het hoofdstuk vervolgd met een nadere beschouwing van de thuiszorgomgeving. Er wordt geconcludeerd dat de thuiszorg in toenemende mate wordt beïnvloed door het politieke domein. Tevens heeft de thuiszorgsector, meer dan welke sector ook, te maken gekregen met de gevolgen van marktwerking. Beide constatering hangen nauw samen met ontwikkelingen als de standaardisatie van indicatiestelling, de invoering van openbare aanbestedingen en de aan belang winnende rol van gemeenten in de thuiszorg. Deze ontwikkelingen worden beschreven in samenhang met bredere maatschappelijke ontwikkelingen, waaronder de almaar stijgende zorguitgaven, vergrijzing, technologische ontwikkelingen en een individualiseringstrend.

Hoofdstuk 3 omvat de theoretische fundering van de studie. In het eerste deel van het hoofdstuk worden essentiële elementen van organiseren en managen geëxploreerd. Er wordt aandacht besteed aan de systeemkundige benadering van organisaties, waarbij een organisatie wordt beschouwd als een netwerk van knooppunten bestaande uit

verschillende met elkaar verbonden elementen. Vervolgens worden arbeidsdeling en –coördinatie geëxploreerd alsook drie perspectieven van waaruit arbeid kan worden gedeeld: maximale arbeidsdeling, minimale arbeidsdeling en minimaal *mogelijke* arbeidsdeling. Het eerste deel van het hoofdstuk wordt besloten met een uiteenzetting van de relatie tussen organisatie-inrichtingen, complexiteit en verstoringen, waarbij er onderscheid wordt gemaakt tussen verstoringen die niet en verstoringen die wel worden veroorzaakt door de organisatie-architectuur. Het hoofdstuk wordt vervolgd met een uiteenzetting van de grondbeginselen van de bureaucratische organisatie-inrichting gebaseerd op maximale arbeidsdeling. Het bureaucratische organisatie-model wordt vervolgens vergeleken met een socio-technische organisatie-inrichting gebaseerd op minimaal mogelijke arbeidsdeling. Verondersteld wordt dat een socio-technische architectuur leidt tot optimale resultaten in termen van kwaliteit van organisatie, kwaliteit van arbeid en kwaliteit van arbeidsrelaties. De verandering van een bureaucratische naar een socio-technisch georiënteerde organisatie-inrichting vereist een bepaalde veranderstrategie. Ter introductie wordt een overzicht gegeven van veel voorkomende strategieën voor organisatieverandering. In deze studie wordt echter een alternatief model gehanteerd om het veranderingsproces te beschrijven bestaande uit vier fasen: incubatie, preparatie, start-up en consolidatie. Het laatste deel van hoofdstuk 3 beschrijft een inductief verkregen model om de perceptie van de medewerkers inzake het veranderingsproces en de uitkomsten daarvan in kaart te brengen. Dit model bestaat uit vier factoren: historie van de casus, condities voor verandering, systeemwereld versus leefwereld en externe invloeden. Condities voor verandering worden nader onderverdeeld in personele, structurele, technologische en culturele condities.

Hoofdstuk 4 omvat de methodologische verantwoording van de studie. In het eerste deel van het hoofdstuk worden de principes van kwalitatief onderzoek verkend. Er wordt aandacht besteed aan de regulatieve en reflectieve cyclus als fundament van praktijkgericht wetenschappelijk onderzoek. Tevens wordt de case studie methode uitgelegd als een vorm van kwalitatief onderzoek die het mogelijk maakt een diepgaande analyse te verrichten van een hedendaags fenomeen of object in zijn context op basis van een combinatie van onderzoeksmethoden. In het tweede deel van het hoofdstuk wordt het ontwerp van de studie beschreven bestaande uit vier elementen: tweevoudige case studie, vergelijkende analyse, reflectie en documentatie. De tweevoudige case studie omvat een analyse en beschrijving van Klein Zwitserland en Maas & Waal. Op basis van een combinatie van onderzoeksmethoden, waaronder documentstudie, observaties en interviews, worden het vertrekpunt (bureaucratische architectuur), het beoogde doel (socio-technische architectuur), de behaalde resultaten en de veranderstrategie in beide cases geanalyseerd. Tevens wordt er aandacht besteed aan de perceptie van de medewerkers, waarbij wordt verondersteld dat er sprake is van een wederkerige relatie tussen hun perceptie enerzijds en de

veranderstrategie en de veranderaankomsten anderzijds. De vergelijkende analyse omvat een cross-case vergelijking van Klein Zwitserland en Maas & Waal, waarbij wordt nagegaan in hoeverre beide organisaties een effectieve organisatieverandering hebben gerealiseerd. Tevens wordt er gezocht naar interne factoren die de verschillen in de behaalde resultaten kunnen verklaren. Hiermee worden factoren bedoeld die specifiek zijn voor Klein Zwitserland en Maas & Waal. In de reflectie worden externe verklaringsfactoren geëxploreerd en wordt bestudeerd in hoeverre de verandering naar een socio-technische organisatie-inrichting wordt beïnvloed door de externe omgeving. Het laatste deel van het hoofdstuk wordt gewijd aan de methodologische kwaliteit van de studie. Een combinatie van interventies wordt toegepast om deze kwaliteit te bevorderen, waaronder triangulatie en empirische validatie van de resultaten door de organisatiepraktijk.

Hoofdstuk 5 geeft een uiteenzetting van de Klein Zwitserland casus. Klein Zwitserland is een thuiszorgorganisatie in het uiterste zuiden van Nederland. De organisatie is verantwoordelijk voor een breed pallet aan thuiszorgdiensten, waaronder huishoudelijke hulp, persoonlijke verzorging en verpleging. Klein Zwitserland is het resultaat van een moeizame fusie tussen twee thuiszorgorganisaties in 2006. Het management van Klein Zwitserland besloot in 2009 om een veranderingsproces te initiëren naar een socio-technisch georiënteerde organisatie-inrichting. Negatieve resultaten ten aanzien van cliënten (suboptimale kwaliteit en discontinuïteit van zorg), medewerkers (suboptimale kwaliteit van arbeid) en ketenpartners (ontevredenheid over inflexibele houding van Klein Zwitserland) vormden de aanleiding tot dit besluit. Het management beoogde een alternatieve organisatievorm te realiseren, waarbinnen ‘kleine, zelforganiserende teams verantwoordelijk zijn voor het aanbieden van alle zorg en ondersteuning in een vooraf vastgesteld gebied’ op basis van ‘maximale regelcapaciteit’ en ‘verantwoordelijkheden die lokaal zijn ingebed’. De analyse van de casus laat een discrepantie zien tussen de beoogde doelstellingen en de behaalde resultaten: primaire taken en verantwoordelijkheden zijn slechts gedeeltelijk ondergebracht in de teams, het primaire proces wordt nog steeds voor een belangrijk deel centraal aangestuurd en de organisatie heeft moeite zich te ontdoen van ingesloten bureaucratische patronen. Ten aanzien van de veranderstrategie van Klein Zwitserland wordt geconcludeerd dat de organisatie zich heeft laten inspireren door het socio-technische gedachtegoed, maar onvoldoende invulling heeft gegeven aan belangrijke socio-technische ontwerpprincipes. De ontwikkeling van de kwaliteit van organisatie in termen van centralisatie, hiërarchisering, formalisatie, standaardisatie en specialisatie, wijst op een minimale flexibiliseringstrend. De NOVA-WEBB resultaten laten een gemengd en licht negatief beeld zien ten aanzien van de kwaliteit van arbeid: vergeleken met het referentiebestand scoort Klein Zwitserland beter op vijf dimensies (functievoldigheid, vaardigheidsmogelijkheden, kwalificatiegebruik, organiserende taken en informatievoorziening), maar slechter op acht dimensies (kort-cyclische taken,

moelijkheidsgraad, autonomie, taakeisen, regelproblemen, emotionele belasting, beloning en werkzekerheid, en tijdsautonomie). Het laatste deel van het hoofdstuk wordt gewijd aan de perceptie van de medewerkers. Medewerkers ervaren een negatieve invloed van de turbulente historie van Klein Zwitserland op het veranderingsproces. Eveneens geven zij blijk van het ontbreken van personele, structurele en culturele condities voor verandering. Ten slotte percipiëren zij de dominantie van de systeemwereld over de leefwereld als negatief in samenhang met externe invloeden in termen van overheidsbemoeienis.

Hoofdstuk 6 beschrijft de Maas & Waal casus. Maas & Waal is een aanbieder van intramurale en extramurale zorg in het zuidoosten van Nederland. De organisatie is verantwoordelijk voor een breed spectrum aan thuiszorgdiensten, waaronder persoonlijke verzorging en verpleging. Omwille van strategische redenen besloot de organisatie in 2012 te stoppen met het aanbieden van huishoudelijke hulp. Het management van Maas & Waal besloot rond 2006 om een veranderingsproces in gang te zetten naar een socio-technisch georiënteerde organisatie-inrichting. Uit een analyse van een externe expert bleek dat de bureaucratische architectuur onvoldoende aansloot bij veranderende prestatie-eisen in de omgeving en een nieuwe strategische richting van de organisatie. Het management beoogde een alternatief organisatieontwerp te realiseren dat, naast efficiëntie en kwaliteit, flexibiliteit en innovatie stimuleert. De nieuwe organisatie-inrichting gaat uit van de integratie van taken en lokale regelcapaciteit in zelfsturende teams, biedt ruimte voor een extern georiënteerde cultuur op basis van professionele autonomie van medewerkers en omvat systemen met een ondersteunende functie in de richting van het primaire proces. Ten aanzien van de veranderstrategie wordt geconcludeerd dat Maas & Waal strikt heeft vastgehouden aan de socio-technische ontwerpprincipes en –volgorde. Tevens heeft het management op basis van het zogenaamde sterrolhoudermodel intensief geïnvesteerd in de voorbereiding, betrokkenheid en ontwikkeling van medewerkers en teams. De ontwikkeling van de kwaliteit van organisatie in termen van centralisatie, hiërarchisering, formalisatie, standaardisatie en specialisatie, wijst op een flexibiliseringstrend. De NOVA-WEBB resultaten laten daarentegen een gemengd en negatief beeld zien: vergeleken met het referentiebestand scoort Maas & Waal beter op vier dimensies (functievolligheid, vaardigheidsmogelijkheden, kwalificatiegebruik en organiserende taken), maar slechter op acht dimensies (kort-cyclische taken, moeilijkheidsgraad, autonomie, taakeisen, regelproblemen, emotionele belasting, beloning en werkzekerheid, en tijdsautonomie). In het laatste deel van het hoofdstuk wordt aandacht besteed aan de perceptie van de medewerkers. Met uitzondering van verandermoeheid in termen van het ervaren aantal veranderingen in het verleden, geven medewerkers geen blijk van een negatieve invloed van de historie van Maas & Waal op het veranderingsproces. Eveneens geven zij aan dat de condities voor verandering, met uitzondering van technologische condities en een hoge werkdruk,

grotendeels aanwezig zijn. Desalniettemin percipiëren zij de dominantie van de systeemwereld over de leefwereld als negatief in samenhang met externe invloeden als gevolg van overheidsbemoeienis.

Hoofdstuk 7 omvat een vergelijkende analyse van de resultaten van Klein Zwitserland en Maas & Waal. In het eerste deel van het hoofdstuk wordt nagegaan in hoeverre beide organisaties een effectieve organisatieverandering hebben gerealiseerd. De onderzoeksbevindingen suggereren dat Maas & Waal dichter bij een socio-technische organisatie-inrichting is gekomen dan Klein Zwitserland. In tegenstelling tot Klein Zwitserland blijkt van een discrepantie tussen de beoogde doelstellingen en de behaalde resultaten binnen Maas & Waal geen sprake. Ten aanzien van de ontwikkeling van de kwaliteit van de organisatie heeft Maas & Waal een sterkere flexibiliseringstrend doorgeemaakt dan Klein Zwitserland. Opvallend is dat de NOVA-WEBBA resultaten een negatief beeld schetsen voor beide organisaties. Er dient echter rekening te worden gehouden met factoren die de resultaten mogelijkwerwijs hebben beïnvloed, waaronder verschuivende preferenties van respondenten. Ten aanzien van de perceptie van de medewerkers blijken de medewerkers in Maas & Waal positiever te oordelen met betrekking tot de historie van de casus en de condities voor verandering. In het tweede deel van het hoofdstuk wordt gezocht naar interne factoren die de verschillen in de behaalde resultaten kunnen verklaren. Onder interne factoren worden die factoren verstaan die specifiek zijn voor Klein Zwitserland en Maas & Waal. Er worden drie belangrijke factoren gevonden ter verklaring van de verschillen. Ten eerste is Maas & Waal eerder gestart met de verandering dan Klein Zwitserland, waardoor er binnen Maas & Waal meer tijd was voor het internaliseren van veranderingen. Ten tweede wordt het veranderingsproces binnen Maas & Waal nauwelijks belemmerd door een turbulente historische context, terwijl de turbulente historie van Klein Zwitserland tot gevoelens van structureel wantrouwen heeft geleid. Ten derde blijkt Maas & Waal meer dan Klein Zwitserland een veranderaanpak en –strategie te hebben gevolgd in lijn met socio-technische organisatieverandering. Maas & Waal heeft intensief geïnvesteerd in de voorbereiding, betrokkenheid en ontwikkeling van medewerkers en teams. Daarbij heeft het management strikt vastgehouden aan de socio-technische ontwerpprincipes en –volgorde.

Hoofdstuk 8 beschrijft de invloed van externe factoren op de verandering van een bureaucratische naar een socio-technisch georiënteerde organisatie-inrichting. Medewerkers van Klein Zwitserland en Maas & Waal ervaren een toename van externe invloeden zoals een groeiend aantal regels en procedures en steeds verder doorgevoerde bezuinigingen. Zij ervaren deze invloeden als negatief. De toename van externe invloeden impliceert een spanningsveld: terwijl thuiszorgorganisaties een socio-technisch georiënteerde organisatie-inrichting trachten te bewerkstelligen om beter in te kunnen spelen op de turbulente omgeving, lijkt deze omgeving de

verandering naar een dergelijke architectuur in de weg te staan. Thuiszorgorganisaties lopen het risico vast te komen zitten in een zogenaamde ‘dubbele houdgreep’. Hiermee wordt verwezen naar de situatie waarin thuiszorgorganisatie niet alleen moeten zien te breken met een interne vicieuze cirkel der bureaucratie, maar tevens worden geconfronteerd met externe bureaucrativering. Onze veronderstelling is dat socio-technische organisatievernieuwing enkel kan worden voltooid indien de omgeving hiervoor voldoende ruimte en flexibiliteit biedt. We onderbouwen dat de thuiszorgomgeving niet aan deze conditie voldoet. In plaats daarvan worden thuiszorgorganisaties ‘samengeknepen’ door een toenemende invloed van verantwoordingsmechanismen, wet- en regelgeving, politieke besluitvorming, maatschappelijke opvattingen en bezuinigingen. Deze omgevingsinvloeden hebben een externe vicieuze cirkel der bureaucratie tot gevolg, welke interne bureaucrativering aanwakkert en kan leiden tot de dubbele houdgreep. In het laatste deel van het hoofdstuk wordt verkend hoe organisaties kunnen omgaan met de dubbele houdgreep. Er worden drie mogelijke richtingen geëxploreerd. Een eerste richting betreft een exploitatieve route, waarbij organisaties zoeken naar wegen om de bestaande organisatie verder te verbeteren ondanks de aanwezigheid van externe bureaucrativering. Een tweede richting betreft een exploratieve route, waarbij organisaties nieuwe bedrijfsmodellen verkennen naast de bestaande organisatie. Een derde richting betreft een ondernemende route, waarbij organisaties de bestaande organisatie laten voor wat het is en enkel investeren in unieke vernieuwende bedrijfsmodellen.

Hoofdstuk 9 omvat de belangrijkste conclusies van dit proefschrift ter beantwoording van de vraagstelling. Het vertrekpunt van verandering betrof voor zowel Klein Zwitserland als Maas & Waal een bureaucratische organisatie-inrichting. Beide organisaties ervoeren tekortkomingen van deze organisatievorm en trachtten te komen tot een socio-technisch georiënteerde architectuur. De aanleiding voor de organisatieverandering was verschillend: waar Maas & Waal trachtte te anticiperen op een veranderende omgeving, leek Klein Zwitserland vooral te willen afrekenen met de turbulente historie. De onderzoeksbevindingen rechtvaardigen de conclusie dat Maas & Waal dichter bij een socio-technische organisatie-inrichting is gekomen dan Klein Zwitserland. Er wordt geconcludeerd dat verklaringen voor de gevonden verschillen vooral dienen te worden gezocht binnen het veranderingsproces: vergeleken met Klein Zwitserland had Maas & Waal meer tijd voor het internaliseren van veranderingen, was de uitgangssituatie van Maas & Waal gunstiger en heeft de organisatie een veranderstrategie gevolgd die meer in lijn is met de socio-technische ontwerpprincipes. Als belangrijkste conclusie ten aanzien van de invloed van de externe omgeving geldt dat thuiszorgorganisaties, naast het doorbreken van de interne vicieuze cirkel der bureaucratie, moeten investeren in het omgaan met externe bureaucrativering. In het laatste deel van het hoofdstuk worden methodologische en theoretische overwegingen

opgeworpen. Achtereenvolgens worden er enkele kritische kanttekeningen geplaatst bij de NOVA-WEBA methode waarmee de kwaliteit van arbeid werd onderzocht, en wordt er aandacht besteed aan mogelijke beperkingen van observaties, interviews en documentstudie als de belangrijkste onderzoeksmethoden. Vervolgens worden enkele specifieke beperkingen van de studie besproken en wordt de generaliseerbaarheid van de bevindingen verkend. Er wordt afgesloten met een kritische noot ten aanzien van het ontbreken van een instrument waarmee socio-technische organisatievernieuwing integraal en wetenschappelijk kan worden geoperationaliseerd.

Dankwoord

Dankwoord

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Curriculum Vitae

Curriculum Vitae

Tom Peeters was born in Thorn, the Netherlands (1987). After completing his secondary education (VWO), he studied Health Sciences at Maastricht University, with as specialisation Healthcare Policy and Management. He obtained his bachelor degree in 2008 and then started the Master of Public Health at Maastricht University, with as specialisation Health Policy, Economics and Management.

After his graduation in September 2009, he started to work as a junior teacher at the Faculty of Health, Medicine and Life Sciences (FHML) of Maastricht University, with organisational science, organisational change and transformation, and healthcare policymaking as main topics of interest. From 2010, he combined his position as a junior teacher with a PhD project on organisational redesign in Dutch home care. This project contained case study research on the effectiveness of the socio-technical type of design in homecare provider organisations as an alternative to the bureaucratic type of design. During the PhD trajectory, he closely worked together with researchers from several research groups, such as the Dutch ST-Group (www.st-group.nl). Since August 2015, Tom works as a consultant at Vandaag Zorgvernieuwing (www.vandaagzorgvernieuwing.nl). He is responsible for several projects on organisational redesign and innovation in Dutch healthcare organisations, with a strong focus on long-term care organisations.

Already from his early years, music and musical performance play an important role in his life. In 2012, he founded music school xPRZ, which provides music lessons to people and particularly children with mental disorders (www.xprz.nl). As a co-owner, he is responsible for operational, tactical and strategic management issues. As a teacher, he is responsible for teaching piano, keyboards and accordion.

Thuiszorgorganisaties worden geconfronteerd met een toenemende omgevingsturbulentie als gevolg van veranderingen in de langdurige zorg. Zij moeten onder meer omgaan met nieuwe wet- en regelgeving en een decentralisatie van verantwoordelijkheden naar de gemeenten. Tevens worden er hogere eisen gesteld aan hun dienstverlening vanuit het perspectief van cliënten en medewerkers.

Thuiszorgorganisaties zijn zich er in toenemende mate van bewust dat een bureaucratische organisatiearchitectuur de flexibiliteit ontbeert om in te kunnen spelen op deze omgevingsturbulentie. Zij beogen daarom een organisatieverandering te realiseren naar een socio-technische organisatiearchitectuur, welke uitgaat van volledige taken en verantwoordelijkheden in zelfsturende teams. Dit proefschrift beschrijft in twee case studies de effectiviteit van een dergelijke organisatieverandering, waarbij de historie van de organisatie en de gevolgde veranderaanpak en -strategie een belangrijke rol blijken te spelen. Tevens worden organisaties geconfronteerd met externe factoren waaronder een toenemende verantwoordingsdruk vanuit de overheid. Dit proefschrift beoogt een aanzet te geven tot het vinden van een antwoord hoe om te gaan met externe bureaucratisering, naast het doorbreken van de interne vicieuze cirkel van de bureaucratie.