CASE STUDY

Improving the quality of public service and reducing costs: lessons from the public youth protection agency of Amsterdam (Netherlands).

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Improving the quality of public service and reducing costs:
lessons from a field trip to Childprotect, the public youth protection agency of Amsterdam

Introduction

Improving the quality of public service and reducing costs. These seemingly incompatible expectations reflect the saying 'do more with less' that no one seems to take seriously but which is used frequently by politicians and senior public managers anyway. Yet, there are cases that rise to this challenge. One such case is ChildProtect in Greater Amsterdam (Netherlands). This is the agency helping vulnerable children and youth in Amsterdam and its surrounding municipalities. As it was awarded Best Public Sector Organisation of the Netherlands in 2015 as well as the European Public Sector Award for the category of local government in 2015, it was the subject of a study visit, organised by the European Institute of Public Administration on 25-25 February 2016 in Maastricht.

This case study draws on that study visit among other sourcesi. It focuses on how the "Vanguard" approach for improving performance in services was put to use. At the end of the case, an analysis is conducted on the basis of a governance perspective.

Picture 1: study visit at Childprotect

Childprotect in trouble

ChildProtect looked, on a yearly basis, after 10000 children at risk, with about 600 staff, working with families and partner organisations to provide them with safe and supportive environments. Children – minors between the ages 0 to 18 – were usually referred to the agency by teachers, police officers, doctors or other professionals who judged they may be at risk of abuse or neglect. Parents could choose to accept the help of the agency voluntarily, or the case might be referred to the child investigation council who could seek a court order to place the child under care of the state. Other children, such as those with a suspended sentence imposed for an offence, were referred to the agency as part of their parole program. In each situation, a range of welfare organisations could then

be mobilised to care for the children and support the families, including foster homes, parental support groups and mental health services.

However, in 2008 the government bodies overseeing ChildProtect (notably the inspection services and the Amsterdam alderman in charge) placed it under heightened supervision. They felt the agency was unable to fulfil its core mission tasks: assessing the risks posed to vulnerable children, providing timely help where required, working effectively with the families of children, and controlling its own organisation and finances. The CEO was asked to resign.

In February 2009 the team of directors was strengthened with a new CEO who focused at first on the basics: gaining control of the budget and reducing the waiting lists. Also, discussions with staff brought up all kinds of ideas and opinions on why they were really there, what their purpose was. In addition, there were all sorts of opinions about what was wrong with the organization. They only thing people seemed to agree on was that it was never their own fault but that there was no leadership. Programme management was set up which focused on three major elements: case management methodology, development / learning of professionals and, finally, a professional working environment. This programme management was led by the director of innovation, a programme manager and several project leaders recruited from the team managers that were leading daily practice. New competences were formulated for people in behavioural terms (what people should do, how they should act) e.g. case workers should go to families' houses rather than stay in the office and send them a lot of letters that these families did not open anyway (out of fear of what could be in them). A new mission statement was agreed on: "Every Child Safe, Forever".

While this helped to change existing staff mind-set, reconnecting them with why they were there, as well as ensure that new hires had the right profile, after two years, most service and financial indicators had still improved only modestly.

"Check" what is going on

Seeking clients and purpose

In 2011, ChildProtect and its stakeholders had enshrined an aspiration to keep 'Every child safe' as the primary goal of the organization.

Instead of now pursuing this goal through a top-down change program, the chief executive and his team opted to devolve the next step to the professionals. A core group of ten case workers, two team managers and two psychologists (the "Vanguard") was given free rein to redesign the care process, along with a powerful mandate to cut away anything which did not contribute to keeping children safe. Along with a consultant trained in the "Vanguard Method", developed by John Seddon[1], that adapted key elements of Toyota Lean Thinking to the service industry, this group went through a rigorous examination process referred to as "check", followed by a "plan" phase (design a perfect process) and ultimately a "do" phase (making it the new normal).

[1] For example see Seddon, J. , The Whitehall Effect: How Whitehall Became the Enemy of Great Public Services - and What We Can Do About it, 2014

During check, it became apparent that it was not very clear who the client was of the organisation. At first, the question was whether society was the client. Or was it the family, or the child? Overall, the team realized that they were focusing on family issues rather than on child safety. This happened based on real cases. For example, there was a discussion relating to a alcohol addicted father who, to overcome his issue, moved back in with his parents. He would still need quite a bit of time to deal with this issue, but in the meantime, the situation did stabilise for his daughter. If the child is the client, then the case can be closed. But if the family is the client, then it still would continue. It was decided the focus was on kids.

The organisation, despite its mission statement, was in reality also not very clear on its purpose. During a first engagement that took place only with the parole section of the organisation, all sorts of goals were put forward: get kids back to school, find work or another proper day occupation, have a good contact with parents, have no contact with parents, be able to go through life independently, no more contact with police and justice, prevent to fall back into crime. When the scope was broadened to the other sections, it becomes clear the purpose is very much determined by what the staff actually do. They then realised that many of the problems kids have are transferred from generation to generation. Perhaps dealing with that is the purpose? But no methods are used that can do this. Ultimately, the "Vanguard" team came to the conclusion that safety for children was indeed what they were in the first place created for and hence should focus on. Hence the formal mission was endorsed.

Clients enter into contact with the organisation with demands… that are hardly met

During "check", the "Vanguard" team researched, from the client's point of view, what happens to the client from the start of contact to achievement of the purpose.

Contact is usually not voluntary in this organisation (e.g. a court order). It is discovered that when a case arrives in the organisation, an intricate pattern starts. Secretaries takes cases out of the "stock" of the region he/she is responsible for and then creates a file that is sent to team leaders, psychologists and coaches. These then distribute again to other colleagues. The latter often also take the case on a temporary basis to then allocate it to a colleague who will finally treat it.

People that end up with Childprotect usually are in difficult circumstances. Sometimes they are emotional or upset but always, when you listen well during a first meeting, they care that the child is safe. Kids that got into trouble themselves, say things like "I do not want to get into trouble anymore", "I do not want to get into contact with the police or justice again", "I need help with school, free time or looking for the right help". But most frequent is "how can I get out of here as quickly as possible?".

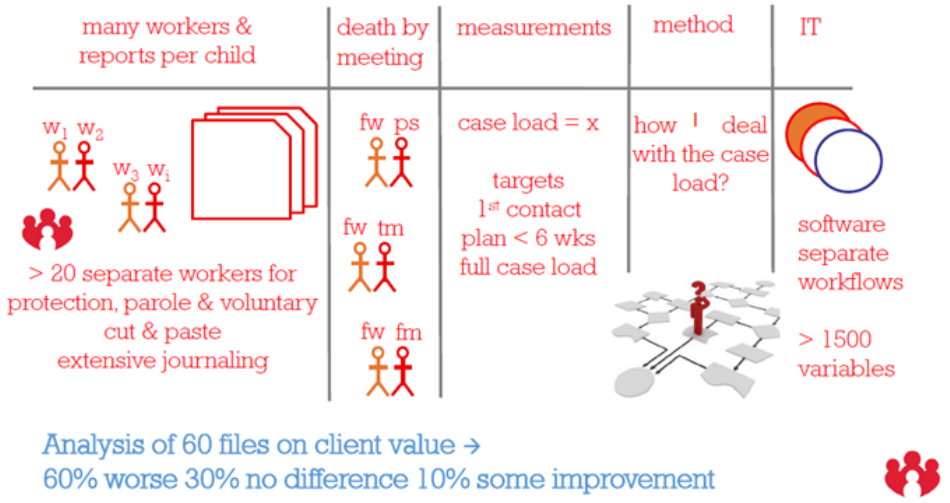
Normally, detailed research on what client demand looks like and how it is treated happens with "live" cases (e.g. listening to contact via the phone, looking at emails, being present during meetings, etc.) but as at ChildProtect this can take months/years, they decided to dig up 60 recently closed cases. They went through the extensive reports and marked in red when case workers were doing things that did not contribute to the purpose of keeping every child safe and hence were not adding value. They found out that there was a lot of activity (hence people did work hard), but that very

little of it was noticed by the families. 60% of these got worse, 30% stayed stable and only 10% got better.

How does the work flow through the organisation? What do managers spend their time on?

The result of the analysis is summarized in the figure below.

Figure 1: results of "check"



The professionals at ChildProtect were split organisationally across three roles: social workers who worked with parents on a voluntary basis and referred children to other services; guardians who had the legal responsibility for children under state care (based on, a court order); and parole officers who worked with (convicted) juvenile offenders. These different professional groups worked in separate teams. Some families were as a consequence confronted with a variety of different case workers from ChildProtect and each time the case worker started from scratch: getting to know the family, building trust, discussing difficult subjects, gathering information, taking decisions. If more children were involved, the number of case workers could grow even larger. Some families were in the system for 8 to 10 years and had been in contact with 20-25 persons from Childprotect as well as other services. At the same time, when a family had more than one child, but only one was in the system, the others were disregarded until they too got into trouble.

While the various case workers involved with the family held frequent meetings with each other to talk about the families, they hardly seemed to talk with the families.

What became also clear from the files was that in many cases, clear signals existed that kids were not safe and parents unfit but nothing was done with these signals. Case workers simply did not know how to act on these.

Case workers spent a lot of time complying with (real or imagined) prescribed protocols. This entailed that all the families are dealt with in the same manner, e.g. if parents have a mental disability, they are approached as if they can do everything anyway. Agreements are confirmed in formal letters while it is already challenging for these parents to remember and stick to three

agreements out of a conversation. Extensive case reports also had to be written, many of which ballooned to be more than a hundred pages. On the whole, the professionals spent up to sixteen hours per week reporting on their clients, rather than actually delivering case management services.

When asked why they filled out all of these reports, they told the protocols demanded it; however, no such specific instructions could be found. Rather, as one case worker later commented, 'I think it [the report] gave me a feeling of security, and the feeling that I have done my job well'. Basically, they were mostly trying to cover themselves. This was also apparent in the practice of copying everyone into emails, even though these were hardly read. Also, this need to be covered is why they spend a lot of time discussing with team leaders, psychologists, colleagues… The large case files were hardly read when someone needed to transfer a case to a colleague.

The formal quarterly reports contained a diversity of information: number of measures, number of requests, length of measures, number of kids in special care (families that create many kinds of problems), kids flowing in and out, number of cases per worker, number of complaints, number of safety measures, number of plans, number of indication delivered during a period, absences due to sickness, number of side activities…

However, team managers mainly focused on the size of the case load and their capacity for taking on a new case (deducting side activities, leave, training hours from the formal work hours). This was the main "performance" measure. At any one time, a social worker would be responsible for around 60 children, a guardian 18 children, and a parole officer 22 children. The concern was with the quantity of work but no information existed on quality. In practice, this meant that many children were formally under supervision of the agency, but the case worker would focus on the highest risk children and only passively monitor the others. Often, as a consequence, the situation of the 'lower-risk' children deteriorated over time, generating the need for more specialised services downstream.

Also, arbitrary targets existed e.g. see a family in 5 days, have a plan signed in six weeks, have an evaluation plan after 6 months,…. That did not really help improve the situation but only maintained an illusion of control. For example, having a plan signed did not mean anything was actually in the plan, let alone that the family was going to stick to this plan. However, a special function was created to "chase" workers to deliver these output on time.

In short, operational managers did not have much information that helped them to form an image of the work their team members are doing with the families.

The IT system reflected the three functional silos discussed earlier. It also forced case workers to go through all the (many) prescribed steps for all children in a family via a workflow system, even though this is not always useful.

ChildProtect was also highly dependent on the cooperation of other organisations to provide foster homes for children, support for the parents, or specialist mental health services. All of these organisations worked with their own protocols and methods, often causing friction between their respective employees. Moreover, these organisations were also facing financial pressures, making them extra wary of taking on complex or poorly reimbursed cases.

Plan for perfect

By eliminating all processes that were judged not to help achieve the purpose of keeping every child safe sustainably, the "Vanguard" group then designed a new method for providing child protection. This is called the "Plan" phase in the Vanguard approach. It refers to "planning for perfection", ignoring whatever current procedures and ways of doing things exist.

Revisit the purpose

At the start of "plan", the purpose has to be revisited and settled on. If safety is the goal, then one must have a common view of what safety is and how one works on it. If kids enter into contact with Childprotect, then this means other institutions have not managed well or kids have come into contact with justice. The causes of the lack of safety around the kids need to be signalled and dealt with and the family then has to have the capacity to continue under their own steam and get other help if needed. Safety does not mean that these kids will be assured the same kind of future as the workers at Childprotect aim to provide for their own kids (perspectives of a good and successful school career, getting their own family,…). Safety deals with "bed, bath, bread" and the absence of abuse or being witness to violence. It also means that kids are not limited anymore by the disability of parents. When this is achieved, then the family is ready to be transferred to other services.

Design for perfect, ensure clean transfers

During "plan", the team focuses only on work that has value towards achieving the purpose, which in this case consisted of:

- Making contact
- Understanding the situation
- Making a plan together with the family
- Taking the journey together with the network partners
- Ensuring that things continue to go well

Everything else can be labelled as "waste".

The organisation also gave the "Vanguard" team a few pointers: one family- one plan - one worker - one method. From that the "Vanguard" team formulated a set of **basic principles.**

A first principle was that one case worker would now work with an entire family(system) and would focus on mobilising all the partner organisations, the informal network and other family members involved (all these task are mediated by the same case worker). This is referred to as "bringing the **WHOLE system in the room**". That means that all those who can help improve the situation and serve as protective factors (e.g. the grandparents, neighbours, other parties that typically reported the issues in the first place, as well as experts like psychologists) should be present. It also means that e.g. if the father is in jail, the meeting is held in jail with the father participating. This also meant that a case worker brought into the family to report on the oldest brother would also make sure that the younger children were safe, and vice versa. Also, the children are present during the meeting. If the parents start to fight and the case worker stops them, they also see that. They also get explained what is happening and why. When other services are needed, they also should be present (only if this

is really not possible, this happens in a conversation, or, a very good report that contains only the info needed by the other service to start working). This referred to as **a clean transfer**.

Second, it was also recognised that just telling the families what is good for them does not work. The essence of the work lies in getting the families to come to a joint judgement of what is not going well and how to improve. Communication via letters, phone and e-mail or from behind a desk in a meeting, has been demonstrated to be ineffective. To influence families, one needs to be in the families. To help case workers in deciding what the next steps to take with families should be, the evidence based method of the "**Functional Family Parole Services**" (FFPS) was adopted[2]. The "plan" team members that were not familiar with this received training and started experimenting with this, to their great satisfaction. Hence, families now enter directly into contact with the right person at Childprotect, who understands what happened, discusses what they did and searches and deals with the causes together with them. The whole family must agree with the problem analysis and be prepared to accept help. This help must fit the needs of family and lead to a change of behaviour of the family that is sustainable.

There are now three **phases in an engagement** with the family: 1) engage and motivate 2) support and monitor 3) generalization. On the first day, one case worker (and if it is a threatening situation, two case workers) will be present. In the first 6-12 weeks, meetings are held with the family as often as necessary. The intention is to build trust, so while the causes of the safety issues are addressed, the case worker does not rub the families' nose in all of their problems all the time. The basic assumption is that families have a noble intent but that for some reason they are not living up to this. Case workers look for strengths in the family that they can build on. They do not utter judgment and need to respect the ways of the family. But it is paramount that the safety of the child is discussed and if they refuse to do that, then this constitutes an issue that must be addressed. The case worker does this by increasing the families' insight in the harm that children are exposed to.

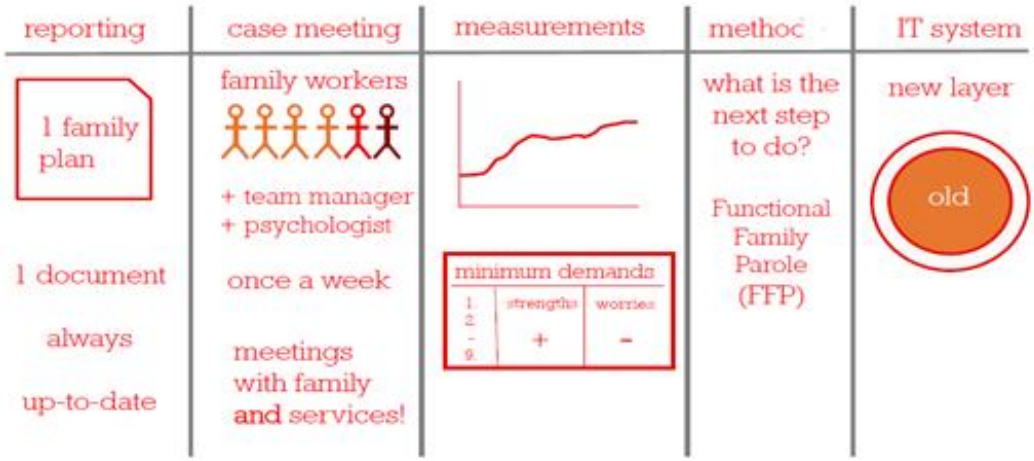
Once a family is secure again for the children, they are **handed over** in person (once again **a clean transfer**) to another service or they are left to themselves with the assistance of their informal network.

To facilitate these principles, the former three organisational 'silos' were simply abolished and replaced with **teams** that can take on any kind of case. A team now consists of case workers, supported by a team manager as well as by a specialist in behaviour/child development (psychologist) and a senior case manager who acts as FFPS supervisor to 6- 8 case managers and therefore has fewer cases to manage him/herself. If extra support is needed, some specialists back at HQ can be consulted.

The newly proposed way of working is summarized in Figure 2.

[2] See for example: Lucenko, B., Mancuso, D. & Felver, M. (2011). Effects of Functional Family Parole on Rearrests and Employment for Youth in Washington State, Juvenile Rehabilitation Administration, RDA Report, 2.34: Executive Summary, Olympia, 1-2.

Figure 2: result of "plan"



How do we know the work is done better now?

Measurement does not revolve around "caseloads" anymore. Rather, it now focuses on tracking acute child safety (referred to as the safety line) and where the family should be (referred to as the central line) so they can continue on their own without involvement of the agency. This is done simply by rating the situation with a score of 0 to 10 where a five is insufficient and a 6 just OK. The ratings are based on information gained from asking 8 basic questions (which were based on research). However, it is not the specific number that really matters. It serves as a trigger to ask "why". These ratings are consistently given every time there is contact or new information. An example is visible in Figure 3. In addition, statistical process charts are made concerning how long it takes to complete a phase of work (see Figure 4).

Figure 3: measurement of the purpose

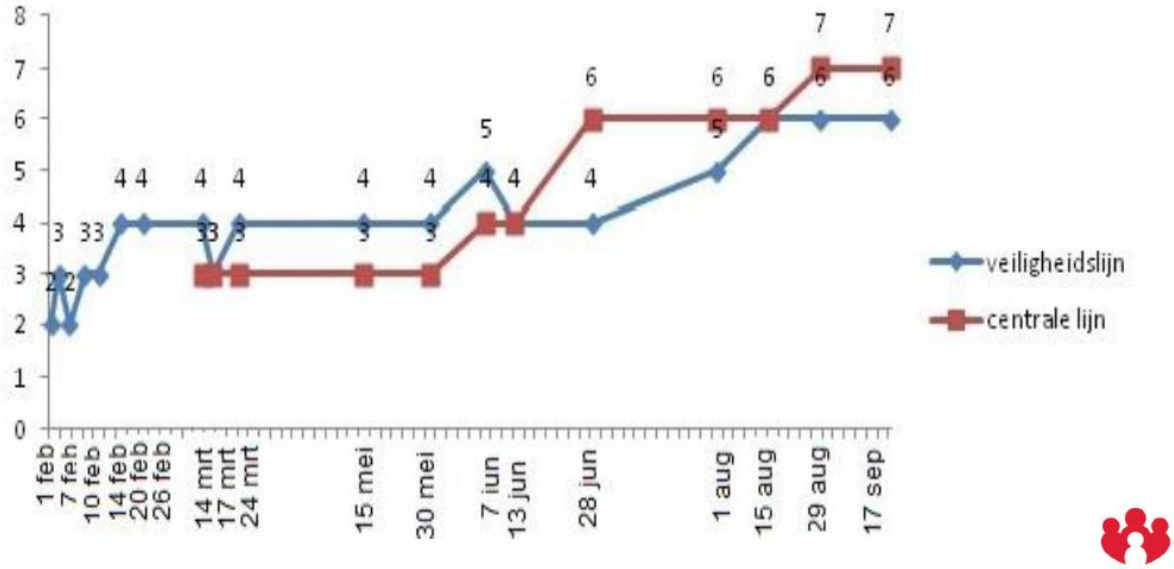
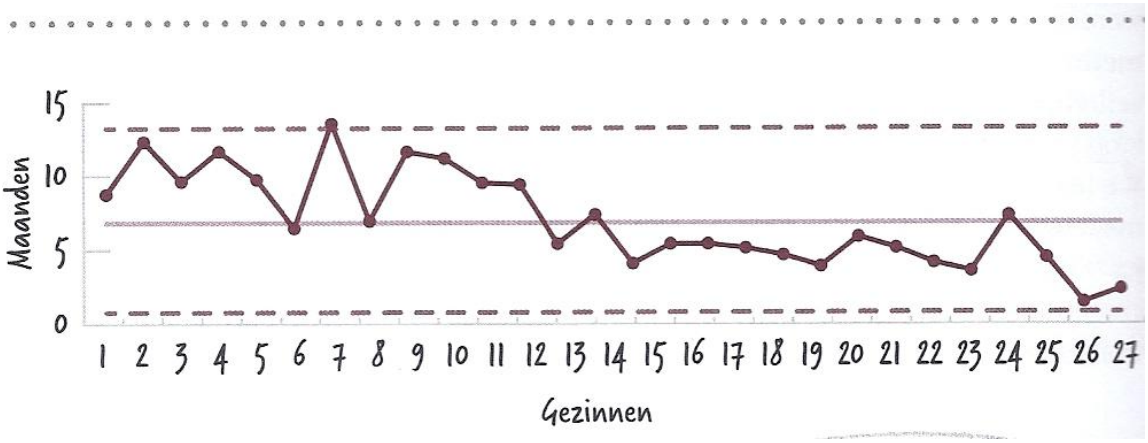


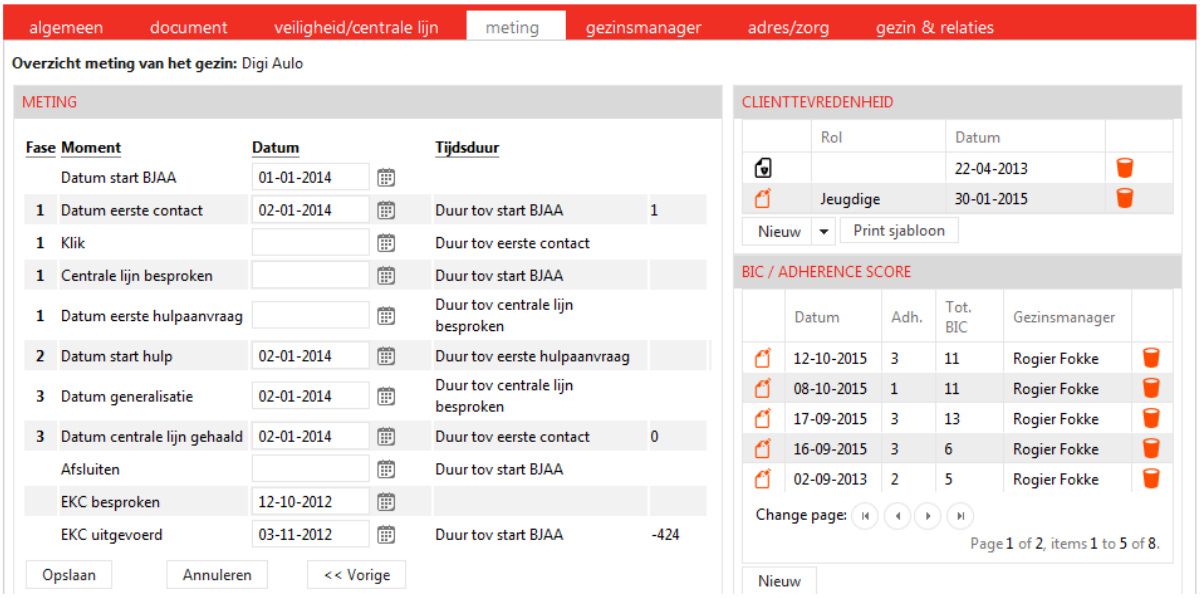
Figure 4: statistical proces schart



Such measurements are always taken as the starting point for discussing a case during the weekly team meetings (lasting on average 4 hours). This is a move away from the one to one meetings that were the norm before towards a meeting where everyone can learn from each other. Also, the "contact" journal that used to be held was questioned. The team decides to try to work without it. This leads to a report that is written together with the family, always actual and in which the history, symptoms, causes, safety concerns and approach can be read. All team members can understand on the basis of this single, up to date report, why the case worker rated the situation as he/she did and how the family has been trying to work on these causes. Reports hence do not have to be so detailed anymore, but focus on events and facts that are relevant to ascertaining child safety. All information regarding a case can be accessed digitally (see Figure 5).

The case meetings help to understand what new knowledge may be needed to progress. During each weekly meeting, 8 to 20 cases are covered. The focus is on the ones that are stuck or where important decisions are to be made. There are no more lengthy introductions about the history of a family and everything that may have been at play for all those years. Now facts are focused on: what are the patterns and what is needed? For each case four questions are asked: 1) who is the child? (rather than focus on the parents or family issues) 2) How did it get to be that way? 3) What does the child need? 4) What is the next step? It is possible that the team invites others in these discussions e.g. if a case really gets stuck, it gets escalated upwards, with weekly meetings with the CEO, knowledge manager, extra psychologists etc. to find the way forward. If a family and a case worker really cannot work together productively, the case worker can be replaced. But this will then happen in a meeting with the entire family group and the team manager and case worker.

Figure 5: family case overview – meaningful measures about family and case worker (fake data)



At the end of a case, customer feedback is also collected (on an 0 tot 10 scale and by evaluating a number of statements like “would you recommend another family to work with ChildProtect?”) This evaluation is done after case closure is reached.

Other management information concerns capacity planning (

Figure 6) where a dashboard shows which team members are dealing with how many families in what phase of the process. The team decides who gets the next family. The match between the family and the worker is important. Does the worker have the capacity to help the family and does he or she have enough room in terms of time? Whether a worker can take a new case depends on the constitution of his case load not on the number. If the families are in phase 2 they need less time than new families in phase 1 or families that are near case closure in phase 3. The latter need a lot of attention to make a relapse prevention plan to keep the children safe forever.

The number of families each individual worker has is therefore not important. However, the team average of families per worker is 14 families. Presently this number is subject of evaluation. As Childprotect and the municipality think that there should be more time available per family we are in the process of lowering the team average to 10 per worker.

Figure 6: capacity planning dashboards (fake data)

Beschikbare vs Gevraagde capaciteit

De gegevens dateren van 23-04-

		Beschikbare FTE								Gevraagde FTE								
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-2012	Gezinsmanager	1,00					0,21			0,79	0,00	0,25	0,45	0,13	0,001	0,00	0,83	13	11,1
-2012	Gezinsmanager	1,00								1,00	0,00	0,25	0,25	0,38	0,003	0,00	0,88	13	14,0
-2015	Junior gezinsmanager	1,00				0,50				0,50	0,13	0,25	0,05	0,00	0,000	0,00	0,43	4	7,0

Fase	V	# V	CL	Duur Fase 0	Duur Fase 1	Duur Fase 2	Duur Fase 3	Duur sinds Start BJAA	Duur hulpv. traject
2	5	13	5	7	116	68		191	198
1	4	2	-	7	129			136	515
1	3,5	1	-	48	89			137	137
0	-	0	-	170				170	170

-2008	Gezinsmanager	1,00					0,17			0,83	0,00	0,00	0,65	0,00	0,001	0,00	0,65	14	11,7
-2015	Junior gezinsmanager	1,00								1,00	0,13	0,38	0,45	0,00	0,001	0,00	0,95	14	14,0

What obstacles are encountered when trying to do the work perfect and clean? How are they addressed?

A system of **issue management** was installed. This means that whenever an issue arises that cannot be dealt with by a team itself, this is escalated upwards, to the CEO level if needed. This can happen on a daily basis. There is no need to wait for any kind of formal upwards reporting timetable.

Issues for example arise around the cooperation with network partners, who have not yet adopted similar practices as the agency. Case workers are asked to get as far as possible on their own first (talking to a variety of other service providers, convincing them…). However, sometimes team members can really not optimally arrange things for the families and need to get support from higher levels of the organization (team manager, region manager; top management) to engage the other organization. This is NOT to find a fix *just* for the specific situation but *preferably* to address the issue structurally and sustainably. By studying all serious issues that occur, organisational and systemic

patterns will emerge and on the basis of the analysis of these patterns further - systemic - improvements can be made.

An example is given in the search for appropriate care for a specific child. The case worker, after contacting many suitable organisations but getting rebuffed each time, realised she was not anymore looking for the best possible care for the child, but just any place that could take her. As she had run out of options she asked help from the team leader, who also did not manage to find a solution. Next, the region manager was pulled in, who, after reviewing critically if everything that could be done was in fact done, takes up the issue at a higher level with the care institution. The region manager is successful. However, the issue is now escalated to top management as it is clear that there is a lack of places at other institutions for dealing with urgent needs like this one. Hence, Childprotect together with the other institution take it up with the funders.

Issues can also cover unmet ICT needs, etc. Whatever creates a blockage that cannot be resolved at a lower level (after having tried), this should be escalated where it is critically reviewed. Issues are noted in a database where they are visible to the entire organisation. This is also reviewed to see if there are any patterns. Is it really a one-off incident or part of a series where similar things keep going wrong. The deeper causes of issues are also discussed.

Developing expertise

Aside from the weekly team meetings that have become learning events, case workers are also given feedback quarterly regarding how they are applying the FFPS. This is done on the basis of their case notes (what was done, what was the effect) during a team meeting and by supervisors coming along to a case to observe.

In addition, teams conduct an internal audit once a year on each other. Staff look at the case meetings and what they do well (using appreciative inquiry). Observation, interviews and checks are put to good use (e.g. are the numbers used in measures really meaningful). They dig deep: asking "why" five times is a standard practice. The shared purpose – every child safe forever – is always guiding. The learning gained from these audits is shared among the teams. Visiting each other's meetings is common practice now.

"Rolling in" instead of the usual "rolling out"

The "Vanguard" team worked out from April until July 2011 (in three months) how to deliver the new way of working, including "doing" what was "planned" –hence completing the full check-plan-do process. After this, three other similar teams of volunteers could start in December 2011 (it took a few months before the workers council and stakeholders had approved this new way of working) their own check-plan-do process in order to institutionalize the new way of working. They could do this faster than the "Vanguard" team as they were able to build on their findings. Each team was given three weeks' time off to go through this process. The key message is that they are all entitled to their own learning process.

In week 1 they went through “Check” and “Plan”. “Check” is done in a day, where each person analyses their agenda, e-mails and files for failure demand versus value demand. This tends to provoke a shock that may well depress them. Hence, the Vanguard team offers them their insights concerning how to do a better job. This is done over four days until the new team is clear on how they can start to work. In week 2 and 3 the old files were transferred to the new ICT system that supports family work. In the 10 weeks that followed they went through “Do”.

A complete “rolling in” took a full quarter and other teams had to take over from their colleagues during the three weeks off period. All the time, other units in the organisation (even when not rolled in yet) were obliged to allow / enable the rolled-in teams to work as they had designed it.

To make this possible for all 40 basis teams in the organisation an overall planning was then made. It took a full year, until June 2013, for the entire organisation to take all 40 teams through the process of “rolling in” and have them experience their own check, plan and do. The sequencing of these teams was determined by the closing down of their offices (see infra).

During roll-in, communication is kept to a minimum concerning changes that are made to the work by previous teams. Only the approach is communicated about. Otherwise, communication only creates resistance as other teams have not gone through a process yet that enables them to understand why, for example, contact journals have been abandoned.

Team managers have a crucial role to play in this rolling in. They use the check-plan-do process to understand, by going into the work and seeing what really goes on, what is the value work (versus waste) and to build a “learning climate” in their teams. Afterwards, they do not supervise (read “control”) if and how their team members operate in the field. Rather, they use the team meetings to incite team members to discuss the difficult and sensitive issues (just like the team members have to do with the families they work with). They should focus on facts, reasons and motives.

Team managers had to reapply for their jobs via a process with external experts that knew the organization very well. About 25 % of the former team managers left the organization based on this process. There was no need any more for so many managers so this attrition was not problematic.

The team managers needed to be able to reflect on how the rolling in was going. Hence, they came together weekly, coached by the present CEO (at the time director of innovation) and, initially, a Vanguard consultant. In this way, senior management gets to know the operational managers. It was key for senior management not to take over and propose solutions but rather to coach the team managers into doing their own thinking. The focus remains on applying the principles that were decided as well as causes of problems. Rather than going for quick solutions, that everyone would implement (or not) as they pleased, all variations of a problem are discussed to create solutions that are helpful for all.

Staff themselves did not have to reapply to their jobs. Rolling in focused on volunteers. However, the normal annual performance cycle did show that only 50% of staff performed according to (the new) expectations. Staff were given up to two years to figure out if they could function in the new way of working. If not, they were helped to find jobs elsewhere. Indeed, the agency considered it important not to create enemies among staff that left the organization. Many of these former staff would

indeed end up working in other partner organisations, for example the new “area teams” set up by the municipality as the first contact point as prevention staff workers for the municipal health services, in the various areas in the city. Hence relations had to remain good because the referral to Childprotect is made through the area teams. Quite a lot of staff (40%) opted out of the new way of working. However, there were no more lay-offs than usual.

Each team manager now coaches two to three teams of on average 7 case workers, one senior case worker (supervisor) and a psychologist. The way of working they learned during their roll-in persists. For example, when nationally developed initiatives (guidelines, instruments, check-lists, trainings,…) used to hit the organisation, they were pushed down unthinkingly by management. Now, one team will be asked to investigate. First, they look at how they are dealing with the topic (e.g. making sexual development of kids discussable in a family) today. Next, if they determine there is scope for improvement, they will familiarise themselves with the instrument. If needed, expertise will be called in. Then they experiment with families and discuss results. If this is indeed an improvement, they discuss how to integrate it into their approach. Next, they prepare the other teams that will go through a similar process.

Support services now support the work

Human resources

In terms of HR, recruitment takes into account IQ and personality, based on an evidence based psychological assessment, focused on youth care. The kind of work done by case workers is indeed not for everyone. It was found that police officers and people with interesting life experience have particularly well suited profiles, more so than traditional social workers. Social workers tend to take over, but the case workers need to be coaches of others, empowering them. Also a high capacity for-reflection is required concerning one’s own learning as well as that of colleagues, asking each other open questions without judging. This capacity is also needed to avoid that one starts to behave like the families one is meant to coach.

New staff now also receive a variety of training during a year (about 20 days), depending on their background. FFPS accounts in this allocation for 5x2 days of training over a period of a year and a half. Staff are to put in practice what they have learnt the next day and then reflect on it, including via watching videos showing themselves in action during real life sessions with families.

Secretariat

Also where other internal services still exist, the same principles are used. For example, there is still a small pool of secretaries. These also study the demand they get from inside the organisation and ask constructive questions why certain demands should be taken up (e.g. is it really useful to take minutes of meetings). It soon becomes clear that there is less work for them, but they are also pleased to see much is improving for the kids.

Legal

In the legal department, it is realised that a lot of the questions they get derive from insufficient knowledge of case workers. They develop training that enables case workers to retain and use the

knowledge. Occasionally they provide support e.g. appeals to higher courts if children's' safety demand this.

Facilities

There is also a facilities team comprising IT, application maintenance, business intelligence, facility management, service desk and document management / archiving. The goals for this team are to facilitate case workers to spend 80% of their time out of the office, meeting clients at home as well as partners. They should be able to get their administrative tasks done anytime, anyplace. They also need to be facilitated to travel to and from client locations and their work as a team needs to be supported (team spirit, cross-team meetings, reinforcing creativity and the values of the agency).

The facilities team addressed this in the same way as the case workers had addressed their work with check-plan-do. Assumptions embedded in the existing facilities were revealed ("check") by questioning their link to the purpose of the agency and the new approach for its core activity. Discussion panels were set up with management, case workers, facilities staff to design facilities for being perfect ("plan").

Accordingly, the IT system was reconfigured to focus on families, rather than on individual children.

As rather than spending 80% of their time at their desks, the idea was also that staff should be 80% outside of the office, staff got laptops, smartphones with mobile data connections, public transport cards, access to shared/public car parks, in company catering run by a social profit organization, etc.

This was also accompanied by closing down their offices and relocating them. Teams now are all housed in one central building but do not have their own desk and office anymore. Instead of desk top computers, they now have laptops. This makes sense as they are supposed to be out in the field most of the time anyway. So much of the office space would be unused.

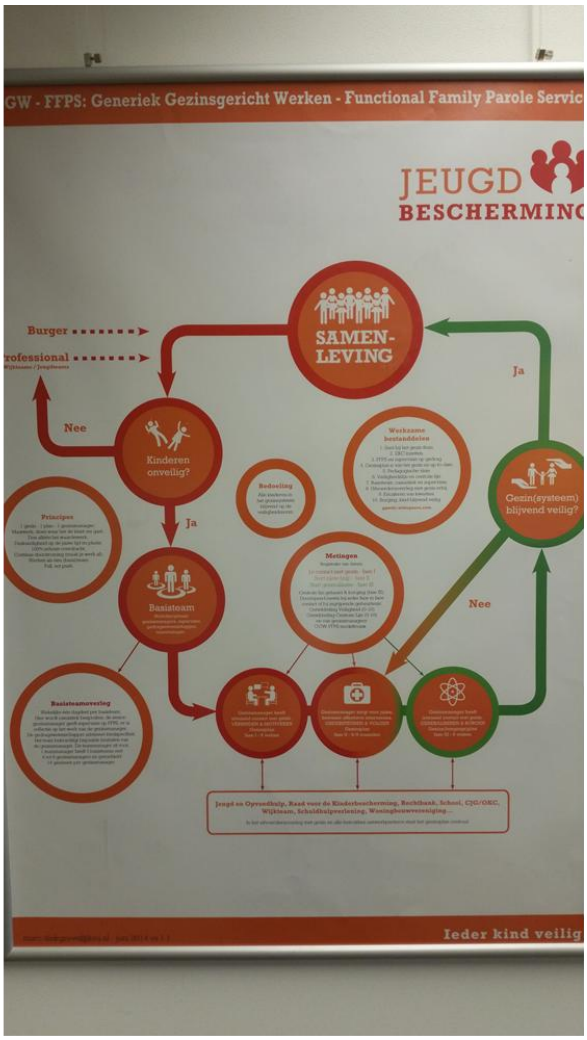
This new arrangement also applies to senior management. They need to be readily accessible rather than hidden in corner offices. While they have no fixed office or desk, they can always be found in the same area of the building. This also applies to other groups that need to be accessible namely psychologists, administration and the service desk.

In terms of the process that was followed, there is today still uncertainty whether it was wise to let the closing of offices determine which teams would roll in when, rather than stick to the volunteer way of selecting teams.

Picture 2: offices before the transformation

Picture 3: offices after the transformation

Picture 4: reinforcing values and approach on site



There is now also only one IT manager who manages 4 external contracts. He focuses on needs and then looks for suppliers that can meet these needs. This gives flexibility (costs become variable) and therefore if there is less staff because there are fewer families that are in trouble, then IT costs also go down.

They way needs are detected is based on issue management. If the same IT question arises over and over again, it needs to be investigated what is causing this. While staff can voice their needs e.g." I want my own printer", this will always be assessed relative to the purpose of keeping every child safe. If the printer is needed because 6 versions of a form need to be printed to be sent to partners, then the question is rather whether this should be taken up more structurally with these partners. Of course, in the meantime, a short term solution may be to award a printer.

This all led to a substantial cost reduction of facility costs (Figure 7 shows in green investments, in red facility costs, in purple ICT, in orange travel costs and in brown telephone costs). This was not a goal as such but the new way of working automatically led to it. The needed investment paid itself back quickly in savings.

Figure 7: facility costs

Exceeding expectations

As a consequence of the intervention, the costs of taking care of an entire family in 2014 were only marginally higher than taking care of just one child in 2011 (by limiting the number of case workers active in any one family) as depicted in Table 1.

Table 1: case loads and costs

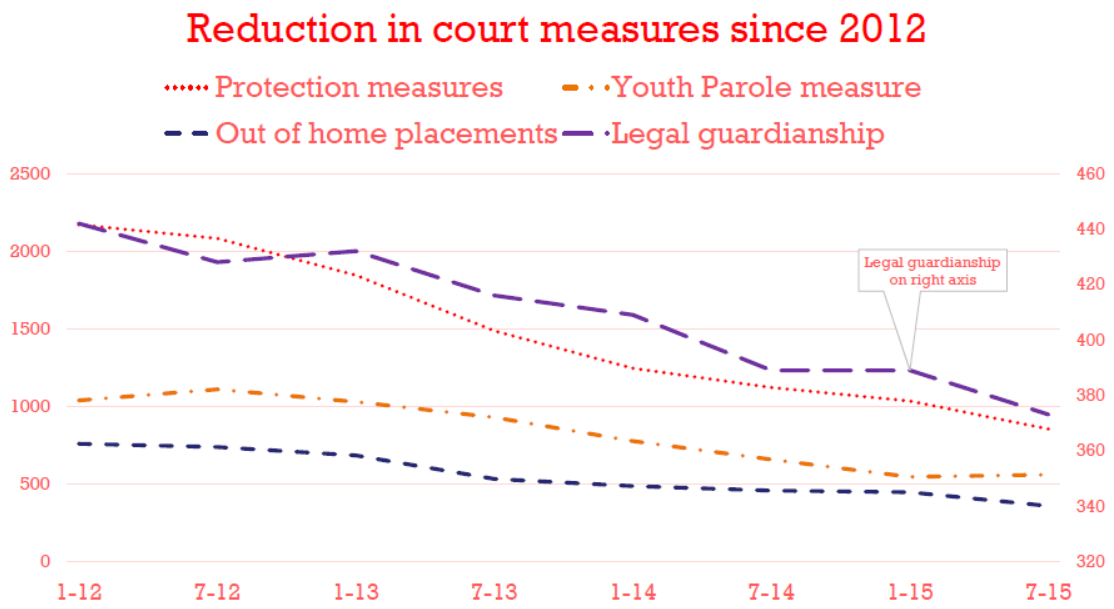
Professional	Average case load	Costs per child (often several cases per family)	Costs per family (including all children in the family)
Situation before 2011			
Social workers	60 children	€3.500	N/A
Guardians	18 children	€7.000	N/A
Parole officers	22 children	€5.200	N/A
Situation after 2011			
Family workers	14 families	N/A	€8.600

Source: Estimates from ChildProtect agency management, 2015

The new focus on early intervention had a significant impact on the outcomes being achieved as can be seen in Figure 8. The number of cases where legal instruments had to be used to compel parents to cooperate was reduced by 60%, and the number of children forcibly being removed from families decreased by 50%. Youth parole decreases with 45% but this is mainly due to a police change at the level of prosecution. Legal guardianship (by a case worker) decreased by 16% (while it rose nationally

by 3%). This is because Childprotect now puts authority as quickly as possible with existing foster parents or a new family or family member prepared and capable to take legal responsibility. The child then has natural persons as parents (rather than a case worker) which feels very different to the child. Other organisations, under pressure to reduce the number of protection measures, converted these into legal guardianships, regardless of whether this is in the best interest of the children.

Figure 8: court measures evolution since 2012



Importantly, the agency increased its ability to pre-emptively detect and help children at risk at an early stage. Client satisfaction rose from 5.8 to 7.5 (on 0 tot 10 scale) , as family members came to appreciate the newly proactive and transparent approach of the agency.

The changes resulted in cost-savings of around 30 million EUR annually: within the agency, this was realised by eliminating unnecessary internal processes and reducing the number of court measures. The total budget was reduced from 53 to 34 million EURO (19 million).A further 11 million EUR (at least) was saved for the child protection system as a whole, as the agency was able to decrease the number of clients it had to refer to specialist services. While other child protection agencies across the country struggled with budget cuts, ChildProtect delivered a balanced budget.

Sick leave amongst case workers was also reduced from 8-9% in 2009 to 6% in 2013. Yet, the agency now only employs about 300 case workers, 40 senior case workers, 15 team managers, 15 psychologists, 15 team secretaries, 7 advisors and account managers,15 HR, facility administrative staff, 1 knowledge ambassador, 2 directors: total 410 (as opposed to 600). The organisation is now growing again as 10 more municipalities outside Amsterdam have contracted Childprotect for 2016.

They take care of 3200 multi problem families with more than 7000 children. This number is down from the 10.000 children who were engaged with Childprotect before the transformation. Half of those cases were voluntary where there were only mild problems and their case management could be closed during the transformation process.

Local politicians started to praise the agency publicly, and it was awarded Best Public Sector Organisation of the Netherlands by a select committee of government experts in 2014. This was confirmed at EU level by winning the European Public Sector Award for the category of local government in 2015.

What issues still remain?

There is an ISO 9001 process in place that was awarded in 2013 after all teams had rolled in. Feedback from staff is that this did not amounted in asking "did we follow the paper procedure?". To avoid that this **external audit** amounts merely to "checking" if procedures are followed rather than support with learning –a real risk that was recognised in advance- the ISO 9001 certificate was connected to EN15224 where learning, using well-maintained feedback loops is key. Such an audit then ensures that the various feed-back mechanisms that were put in place, described earlier, are even more reinforced. Childprotect also looked for and found an ISO auditor that endorses this approach.

It was also crucial to engage in 2013 with a working group set up by the Dutch Ministry of Security and Justice to work on a normative framework that would be used for delivering a certification to provide child protection services. At this time, two thirds of the organisation had already rolled in. The new normative framework could have threatened this new way of working as it was predominantly oriented toward "checking" rather than learning. The efforts of ChildProtect in the working group led to a normative framework that became operational in 2015 and that was acceptable for ChildProtect. Yet, it is still much more rigid than the ISO 9001: EN 15224 audit that ChildProtect engages in on a voluntary basis. Hence, it remains a point on the management agenda to align this framework more with Childprotect's philosophy of learning.

There is also a rather traditional **staff performance evaluation system** with an annual planning meeting prepared and organised by each individual staff member, also addressing the question how the team manager and/or one of the other team roles (psychologist, senior case worker or a colleague case worker) can help. This is oriented towards generic job profiles that specify what is to be done in a particular role. They also clarify the purpose of the role and the contribution, in terms of what is to be achieved, and how this is linked to the shared mission.

Next there is monitoring. Mistakes are tolerated as people are learning, but the mistakes should not be the same ones over and over again. Finally, there is an annual evaluation where performance is graded from A to D. B means that the automatic pay upgrades are maintained, while A means that these can come a year faster. In case of a D, the pay upgrade can be delayed.

This traditional focus on individual achievement is being questioned. While it had its purpose during the transformation, as it was used to clarify if a staff member wanted to be part of the change and contribute to it, the HR staff now consider it too much looking backward rather than forward and think it may have a demotivating effect. The cycle is also too long. The HR staff are now looking at replacing the job profiles and evaluation cycle with a future oriented focus on talent and strength where people can grow horizontally (for example, they can become a psychologist, a senior case worker, a trainer or a consultant to area teams). Staff that do not see their future with the

organization anymore are facilitated to finding a better suited job e.g. by outsourcing, matching through HR consultancy with care providers or area teams.

Also, while **customer satisfaction feedback** is sought when a case is closed, the agency at the moment does not follow up afterwards. They are conducting an experiment at the moment to see how a family situation has evolved six months after they have closed the case and secured the safety of the children by means of the families own plan, with support from their own network and in some cases with professionals support.

Finally, another question is whether the agency should have involved also **the partner agencies** from the start, inciting them to go through the same process. But the risk would have been that they would have overreached and also failed in the home organization.

Conclusion: situating the case in a broader governance framework

Meuleman, L. (2008[3]) states that many problems in practice with "reforms" have to do with conflicts between the three main governance modes of hierarchies, markets and networks (e.g. hierarchically imposed narrow frameworks that render autonomy –a market governance element- useless in practice). The three modes of governance, based on Meuleman (2008) are described and compared in annex 1.

In addition, he states that the same governance modes can also reinforce each other (e.g. where the decision to initiate a network often is hierarchical). He also puts forward that what matters most is to find ways that maximise this reinforcement and minimises conflicts. This is referred to as "meta-governance".

Below, key elements of the ChildProtect transformation case' are put forward (in a non-exhaustive way) as are some of the ways these elements reinforce each other.

Some hierarchical elements in the case are:

- Setting the "purpose" (even though bottom-up input)
- Using the annual staff evaluation cycle to help staff make up their mind if they want to stay or leave
- Using assessment for team managers to decide if they should stay or leave
- Deciding to abolish offices
- Engaging in the Vanguard process and committing to it
- Engaging with other agencies at a higher level, when needed, through "issue management"

Market elements are:

- Outsourcing support services to maintain flexibility
- Autonomous teams that in principle have all the required skills and can do everything that is needed to meet their purpose
- A focus on efficiency (as lack of wasteful activity)

[3] Public Management and the Metagovernance of Hierarchies, Networks and Markets

- Engaging in public relations such as public sector awards

Network elements are:

- Volunteers from the various “silo’s” and functions of the existing organisation come together in a “Vanguard” team
- Cutting across the organisation by studying what happened to children from beginning to end of their engagement with Childprotect
- Systemic approach: getting all other services around the table to find solutions to issues
- Being active in working groups on how to assess quality of agencies like Childprotect

Many of these elements clearly work in tandem. For example, the initiative to set up Vanguard teams (a network element) is taken hierarchically. Also, when all actors around the table encounter an issue they cannot resolve on their own but that requires a change in another organisation’s practice, this is escalated to management who, hierarchically, address it with their counterparts in the other organisation. The relentless focus on reduction of wasteful activity (a market element) also triggered a decision to reorganise the structure of the organisation, abolishing its previous silos (hierarchical).

The Childprotect case is very interesting from a meta-governance perspective as it is not just an ad hoc case where meta-governance happens primarily due to the good fortune of having a few well-placed actors involved that have a high degree of meta-governance competence. Rather, it is describing an approach that intensively builds such competences throughout the entire organisation over an extended period of time and sustains this. As such, it may provide a replicable approach that can help to create various reforms in practice that are appropriate to a given context.

ANNEX 1: modes of governance (adapted from Meuleman, 2008)

	Hierarchy	Network	Market
Vision, values, mission dimensions			
Culture	Hierarchical	Egalitarian	Individualist
Theories	Rational (causal means-end logic), positivist	Constructivist (emphasizing bounded rationality, ambiguity), social structuration theory (patterned social arrangements in society that are both emergent from and determinant of the actions of individual actors)	Rational choice (self-interested users and producers), principal-agent theory, positivist
Judging	**Goal attainment / legitimacy**	**Appropriateness, wisdom via reflexivity and dialogue**	**Efficient use of resources**
Motive	Minimise risk	Satisfy identity of the group (based on empathy and trust)	Maximise (relative) advantage
Motive of subordination	Fear of punishment	Belonging to group, higher purpose	Material benefit
Role of government	Rule society (lower in hierarchy equals less power)	Partners (equal)	Deliver service (with competing providers/producers for users/buyers, also internally)
Response to resistance	**Legitimate power to coerce into conformity or sanctions (Sticks)**	**Persuasion to engage or decide to expel (Sermons)**	**Negotiate deals using incentives and inducements (Carrots)**
Dimensions of orientation			
Organisational	**Top down, formal, internal, "hierarchy of decisions" (each step down implements goals set in the step above)**	**Reciprocal, horizontal , informal, open-minded, empathy, both internal and external (boundaries do not matter)**	**Bottom-up (due to autonomy), suspicious (due to competitive nature of self-interested parties), external**
Actors	Subjects (expect to be "ruled")	Partners (expecting equal positions)	Customers / clients (expecting service at a decent cost)
Choice of actors	Controlled by written rules	Free, rules by trust and reciprocity	Free, ruled by contribution to one's advantage and negotiation

Aim of identifying stakeholders	Anticipate protest	Get their practical knowledge, enhance acceptance	Find reliable, professional, cheap contractors
Dimensions of structure			
Organisation	Line management, centralized control systems, project teams, for cross-cutting issues	Soft structure with minimal level of rules and regulation; process teams within a hierarchy	Decentralised, semi-autonomous units in competition with each other to get resources within a contract setting
Decision-making unit	Public authority	Collective by group	Individual players competing
Control	**Authority, oversight e.g. inspection, directives, legal powers of intervention**	**Trust, mutuality e.g. cooperative interaction, informal consultation, negotiation**	**Price (value for money), rivalry e.g. competition, benchmarking**
Coordination	Ex ante imperatives (rules and regulations)	Reflexive self-organisation	Ex post through exchange in a competitive setting (invisible hand of self-interest)
Transactions	Unilateral	Multi-lateral	Bi-lateral
Roles of communication	Communication about policy: give info	Communication for policy: organise dialogue (across groups –hence dealing with their social and cognitive fixation and defensiveness to "outsiders")	Communication as policy: incentives, PR to get others to take over a public task
Roles of knowledge	Clear facts, expertise suited to well-structured problems with a consensus on relevant knowledge or when little time (calamities)	Involve may parties in the knowledge basis, engage in joint fact finding, transdisciplinary knowledge development, suited to "wicked problems"	Proprietary and hence to be paid for and used for own advantage
Context	Stable via clear and detailed instructions, rules and procedures	Continuous change offers opportunities	Flexible and dynamic through competition
People dimension			
Leadership styles	Directing, little discretion (delegation comes with control)	Coaching and supporting, high level of discretion for lower staff	Delegation, high level of discretion for senior managers
Relations	Dependent	Interdependent (co-	Independent (self-

	(interventionist)	governance, interplay, interpenetration)	governance, interference)
Roles of public managers	**Clerks (administrate) and martyrs ('servants' with little room for creativity and entrepreneurship**	**Explorers producing public value**	**Efficiency maximisers within their "market"**
Competences	Legal, financial, project management, information management	Network moderation, process management, communication	Economics, marketing, PR
Values	Authoritarian, loyal to truth, obedient, disciplined	Communitarian, valuing equality, learning from others, openness, trust	Entrepreneurial, rational, emphasizing personal reward/success over loyalty, valuing competition and autonomy
Objectives of management development	**Allow someone to make the right decisions without constant supervision (hence a means of control)**	**Help with societal learning**	**Provide management tools for efficiency**
Dimensions of results			
Problem types	**Crisis, disasters, etc. that can be resolved by execution of force; problems that can be divided into clear parts to which appropriate expertise can be applied**	**Complex, unstructured, multi-actor/level/sectoral**	**Routine, non-sensitive issues**
Typical failure	Red tape	Never ending talks	Inefficiency, market failure, insufficient attention to outcomes
Production of…	Laws, regulations, controls, procedures, reports, decisions, compliance	Consensus, content, agreement, covenants	Services, products, contracts, out-sourcing, self-regulation
Accountability dimension	**Honest and fair, process**	**Robust, resilient, adaptive, outcomes**	**Lean and purposeful, outputs**

[i] All case information is derived from the following sources:

- Field visit of two days 25-25 February 2016
- Extra information obtained afterwards from Marc Dinkgreve , at Childprotect

- Case study 2015-173-1/2: ChildProtect: an agency under fire, Australia and New Zealand School of Government, 2015
- Coret, 2014, Weten wanneer je het goed doet- De bedoeling weer centraal, Management executive, Sept.-Oct issue Over management.
- Coret, Felser, Schreel, Grünwald, 2014, Weten hoe het werkt
- Additional scientific articles on the case management method and on the learning transformation of Childprotect are available and a number of publications are in progress.