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Self-Steering in Public Service: A Tale of two paradigms

"Self-steering" is a concept put forward as being one of the five key trends in the evolution of the Flemish government in 2017. There is talk about “more autonomy for teams, but at the same time clear leadership which defines the framework", as well as statements such as “…self-organisation and not self-steering, because they have already experimented with self-steering." (De Dycker, Goovaerts, Van Den Broeck, 2017). But all good managers delegate, don’t they? And don’t they always provide a framework? And what is the difference between self-organisation and self-steering?

According to Tjepkema (2002, p. 6-18) self-steering means abolishing the separation of management (referred to as “regulating”) and operational tasks. Self-steering always applies to a group of people or a team, who collaborate daily and bear responsibility for a set of interrelated activities to serve the customer and the common goal. While "self-steering" teams only take over monitoring and managing team performance from their managers, “self-organising" teams also plan the work of the group and determine the members of the team. Thus, the degree of self-steering becomes greater in "self-organising" teams.

This article aspires to situate the concept of self-steering in public service within the conflict between two paradigms of organising, namely the bureaucratic paradigm, building on the "scientific management" of Taylor, vs. the flexible and, by extension, networked paradigm, referring to modern socio-technology (MST) (Kuipers, van Amelsvoort, Kramer, 2012).

This should show that a paradigm shift to self-steering teams as self-organising teams within a flexible regime can improve the effectiveness of public services. Following Osborne, Radnor, Children and Vidal (2015, p. 426) effectiveness is defined as "public value as the indicator of public service effectiveness rather than internal measures of public service efficiency... adding value to the lives of citizens...".

The history of MST started in the 1940s at the Tavistock Institute of Human Relations. Classic social-engineering theory concentrated on the design of group tasks in contrast to approaches such as job enlargement and enrichment, which focus on individual tasks. In the modern version, redesigning the organisation as a whole came into sight (Tjepkema, 2002, p.1-2).

A comprehensive overview of the development of MST is provided by van Amelsvoort (1999, p.9-19). De Sitter (1981,1994) is mentioned there as the principal founder of the Dutch branch of the movement. In Flanders, Geert Van Hootegem is a pioneer (see e.g. Van Hootegem, Van Amelsvoort, Van Beek and Huys, 2008). Van Hootegem, Huys and Benders (2011) argue that growing application areas for MST include services, healthcare and government. They state: "As a customer or citizen you experience daily how hollow slogans about customer service sound, and how empty ISO and similar certificates are. To really focus on the customer, other principles are needed than those currently used by organisations." (p. 53)

In addition, van Amelsvoort (1999, p. 9) states that elements of MST are to be found in many modern approaches such as Total Quality Management (TQM) and the "Learning Organisation", which originated independently from MST. These approaches have a long history in the development of alternatives to bureaucratic organisation. In the case of TQM, the work of Deming (1986, 2000) is significant. He was co-founder of the Toyota Production System (TPS), from which lean management was later derived. The paradigm shift accomplished with it resonates in the title of the book that documented TPS formally for the first time, namely "The Machine That Changed the world '' by Womack, Jones and Roos (1990).

Authors such as Christis (2011) made explicit the connections between MST and lean management": "…I showed that MST and Lean follow the same design strategy (simplifying the production structure as a prerequisite for decentralising the regulating structure)... what Lean discovered via experimentation has been derived by MST from systems theory." and "I therefore conclude that the similarities between MST and Lean are greater than many people think." (p. 97).

Concerning the "Learning Organisation", the work of Senge (1990), building on academics such as Argyris and Schon (1978), represents a significant milestone. Tjepkema (2002, p. 27) explicitly identified connections between the Learning Organisation and MST: "companies start looking for strategies to enhance organisational learning. Self-managing work teams are considered a promising tool in this respect."

2. Two paradigms and two fundamental questions concerning organising

Van Laar, Achterbergh, Christis and Doorewaard (2015, p. 85) mapped the differences between bureaucratic and flexible paradigms building on two sets of fundamental issues.

The first set is phrased in the following way:

- the extent to which the provision of the service, its preparation (purchasing, planning, ...) and any support activities (HR, finance, ...), together referred to as "operations" are put in separate units or not;
- the extent to which any of the (types of) operational activities mentioned above may or may not be split into several parts, performed by different people;
- the extent to which operational tasks of the same type may or may not be concentrated in specialised units.

The **bureaucratic paradigm** strives to maximise the division of operations into (simple) tasks and to put them in separate units. To fulfil an order (a wish of a client), the interplay of many units, or a so-called complex organisational structure is needed. On the contrary, the **flexible paradigm** strives to bring together as many operational tasks as possible in one single team. Thus, to fulfil the order, only one organisational unit is necessary. This results in a simple structure with a complex set of tasks.

As such, the preceding set of issues says nothing yet about self-steering. Therefore, we need to consider a second set of questions:

- the extent to which regulatory tasks are separated from the execution of operations and put into other (management) units;
- the extent to which the strategic, tactical and operational regulation is also assigned to different units. Operational regulation concerns taking decisions during daily work. Tactical regulation is about improving daily work, while strategic regulation asks questions about the purpose of the work, or whether the activities must be scaled up, etc. as stated by Kuipers et al (2012, p. 78);
- the extent to which the various part of the regulation cycle have been separated as subtasks and assigned to separate units. Indeed, regulation can be represented as a four step cycle of observation, evaluation (interpretation), decision and implementation (see also Kuipers et al., 2012, p. 85-88);
- the extent to which 'systems' (collections of standardised, formalised procedures that fix activities into routines) specify maximally what should happen, or whether they provide minimal critical specification (supporting behaviour without fixing it) (Kuipers et al., 2012, p. 411).

Within the bureaucratic paradigm one rather chooses to separate regulation from execution. Also, one chooses to maximally specify based on systems. Within the flexible paradigm, the essence of self-steering is that regulation and execution go together as much as possible in one unit, with a minimum specification by system.

Thus, this second question can be summarised as choosing between the “regulation of service providers”, or “service providers who regulate in interaction with service users”.

It must be clear that, in a bureaucratic regime, the regulation is separated from excution on the work floor, with a maximum specification of the work. This automatically follows from the choice for simple tasks within a complex structure. Indeed, if execution of operations is divided in tasks which are put in different units, there will be a great number of complex interdependencies between these units. This requires a lot of interaction (transfers) between units that do not necessarily have the overview of the entire operational process anymore . Managers at a higher level, who still possess the overview, therefore need to regulate, and they normally try to accomplish it through detailed procedures, standards and planning.

In practice, this often lead to problems. Kuipers et al. (2012, pp. 40-1 and 86-7) argue that this bureaucratic way of regulating forms a closed system. The system then replaces reality. If the interaction proceeds according to relatively predictable patterns, then such mechanical "if ... then" rules work well and the organisation will remain in balance. Even if not everything goes exactly as expected, this is absorbed and is not disruptive. "Reality" is then not substantially different from the system.

If the capacity of the work floor to deal with something unexpected falls away, then an imbalance occurs. The reality and the system no longer overlap sufficiently. This happens either because more activity than expected is needed (quantitative), or because a different response is required (qualitative) that is not contained in the routine repertory of activities. It then transcends the non-routine capacity to timely improvise a new and adequate response (Kuipers et al., 2012, p. 81-84 and 98-99). This capacity depends on the skills and knowledge

of people in the workplace, as well as on the resources they have available. It also depends on their ability to decide, after observation and assessment, to carry out the improvised action (the full regulating cycle). And that non-routine regulating power is extremely limited when maximum specification-based systems exist (p. 99).

If somewhere an imbalance is created, this will obviously manifest itself in the interaction between units. However, precisely because the performers on the work floor have lost the necessary overview to solve interaction problems across units (where a problem later in the process may have been caused by an earlier step in the process), regulating will be accommodated at higher hierarchical levels by specially appointed managers. Because managers at those higher levels are further away from execution, sometimes a very large time lag occurs between observation (real time information), and the remainder of the control cycle. Meanwhile, a disruption has the chance to affect the whole organisation (Van Laar 2015, p. 87).

An overview of the whole operational process is also necessary for tactical regulation (for solving disruptions more structurally) which within a bureaucracy happens almost exclusively at higher levels. This makes effective tactical control not self-evident. The bureaucratic organisation, as a closed system, also determines how, based on shared principles and values, reality can be looked at (observation as the first step of the control cycle). To structurally improve, it is usually necessary to firstly challenge the underlying principles and values in question and then look at reality from a new perspective. Kuipers et al. (2012, p. 85-88) refers to this as "double loop" learning, which is the basis of structural improvement. In fact, a fifth regulating step is then added to the four step control cycle, namely “re-norming”, to allow ensuing observation in a different way.

If judging and decision-making in the regulating cycle take place at higher levels, information (observation) should be transferred in a manner that facilitates its processing at these higher levels. The chances are great that, in addition to the above-mentioned time lag of information transfer, information becomes so simplified, abstract and general that it does not lead to ‘re-norming’. Therefore, it does not give rise to new interpretations of information nor ensuing innovative decisions. And then there is the assumption that the imperfection of the observation is not "anticipated" (the "gaming" detailed in Bevan and Hood, 2006). To avoid these problems, it is appropriate to situate the whole regulating cycle as close as possible to execution, which is exactly what is done in the flexible organisation. In a bureaucracy the maximally specified systems and hierarchical control cannot however not simply be replaced by "self-steering’’ in the workplace. Endless discussions and conflicts will arise that require intervention from the hierarchy and will create the self-fulfilling prophecy that the workplace is not ready for more autonomy.

3. A third question arises: observing "inside-out" or "outside-in"?

A flexible regime, characterised by complex tasks within a simple structure and self-steering, can respond faster and more adequately to disruptions. While this is probably true when it comes to purely operational disruptions, it may not apply to disturbances that require a tactical or even strategic response. In general, if you are looking at the wrong issues or looking the wrong way, it does not matter who regulates, either at the workplace level or at higher levels. Also on the work floor one is looking at reality from the point of view of existing principles and values, and therefore only sees through the lenses that are available

in the organisation. The solution is obvious: one must leave the organisation to observe the organisation from a different perspective.

Authors like Senge (2008, p 10) put it as follows: "All real change is grounded in new ways of thinking and perceiving". Empathy becomes the key feature, as also emphasised by Scharmer and Kaufer (2013, p. 147): "Empathic listening allows the individual to see reality from the perspective of the other and sense the other person's circumstances". The relationship between empathy and innovation (the consequence of effective tactical or strategic control), is well known from the concept of "design thinking". "To inspire human-centred innovation, empathy is our reliable, go-to resource" (Kelley and Kelley[1], 2013, p. 22). This involves discovering the reason why – from the perspective of the customer – the service should exist. It also confronts the organisation with the enormous variation that exists among customers. They all have different abilities and limitations as well as different expectations. In addition, there is a huge difference between services and large-scale production. Workers providing services at the workplace are faced with this diversity among customers daily, while in production the confrontation is almost always indirect.

In a bureaucratic regime, empathic listening makes little sense. Even if this results in new insights in the workplace, it will prove to be very difficult to introduce these insights in a meaningful way at higher levels, where something must be done with them. The information must be manageable and therefore will be abstract. Thus, it is also prone to misinterpretation and "gaming" as already pointed out above. However, the source of the problem lies in the misguided separation between those who make the observation (shop floor) and those who must respond to it (management), which itself is a consequence of the maximum separation of operational tasks.

We summarise this third question as follows: namely, whether we go for an "outside-in"[2] or an "inside-out" perspective, as the first step (observation) of a control cycle that takes place fully in the workplace.

4. Should everybody experiment with perfection or is it about "rolling out" a negotiated organisational design?

To achieve ambitious change, the choice is often made to define a vision, mission and strategy at management level and then to consult the rest of the organisation. As a next step, an attempt would be made to delegate a group of people from different parts of the organisation to think about redesigning the organisation. Subsequently they would implement this new design across the organisation, which is called "rolling-out" of the change.

It is assumed that strategic regulation concerning vision, mission and strategy cannot primarily be done by the work floor and that management must provide the "framework". Of course, this is correct. If the organisation was organised according to bureaucratic principles, then the work floor would not have the overview necessary to address such questions. Equally, it can be assumed that the management is also not optimally equipped to address

[1]Tom Kelley and David Kelley are the founders of IDEO, a leading design consultancy connected to Stanford University, one of the leading academic institutions on "design thinking".
[2]This term is also used by Seddon, 2003, p. 11 but is used to contrast with the top-down perspective.

such questions, as it is far removed from external reality and used to working with abstract, general and simplified information. This is not very useful for the re-norming needed for effective regulation, whether tactical (on the "what" of implementation) or strategic (on the "why").

Therefore, it is a plausible idea that management and shop floor must find the answers together. This however should happen using a method which is coherent with the paradigm shift that one is trying to achieve.

An operational team, rather than a working group of representatives, can be put together with all the expertise that is necessary to serve customers, including in terms of support and regulatory tasks. The latter means that from each management level, up to the level of CEO, someone is to be assigned to the team. This is an expression of the first two organisational principles discussed in this article, which aim to establish a simple structure in which the work floor regulates complex tasks. At this point, the team does not yet know what these tasks will involve, because these must still be designed by the team itself.

The third principle, the adoption of an “outside-in” perspective, should enable the team to regain the overview of what is happening and to find out "who" the customers are and "why" the team exists, looking from the perspective of these customers (empathy). Then it becomes possible to experiment with the "what" of the service. Initially, one pursues this to perfection by reasoning from the perspective of the diversity of customers, rather than from the existing organisation. This then results in radical innovation.

A resulting new method is then NOT rolled out to the rest of the organisation, but every individual in the organisation should go through a similar process as the first team. Indeed, referring to the classic article by Benne and Chin (1969), one can adopt an empirical-rational strategy which assumes that you are able to convince others with objective data. This only works if you remain within established norms and do not affect the interests of others. Therefore, this approach is of limited usefulness within the frame of the method outlined above. One can also use power to force others, but this is only effective with a management which has enough credibility and trust. It also reinforces the existing dependency of the work floor on management. The normative re-education approach, on the contrary, assumes that behaviour is determined by attitudes, values and norms and that these can be affected by stimulating initiative and participation, mobilising local knowledge and self-analysis.

The principle of normative re-education assumes that everyone goes through the same normative learning process. This again involves looking from the outside at the inside of the organisation, planning a change as "perfect" and experimenting until it works better than before. In a model where redesigning takes place in one go, with representatives from all levels and units, the entire organisation may be in an abstract sense "involved", but this does not apply to every individual to the same degree. This makes it difficult to roll out the changes, however meaningful. It is also likely that one remains at a low level of self-steering because one has not learned how to self-(re)organise from the very beginning.

Tjepkema (2002, p. 9-10) suggests that the degree of self-steering in teams usually starts from a relatively low level, with the intention that it should increase over time, and also include a transition from self-steering to self-organising teams. Starting self-organising teams from the very beginning allows everyone to question the primarily bureaucratic principles and values that underpin the current process (re-norming). This is a very suitable way to

make the transition to a more flexible regime. As Chin and Benne (1969) argue, the best way to discover new values is from practice. The traditional model whereby, through participation in working groups, negotiations take place on mission, vision, strategy and organisational design, is rather based on an empirical-rational model founded on rational arguments. In public services, where direct and daily interaction with the customer takes place, normative re-education is easier to realise than for instance in manufacturing, where the shop floor is usually only indirectly in contact with customers via the product. This is probably the reason why in production one chooses self-steering teams rather than self-organising teams.

We can summarise the change issue in public service as follows: allow everyone to experiment with perfection or roll out a negotiated organisational design! The following chapters deal with practical examples that attempt to concretise the principles which are discussed in this article. We start by discussing the "inside-out" versus "outside-in" approach as this is crucial, both from the perspective of change management considering a paradigm shift and from an organisational effectiveness perspective.

5. "Inside-out" or "outside-in": examples from the UK on "troubled families" and social housing

An "inside-out" approach starts from inside the government organisation and looks outwards to the public. An example (Tweedie, 2016) of this approach is found in the UK where in 2012 the "Troubled Families" programme was created. Through this programme, English local authorities could receive £3,200 for every family they could recruit and £800 extra for each successful family. Success was defined based on criteria such as finding work, reducing truancy of children, reducing the number of crimes, etc. In the summer of 2015 Prime Minister Cameron suggested that the programme was extremely effective: " I can announce today that almost all the 117,000 families we started working with have now been turned around." However an independent analysis by the National Institute for Economic and Social Research noted that "Across a wide range of outcomes, covering the key headline objectives of the programme – employment, benefit receipt, school attendance, safeguarding and child welfare – we were unable to find consistent evidence that the Troubled Families programme had any significant or systematic impact." (Tweedie, 2016).

Tweedie (2016) reported the following about the programme:

- Families were considered a "success" even though members of the family were still involved in drug abuse, crime, truancy and committing or undergoing domestic violence, as long as there was only one family member that no longer received financial support;
- Where the figures were available it could be inferred that strange things were happening. For instance, data from the local administration of Poole in Dorset showed that an average of 372 days was required to move a family away from slippery ground. But, this varied between 1,852 and 8 days;
    - Families were sometimes selected on a very weak basis, for instance because of a single complaint from neighbours about noise. This was not surprising since the central government had fixed the total number of families at 120,000. Local

authorities besturen, with cramped budget, were delighted to “find” the number of “planned” families.

A second example (Cottam, 2013), the LIFE programme for "troubled families", did choose an “outside-in” perspective starting from the early design phase of the programme. It looked from the position of the citizens towards the social services. This case was not explicitly situated within MST but within the relatively recent "design thinking" approach as described by Camacho (2016).

In order to experience what the reality of these families looked like, future workers on the programme spent eight weeks of their time in the town of Swindon among the most problematic families. Families were also given video cameras to document circumstances that the workers otherwise would not know about. Earlier experiences with service providers were also visually mapped. These were called "customer journeys”. They showed that contacts could be as high as 73 services, provided by 24 departments. The pattern was that interventions had been purely reactive: when a crisis occurred then a service provider would arrive to manage the situation. Once this had been dealt with, the busy service providers left to deal with the next crisis somewhere else. In the end, it was concluded that not one family successfully exited these social services.

Once the new service was established, in co-creation with the families, the social service providers were keen to continue working from an “outside-inside” perspective. For this purpose, an information system has been developed, which forms an integral part of the approach. After all, service providers support families to make their own plans for the next steps. They decide what they want to change, how they are going to do this, who will assist them, what will be different once they have done it, and when they are going to rethink. For each family, the plans differ, depending on what is most meaningful at the time. Together with the family, the service providers in the programme plan when they will meet again. Meetings are held to discuss what took place and why things happened. The service provider then also makes observations on the spot, which can be discussed.

On the basis of available data, the service provider formulates an opinion during the interactions, based on a framework with a given number of "capabilities”.[3] These are issues that are important in enabling most of the families to lead a meaningful life. An example of such a "capability" is "self-esteem". The service provider uses a scale from 1 to 4 where 1 represents a lack of self-esteem, indicating that the person has no faith in him- or herself and is struggling to express it. 4 stands for self-confidence, self-satisfaction and self-respect.[4] This allows progress or decline to be tracked, and at the same time the reasons for this to be discussed with the user of the service. The information system supplies the service providers with details of what the capabilities mean as well as examples from practice. The intention was that these examples would be continuously added to based on the interaction with the families. The focus is on how a "capability" can be made concrete and observable within the context of the family (for instance, a statement in an interview indicating the extent that a person sees him/herself as valuable). It is important to know that this is not a standardised box-ticking questionnaire. After all, the citizen is not asked in a direct way whether his or her

[3]This refers to the theories of the welfare economist and Nobel prizewinner A. Sen as described in Alkire and Deneulin (2009).

[4]See Wauters (2015) p. 60-1 via http://www.latitudeconsulting.eu/images/toolkit_innovatie.pdf for a visual display.

self-esteem has grown. This should rather be reflected in the interaction, through conversations and direct observation between citizens and service providers.

The LIFE programme was described as an example of good practice in 2012 by OFSTED, the Office for Standards in Education, Children's Services and Skills. It was a pilot programme run by service design agency Participle, making use of project funding. In 2015, Participle decided to terminate this and other projects. After all, it never intended to become a regular service provider, but rather to demonstrate the potential of systemic service design.[5]

The systemic approach constitutes a step forward compared to traditional standards such as the number of offences and absences from school. It makes an attempt to grasp the reality as experienced by families and to examine the underlying causes so that effective treatment becomes possible. Nevertheless, this system is still halfway between “inside-out” and “outside-in”. It works with predetermined criteria and scales, fleshed out by the service, albeit with more proximity and focus on the real situation of families. Predetermination, however, reflects the desire to aggregate data to generalise, for instance how many people make progress on which dimensions.

This can be contrasted with the approach described in Gibson (2016)[6] and Davis (2016), in which the criteria are completely determined by individuals themselves. As a result, we find "criteria" such as "I want to work", "I want to reduce my spending" but also "I want to prepare meals" and "I want to go on hikes". The individuals decide whether there is still a long way to go and how far. It then becomes impossible to aggregate or to generalise. The integration of the measuring instrument as a tool for the benefit of the citizens themselves is then complete.

It is no longer the job of the service provider to form an opinion about the level at which an individual is located. It is up to the individual to explain why he or she feels there is still a lot or a little work to do. In this way, the service provider looks at the reality entirely from the perspective of the citizen. This does not mean that the service provider must agree, but it does constitute a starting point for dialogue.

An “outside-inside” approach offers several advantages. First, the question arises why the service exists from the perspective of the citizens. In the case of "troubled families" it is about living a life that is worthwhile. What makes life worthwhile varies greatly from person to person. Only the individual can answer whether his or her goals are achieved. It is up to the service to interact with the individual to materialise these targets and to work in co-creation/coproduction with the individual. Coproduction becomes a natural way of working in an outside-in approach as the starting point is the real context of a specific citizen. Then, it is not difficult to observe that the individual and their environment have a lot to offer in the pursuit of his/her goals. The LIFE programme, for example, included a lot of activities in which contact between the neighbourhood and the "troubled families" was restored. In this way, the direct environment could play a positive role in pursuing a better life for these

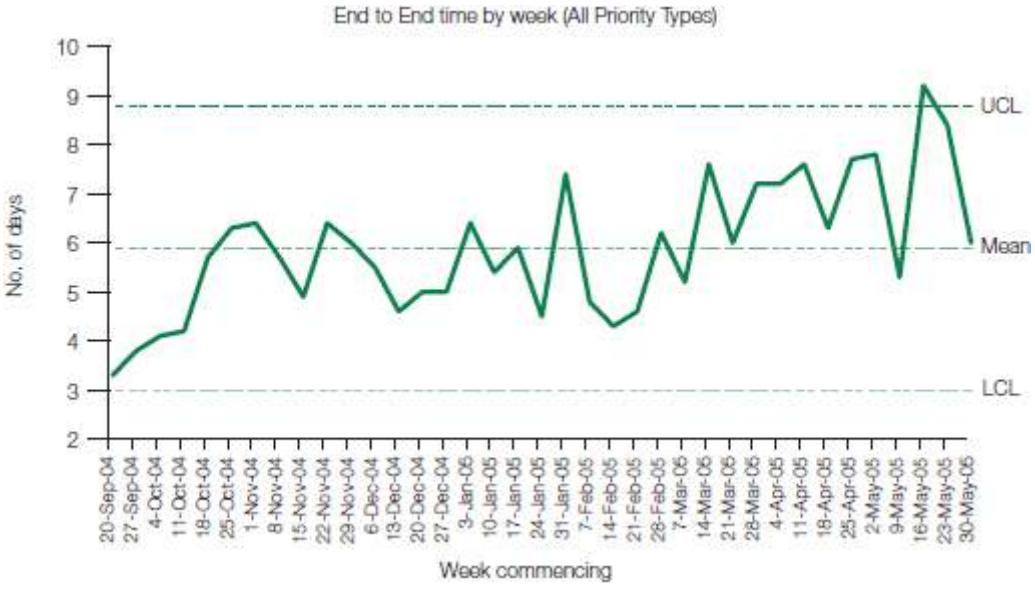
[5]www.participle.net documents the different pilot programmes, created and demonstrated by Participle.

[6]See https://vanguard-method.net/2016/09/14/why-better-measures-lead-to-better-lives/ for a visual display.

families. Finally, an outside-in perspective naturally raises the question why there is so much variation for families in achieving their objectives. Why does it take so much time to achieve the desired progress in one "troubled family" compared to another? Indeed, an outside-in approach attaches little importance to averages. The average person and context does not exist and therefore cannot serve as a concrete starting point for services. Better average results that lead to greater variation in outcomes for citizens are not seen as progress. The goals is rather to reduce variation in combination with better average results.

An example how this variation can be visualised, from an inside-out perspective, is found in another case, the repair service of the social housing service in Tees Valley in the UK (ODPM, 2005, p.52). This case is an example of “lean thinking” as adjusted for service provision in the way described by Seddon (2003).

Figure 1: statistical process chart for repair times



Bron: ODPM 2005

Figure 1 shows (on a weekly basis) the average time needed from the notification of a problem until the repair is completed "in a manner that meets the expectations of the resident”. The example shows that the average is 5.9 days with a statistical upper limit (UCL) of 8.8 days. The average of 5,9 was generated after the redesign of the service during the summer of 2004. The average for the years 2003-4 was however over 28.8 days, with an increase in March and May 2004 to 46 days. Yet the average is not interesting in itself. What is interesting is the variation in duration: is it predictable? Does it remain within statistical control limits and is it therefore "normal"? For example we see a peak in the week of May 16 as well as an upward movement of repair times in the period as of March 21. Unexpected variations raise the question what the reasons are for these variations. Also, with the chart, one knows which specific transactions need to be studied to answer this question.

Before the redesign, the traditional targets to complete repairs, which were closely monitored, were almost 100% achieved. But when the time was considered from a systemic point of view, in the present case from the social housing tenant perspective, it only showed

88% achievement (ODPM, 2005, p. 53). What the tenant considers as "finished" is not the same as what is considered as such by the service. The explanation provided by ODPM (2005, p. 32) states: "If a job could not be done owing to lack of time, materials or access, the job was passed back for rebook. This process involved cancelling the previous job, entering a new one and starting the whole process again". The sudden rise in March and May 2004, considered from the “outside-in” customer’s perspective, was due to an increase in misdiagnoses by the call centre, where at that time new employees were hired. This was not picked up by the traditional "inside-out" targets but it was actually signalled by the new method of measuring.

The examples clearly demonstrate the effects of an "inside-out" approach. Since the information should be easy to process for management, a limited set of abstract "measures" (using averages), is being used, which can never reflect the complex reality in all its diversity. If these criteria are coupled with incentives (like money and monitoring), leading to "gaming”, it is not surprising that decision-makers (like Cameron or supervisors of social housing), located far from the action, draw the wrong conclusions. An "outside-in" approach within a regulating cycle which is integrated at the work floor level is able to productively deal with the variation one is confronted with as it occurs.

6. Complex organisations with simple tasks or complex tasks with simple organisations? Examples from home care (NL) and social housing (UK)

The case of home care in the Netherlands as described by Van Dalen (2010) illustrates the importance of this issue. In the Netherlands, home care has a high degree of separation of operational tasks into (simple) sub-tasks, which are carried out by different units.

This means that a person who needs help must first fill out an intake form, on the basis of which an indication centre decides how many hours of a specific type and level of care should be provided. The result is then sent to a regional care office, which contacts a range of health professionals who can provide that care. The planners at the healthcare provider will then schedule the various specialised professionals (who, what, when, how long, what). Providing indications, contacting the client and planning (all preparatory tasks) is thus separated from the service delivery itself and put elsewhere. Specialised caregivers then execute the plans. As a consequence, the actual care is split up in a relatively high number of different care tasks performed by different health care specialists (who identify primarily with colleagues with the same specialisation).

In this system, the client may see up to 20 different people to perform specific tasks in a short period of time. The caregivers execute their jobs as quickly as possible and leave for the next customer. If they are pressed for time, they have no other choice than to execute the tasks less than perfectly. They cannot take into account the client’s specific needs, and spend a lot of time travelling from client to client. Finally, since the indication centre has allocated a specific amount of hours, these will be used, whether or not it is really necessary.

That it can be done differently is shown by the example of “Buurtzorg”, a Dutch care organisation working with small teams of 10 to 12 people, focusing on a limited number of people who need care and with a limited geographical scope. Each team member is multifunctional: he or she can execute different tasks at different levels. As the team only has a limited number of customers, they know the clients well and can easily determine what

this person needs and how this evolves. They can decide what to do first and what they need to spend time on, in terms of clients and tasks, given the context and interaction with the client. They also perform the indication, together with the clients who were referred directly to Buurtzorg by local actors (for instance the general practitioner). Preparation (planning, needs assessment) and services are thus brought together as far as possible in the same unit. As much as possible, a variety of tasks is executed by the same person or at least by a member of the same team. On a monthly basis, 15% of the clients see one or two different care providers, almost half of the clients see three to four care providers and the rest between five and nine.

The advantages are illustrated in a report by KPMG and Plexus in 2015, stating that "Buurtzorg delivers high quality care for slightly less than the average costs". Buurtzorg scored as the 6th best healthcare provider from a total of 360 institutions. In the report, adjustments were made concerning the level of care to ensure that the comparison was not distorted by a different number of clients that require more intensive care. In 2015, Buurtzorg was rated for the fifth time in succession the best employer in the Netherlands in the category of non-profit organisations with more than 1,000 employees. In 2016, it finished second.

A similar story can be told about the repair of social housing in Tees Valley, UK. If something was broken, the tenant had to call a call centre. The job was entered into the IT system and sent to a manager who would schedule service providers such as plumbers and carpenters, and their materials. The call centre arranged the appointment. Again, preparations such as the diagnosis and planning were located elsewhere, separated from the service. Each day, the service providers collected the assigned materials and went to the location to carry out the planned job (ODPM, 2005, p. 34). The reform of the service followed similar principles as at Buurtzorg. Instead of making the diagnosis, the call centre now provides the contact details of the client to the repairers who then call the tenant themselves. They become the owners of the work to be done, until it is finished from the perspective of the client. They need to make the appointments with the client and determine the necessary materials, which implies they need to diagnose themselves and deploy colleagues if needed (ODPM, 2005, p.52). As already mentioned above, the time to do the job decreased and customer satisfaction went up from 77.2% to 94.4% being "very satisfied" or "satisfied with the overall service" (score 7 out of 10 or higher) with 61% scoring 10 (ODPM, 2005 p. 53). There are also substantial cost reductions (ODPM, 2005, p. 58) and ODPM concludes that “the systems thinking pilot appears to have worked well at Tees Valley" (p. 54).

In summary, the examples show that the assumption that extensive division of labour in services – whether it is transactional (repair) or relational (care) – is more effective, is neither proved by practice nor in terms of quality from the "outside-in" perspective of the customer or in terms of cost.

7. Regulating service providers, or service providers who regulate in interaction with service users: JBRA in Amsterdam (NL) and Buurtzorg (NL)

Amsterdam Region Youth Protection Agency (JBRA) (Wauters and Dinkgreve, 2016) has the

task of creating a safe home environment for children in families where something has gone seriously wrong.[7] Traditionally, regulating happened in the form of quarterly reports to management. Those reported a lot of data but management steered mostly on the number of cases per employee. These employees were divided into three departments, each with a different target workload, reflecting the seriousness of the problems with the children. Thus, an employee had to take care of 60 children with families who had volunteered to register. In the case of children who had been placed under the responsibility of the government, the workload was about 18 and in the case of children that had done something wrong themselves (e.g. with a suspended sentence), the workload was about 22.

In addition, the approach was also strongly driven by the IT system, which defined the steps to be taken for each child. For many of these steps, targets were defined, for example that interaction should take place within five days or that a plan had to be made and signed by the client within 6 weeks.

This meant that the operational staff regulated very little themselves. When a case was registered, a secretary would create a "file" and send it to the team leaders, psychologists and coaches. They then divided cases between colleagues, who most of the time accepted a case temporarily to transfer it later to a colleague, with the aim of achieving the ideal caseload. What had to happen in a family was mainly controlled by the IT system (maximum specification) and they usually did not get around to performing tactical nor strategic regulating.

In practice this led to a situation where employees just focused on those children who were most at risk, while the others were only passively monitored. The result was that low-risk children became more problematic over time.

Sometimes the same families were faced with different care providers from the three departments. They repeated all steps required by the IT system, even though these children and families were already known. Children who were not logged into the system yet, would get no attention until they were formally considered to be in trouble. Detailed reports, as long as 100 pages, sometimes taking 16 hours of time per week, were hardly used when a child was transferred to another care provider.

Emails were sent to everyone, although not read, and many meetings took place about the families, while little time was spent with the families. The objective seemed to be to make sure that all required steps were taken and that staff could not be blamed. For instance, it had to be logged that a letter had been sent to a family to remind them of an obligation, while staff understood many of these families do not even open such letters. There was also a high degree of formalism regarding the targets. Achieving the target meant uploading plans in the IT system , regardless whether anything useful was written in them or that a family was going to do something. A special function was even created to chase everybody to upload plans.

JBRA came under severe pressure due to its poor performance, and consequently a radically different approach was chosen. A previously mentioned variant of “Lean” as developed by Seddon (2003) was introduced. A complex structure, with simple tasks and an inside-out perspective, was to be transformed into a simple structure with complex tasks and an

[7]See www.jbra.nl

outside-in perspective. From then on families, instead of individual children, were considered to be "cases". The focus was on the safety of the environment for the children and “every child safe" became the mission of JBRA. The three departments were abolished. Nowadays, multi-functional neighbourhood teams exist, focusing on families, whether it concerns a voluntary registration, placement or probation. Now, a team consists of counsellors, supported by a team leader, a specialist in behavioural and child development and by a senior counsellor, who assists 6 to 8 other supervisors, and consequently deals with fewer cases. If there is a need for more specific support, specialists are available at headquarters to be consulted.

The average number of households per supervisor has become 14 but JBRA believes this should be more like 10. This is merely a matter of capacity planning. New cases are picked up by a team when there is capacity available and not earlier.[8] Targets in terms of cases per counsellor no longer exist. The responsibility for a family remains with one counsellor, which should also ensure that the whole system – parents, children, other service providers as well as grandparents, neighbours and anyone who plays a role – can be present when interacting with the family. Instead of instructing families, the switch has been made to influencing the family to reach a joint opinion on what can and cannot be tolerated. One tries to ensure that all parties involved gain insight about the damage that can be caused in children and what help the family can expect to prevent this.

This allows the daily work (at the operational level) to be left entirely to the team. After every interaction, instead of a whole series of targets, a score is given from 0 to 10, where 5 is insufficient and 6 is just the narrowest of margins, on the safety of the child and to what extent the family is ready to be released. The scores are given based on answers to some standard questions. The current score is not important, but the evolution of the score is as it forms the basis for the question "why?". During the weekly team meetings, which take an average of four hours, 8 to 20 cases are discussed. The emphasis is on those cases in which no progress is being made or where important decisions should be taken. If a case is really stuck, extra attention can be given e.g. through weekly meetings with the knowledge manager, CEO, additional psychologists or others to help to determine the next steps.

Sometimes, a team concludes that a structurally blocking factor has arisen, which everybody agrees cannot be solved at the level of the team itself. This is then immediately reported to a higher level without considering formal reporting rules. The core task of the management is to tackle structural problems for which the team itself does not have the resources. The management, however, does not accept this just like that and will always challenge the team to determine whether it really has tried everything possible at team level and whether the same problem is also recognised by other teams. The higher level at JBRA, driven by the lower levels, intends to find a structural, rather than a short-term solution. In other words, the regulating cycle at a tactical level start within the teams, and if necessary involves the higher levels. This is always done pragmatically, from a real and well-understood demand from the work floor, which will be urgently addressed by higher level management.

A typical example of something that is signalled by teams, to be solved at a higher level, are structural problems in collaborating with other organisations, when intensive networking between the JBRA teams and members of these organisations is not resulting in preventing

[8]Which actually leads to waiting lists. But waiting lists are a matter of capacity; with the same capacity the problem can only be solved by compromising on quality.

the same problems for arising repeatedly. Raab and Kenis (2009, p. 199) make the distinction between "serendipitous networks as "networks per se" ("networks") which do not develop a collective identity, and consciously created "goal directed networks as "networks für sich" ("networks for themselves"). At JBRA it concerns the latter kind. It is also clearly about effective networking based on what Laegreid and Christensen (2007) call "instrumental negotiation", by which one pragmatically achieves bottom-up, smart, local cooperation. This is the opposite of "instrumental hierarchical coordination" in which one tries to achieve "joined-up government" from above, strengthening, among other things, the central government strategy units, inter-ministerial units, task forces, etc. within sharper "accountability regimes" which stress longer-term "outcomes".

Although in 2008 JBRA was still in serious difficulties, in 2014 it received the award for best public sector organisation in the Netherlands and in 2015 the European Public Sector Award for local governments.

At Buurtzorg, we find a similar story about the regulating ability of the work floor. As mentioned above, neighbourhood teams have full autonomy regarding their daily operations with their clients. When a team runs into a problem it cannot resolve itself, it can be shared with the "web community". Other teams can react if they already found a solution. If nobody has a solution, and other teams recognise the problems as relevant, a working group of teams will be established.

In summary, the examples explain that when teams regain the overview of the operational process within a simple structure with complex tasks, teams are perfectly able to regulate operationally. Also, tactical regulation to improve performance in a structural way almost automatically happens. It is then also clear what the new role of management comprises: to eliminate obstacles for structural improvement that are beyond the reach of the teams themselves. However, this is always done at the request of the teams themselves.

8. Everyone to experiment with "perfection" or "rolling out" a negotiated organisational design: JBRA in Amsterdam (NL) and Buurtzorg (NL)

In order to achieve sustainable change, JBRA put together a team of volunteers, bringing together all relevant functions from different departments, completed with two executives and the CEO. This team worked full-time for several months on a project:

- To look from the outside to the inside, analysing 60 cases in detail from the perspective of families and capturing what the purpose of the service should be;
- To design a service that is "perfect", which can only be achieved by disregarding all existing "system conditions", e.g. current rules, targets, etc. and building on new principles, which were put in contrast with the existing ones, as well as building new outside-in measuring instruments;
- To try out this service to discover in practice what works and what does not, for the purpose of achieving "every child safe";

- To integrate requirements that may not be conducive to achieving the objective but that cannot (yet) be avoided, e.g. reports to the municipality in figures that do not really matter.

After the first team had done its job, three new, similar teams of volunteers were given the time to go through the same process as done by the first team. These new teams did not get to see the new design of the work done by the previous team. However, the first team provided all the information and analysis they had collected and executed. The teams could collect additional information if thought necessary. Then the next three teams could redesign their work, just as the first team did. Of course this process of "learning to learn" went faster than in the first team, because there was already so much data available. Ultimately, all the teams at JBRA were involved in this process. Because the entire management chain was represented in the first team, there was also an automatic agreement with the management regarding the main purpose of the organisation and the new method. The teams that followed had to get the agreement of the management, that now could engage in reflecting with the teams based on their own practical experience within a team.

Also at Buurtzorg, each new team must decide for itself in what way it will work, respecting a limited number of general principles, which correspond broadly with what is described in this article as a flexible regime. The team can learn from other teams and coaches, but should also take its own decisions and may thereby make mistakes. "Employees feel that initial problems, reinventing the wheel and the struggle that goes along with it, really belong to learning how to organise" (Van Dalen, 2010, p. 54). Its importance should not be underestimated, as evidenced by the following: "Some of the first neighbourhood care teams have been fairly intensively supervised; especially in these teams you now can perceive more dependent behaviour and less autonomy than in other teams." (Van Dalen, 2010 p. 73).

In summary, it can be stated that the examples show that the basis for self-organisation should be established from the beginning, with the creation of a team. This does not mean that you cannot learn from others, but ultimately each team should take responsibility for organising itself. Important principles that correspond with the basic principles of a flexible organisation should be observed and monitored by the management.

9. Conclusions

On the basis of this article it must be clear that the question is not whether one wants to introduce self-steering or even self-organising teams. The question is whether one aspires to introduce a paradigm shift, of which self-steering/organising team forms part.

Osborne et al. (2012, p. 147) warn that the use of approaches such as "Lean" and "Business Process Re-engineering" to operationally improve public services will fail to meet the needs of the users of public services. Since two of the four examples discussed in this article are explicitly based on "lean thinking" it is important to understand that Osborne et al.'s (2021) criticism is directed toward the underlying paradigm in which many "Lean" processes take place. It is usually purely about deploying a loose collection of techniques, which quite often strengthens the bureaucratic regime.

Osborne et al. (2012, p. 135) also state that "current public management theory is not fit for purpose... it draws upon management theory derived from the experience of the manufacturing sector, which ignores the reality of public services as "services". They argue

that a dominant focus of internal operational management on efficiency misses the essential interaction with external service delivery and effectiveness. Thus, they argue for a "service-dominant" approach, that emphasises the intangible elements of services. The fact is that production and use of a service take place simultaneously, where the user is de facto co-producer of the service. This, too requires a paradigm shift.

At first sight, the "product-dominant" approach has much in common with the bureaucratic paradigm expressed in the cases above. For instance, capturing the “output” as an end in itself forms the expression of an "inside-out" perspective, whereby a service provider is artificially shut off from real interaction with the user, who is in the real world. This creates the illusion of predictability, which is the precondition for the functioning of a complex structure with simple tasks, in which service providers are "regulated" by managers and systems.

The "service-dominant" approach with its emphasis on interaction and effectiveness starts rather from the idea that an enormous variation exists in the interaction between the service provider and the user. This is illustrated by the following statement: "At the most extreme, no service has ever been produced identically for two people" (Osborne et al., 2012, p 139). This implies a higher probability that reality will not correspond with expectations and that a paradigm shift to a flexible regime is required. Their claim that product-dominant thinking “focuses on intra-organisational processes at a time when the reality of public services is inter-organisational” (Osborne et al., 2012, p. 135) corresponds to the above-mentioned trend toward networks that is required by a properly functioning flexible regime.

The analysis by Osborne et al. (2012) is relevant: indeed, a fundamentally different theoretical basis for public services is needed. But in making the switch one must go beyond a shift from a product logic to a service logic. After all, the dominance of the product logic is a result of the dominance of the bureaucratic model. This model is as problematic for production in a rapidly changing world as for service. Future research on public services should focus on exploiting existing knowledge about bureaucratic, flexible and by extension network regimes, rather than developing a completely new theory.

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