Master Thesis Research

Organizational structures in municipal social district teams

An investigation into the structural design choices and possible improvements based on organizational design literature

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Abstract

In this research, we have tried to find out how social district teams are currently organized and how their design could be improved based on organizational design literature. We found that social district teams already conform well to the normative theories, however some improvements can still be made. Due to the nature of governmental organizations with democratically elected bodies, these normative theories are hard to completely apply to social district teams, however some room is available. These improvements are mostly centered around the control structure of social district teams. We also found that in practice municipalities made use of pre-existing organizational models which were advised before the decentralizations, but that they were barely directly applied without changes. This implies that municipalities have actively tried to alter these models to fit their local situation, one of the main drivers behind the decentralizations. In the Discussion we have suggested possible future alleys of research which we find add valuable knowledge to the field.

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Content

Preface

In my youth, I always wanted to be a manager. Taking responsibility and steering an organization towards a brighter future seemed very appealing to me. I gained an interest in both the financial side (earnings, losses, debit, credit, etc.), but also in the managerial aspect of it (strategy, culture, structure, etc.). Studying Business Administration thus seemed logical to me. During my bachelor's degree, my attention was caught by organizational design. Analyzing an organization, decomposing its elements and building it back up to create a more harmonious entity was something I never thought of, but it enticed me. In addition, I was approached by chance to start doing some work for the local municipal council. Here, I got close to a public organization. I found out that there are massive differences, not only in goals, but also in design, priorities, laws and more. While I had trouble applying some theories to practice, I found the theories regarding organizational design to be very practical and useful in analyzing organizations, including the municipality I was close to.

I therefore chose to further specialize myself by choosing the Organizational Design and Development master's degree. By now, I was a full-fledged member of the municipal council and highly interested in pursuing a career in the public sector. It only seemed logical to combine the two. I was aware of the massive challenges Dutch municipalities were facing (and still face!) in handling the decentralizations of 2015. One of the structural aspects of these decentralizations, which almost all municipalities had to deal with in some shape or form, were social district teams. There were a lot of different approaches, but the "entry" to the municipality had to be designed, which presented a perfect case for applying my study to practice.

I am very happy with the result, although it took somewhat longer than envisioned. In any case, I am delighted that I have been able to present conclusions that, I hope, municipalities can profit off. I also know that I grew a lot on a personal level. During the writing process of this thesis, I moved in with my girlfriend (now my wife), got my first serious job and got to have my first kid. It was a turbulent time, with ups and downs, but I would not want it any different.

My hope is that anyone reading this can find a use for what has been written and that the conclusions will help some people concerned with their social district teams. It has been my pleasure to work on such an interesting topic with a lot of civil servants who were very open and welcoming.

Finally, my thanks go out to the people who agreed to an interview and those that were willing to fill in my survey, as well as the never ending support of my wife, Marleen. I also want to thank Hans Lekkerkerk, who has been my supervisor the entire time, combing his useful insights with much appreciated humor.

For now, I hope you enjoy reading this thesis and that it will be useful to you.

Thomas Eskes

1. Introduction

In 2015 the Dutch government decentralized three responsibilities to the municipalities. Youth care, societal support and participation became municipal responsibilities. A lot of discussion happened around these decentralizations, with calls for postponing it to make sure municipalities were prepared. However, by the first of January 2015 the three fields where decentralized and municipalities became responsible for youth care, societal support and participation.

Youth care is defined by the Dutch government as entailing the following five responsibilities: support for raising youth to adulthood, protecting youth, rehabilitation, mental care and care for youth with (minor) cognitive disabilities. It is part of the Dutch policies for care and well-being (Jeugdzorg Nederland (n.d.), Rijksoverheid (n.d.)).

Societal support is defined in the law (Wet maatschappelijke ondersteuning) as encompassing the following responsibilities: Supporting social cohesion and quality of life, supporting volunteers and 'mantelzorgers' (volunteers who take care of people with intensive care necessities), supporting people with disabilities or psychological problems in participating in society, offer societal relief, support public mental care, distribute information, advice and client-support, supporting addiction policy and preventively supporting youth with problems. It is part of the Dutch policies for care and well-being (ZorgWijzer (n.d.), Rijksoverheid (n.d.)).

Participation, enshrined in the 'Participatiewet" (participation law), is a combination of three older laws into a new law. The older laws were the Wajong (law for work and labor support for young people with disabilities), the WWB (Wet Werk en Bijstand, law for monthly allowance for the unemployed) and the Wsw (Wet sociale werkvoorziening, law for young people with disabilities to work in so called 'sociale werkplaatsen' (social workshops)) (Participatienieuws (n.d.), Rijksoverheid (n.d.)).

Now, three years after the decentralizations, it is possible to investigate how municipalities have organized these responsibilities. Due to the time pressure and importance of the responsibilities, it is valuable to look at a number of municipalities and discuss their efforts in streamlining the decentralizations, making sure the care was on an equal, or possible higher, level than before 2015. Most municipalities chose to organize their new responsibilities in so-called 'social district teams', teams with people from various professions all working together

to deliver care to their district. Which people are represented in these teams and which tasks they have does however differ.

What is clear is that the effectiveness and efficiency of the social district teams are often in doubt. Quite regularly reports are published criticizing either the financial expectations of the decentralization, the effectiveness of the social district teams (including problems such as long waiting times, inaccessibility for regular people and too much bureaucracy) or both of these symptoms simultaneously (Rekenkamer Rotterdam, 2018; Ombudsman Rotterdam, 2015; Van Arum & Van den Enden, 2018). The Rekenkamer Rotterdam report, among other conclusions, found that the accessibility of the social district teams was lacking due to the structure of the intake procedure. They conclude that clients need to be referred by other organizations, such as the municipality. They are not allowed to apply for care at the social district team on their own. In addition, the members of the social district teams are employees of care distributors. These companies are their legal employers. However in the social district teams, the municipalities are their managers too. They have two organizations that try to instruct them on how to do their work.

These issues all point to the structure and design of the social district teams being the root of the problem. How the social district teams are organized influences to a large extent how capable the teams are in coping with the variety of clients that are sent their way.

The aim of this study is to compare the predicted organizational models for social district teams to the academic literature as well as to the practice. The timescale we research is between 2015, when the decentralizations went into effect, and 2018, when the interviews were conducted. To do this, we will analyze the reports and recommendations made before the decentralizations were in effect (January 1st 2015). Based on these reports, we will analyze what types of organizational designs were proposed. Then we will use academic literature to see to which degree these proposed designs might work, based on three organizational design theories. Third, we will undertake five interviews with various municipalities to find out what organizational designs are in use in 2018, three years after the original models were proposed. Based on the interviews, the early reports and the academic literature, we will analyze where the possible problems exist and how these problems could be solved. The interviews will provide us with models that work in certain municipalities and models that do not work (optimally) in other municipalities. There will thus be two types of possible problems: theoretical (early reports compared to academic literature and models in use compared to academic literature) and practical (what issues do the municipalities encounter in practice?).

While some earlier research has been done on social district teams, an investigation on how municipalities have dealt with the decentralizations three years later is lacking. These municipalities have had the time to work with these social district teams and adjust them to their experiences. It is therefore interesting to investigate whether the predictions made when the decentralizations were carried out have become truth three years down the line.

These efforts are aimed at gaining an answer to the following research question:

> *"How do the predicted and current organizational structures in social district teams fit with Organizational Design theories and which possible problems arise, according to these theories and to the municipalities in practice?"*

The findings of this research can on the one hand help academics compare the theoretical designs to a practical test; these theories are ideal-types, but how do municipalities really organize their social district teams? Are the predictions made by these theories also found in practice? For practitioners, such as the municipalities that employ the social district teams, this study can be of value to compare their own organizational design to the literature and to other municipalities. Municipalities can thus learn from our study to improve their own social district teams. We will for example try to distinguish whether certain models work in certain municipalities. Every municipality has its own characteristics, but some municipalities may be quite alike. When a certain model is not working in one municipality, but a different model is working in a similar municipality, then these municipalities can help each other through this research.

The theories used are based on either expertise on social district teams prior to the launch of the decentralizations or based on expertise in organizational design. For our theory on organizational design, we will use the Modern Sociotechnical Design Theory (MST), which is a theory that focuses significantly on self-steering teams (De Sitter, 1994), the design parameters of the configurational approach of Mintzberg (1980), which focuses on how organizational designs can differ depending on (among others) environmental factors, and Christensen (2009), who has written a theory on organizational design in healthcare**.** Based on the reports written before the decentralizations were in effect, we found that the social district team typology from KPMG Plexus (2013) and Van Arum & Schoorl (2015) was a report that describes which models municipalities were planning on using and were advised by independent advisors.

First, we will discuss the reports that were written in anticipation of the decentralization and digest what models were suggested. We will follow this up with a theoretical examination of the earlier named theories. Then we will dedicate a chapter to the methodology of our research. The results of our work will be divided into a comparison between the theoretical organizational design literature and the suggested models, the interviews we held and what we learned from them and a comparison between the suggested models and the models in use and the organizational design literature and the models in use. Finally we will present our conclusions and discuss the usefulness (both theoretical and practical) of our conclusions and future research possibilities.

2. Theory

In this Theory chapter, we will discuss the organizational design theories of De Sitter (1994), Mintzberg (1980) and Christensen (2009).

2.1 Organizational Design Theories

For our organizational design literature, we will use the Modern Sociotechnical Design Theory (MST) from De Sitter (1994), the configurational approach of Mintzberg (1980) and the organizational design theory of Christensen (1997). Each of these theories has its own merits and downsides, and we will discuss both of these in the next part of this study. To gain a thorough understanding of the designs of the social district teams, we have decided to focus on these three theories and go into more depth, as opposed to gathering more theories which we can only analyze and use more superficially.

2.1.1 The Modern Sociotechnical Design Theory

The Modern Sociotechnical Design Theory (MST) is a theory that was developed originally by De Sitter (1994). It mostly focuses on order flows and production of goods, but it can also be used for other types of organizations. The MST seems to fit the social district teams perfectly, as De Sitter argues that self-steering teams are more efficient at performing their work than individuals that specialize on very specific tasks. Many of the complaints voiced on the social district teams are also complaints De Sitter voices when introducing his theory. The MST therefore fits this research very well.

In the MST, organizations divide two types of tasks over their employees: performance and control. Performance has to do with the actual production process or service delivery. The performance tasks (‘production structure’) are all aimed at actually producing the product or delivering the service. The control tasks (‘control structure’) are all aimed at streamlining the performance tasks by making sure the performance tasks are in line with each other, employees do the right tasks at the right moment and so forth.

The Modern Sociotechnical Design Theory presents eight parameters. The parameters have an influence on the performance tasks, the control tasks or both. Important to note is that these parameters in essence measure how many relations there are. More relations leads to a higher probability of misunderstandings and mistakes (‘disturbances’) and are therefore negative in this theory. The first three parameters are related to the production structure, the fourth parameter is related to the relation between the production structure and the control structure and the final three parameters are related to the control structure.

The first parameter is the level of functional concentration. This indicates to which extent one group of employees can complete an order on its own. A high level of functional concentration indicates that similar tasks are grouped into one department, and this department has a role in almost all orders. A low level of functional concentration indicates that orders can be completed by a single group of employees and no other groups are necessary.

Second, De Sitter describes the level of differentiation of operational transformations. In the Modern Sociotechnical Design Theory, three types of tasks are divided within organizations. Making refers to tasks that have to do with actually producing the product that the organization is about, Preparation refers to the tasks that are necessary for the Making tasks to happen and Supporting refers to the tasks that are not directly linked to the production process, but are necessary for the organization to be able to run. With the level of differentiation of operational transformations, high levels indicate that these three types of tasks are separated in different groups, while low levels indicate that Making, Preparation and Supporting tasks are all integrated in the groups.

The third and last production structure-related parameter is the level of specialization of operational transformations, which refers to the separation of tasks into smaller tasks. High levels indicate that tasks are separated and divided into many smaller subtasks, while low levels indicate that tasks are broad and employees can complete orders with minimal coordination, since they are responsible for large parts of the process.

The level of separation between operational and regulatory transformations is the fourth parameter and is related to the relation between the production structure and the control structure. It refers to the extent to which operational tasks and regulatory tasks are separated. High levels indicate that operational teams have little autonomy and regulatory tasks are strictly separated from these teams. Low levels indicate that operational teams carry a lot of regulatory responsibility themselves.

The fifth parameter of De Sitter focuses on the difference between the “what” and the “how”. He argues that everything concerning the environment of the organization, and the regulating that comes with the environment, can be described as the “what”. Examples are the choice of resources for the production and the final product that is being put back into the environment. The “how” concerns the inside of the organization: How do you create the desired output from the chosen/available input. De Sitter further states that you can either make broad

regulatory tasks that concern the whole internal process, meaning the tasks stretch from the input to the output. The more this is specialized and separated, the smaller the tasks become. Then there might for example be a manager for different stages in the production process. He then argues that this creates more "what" within the company: every stage-manager will have to discuss with the manager of the stage before his and the manager of the stage after his stage what type of product he wants to get and what type of product he can output to the next stage. This creates more complexity, rigidness and possibly problems. The higher an organization scores on this parameter, the more specialized the regulatory tasks are. A low score depicts broad regulatory tasks.

The sixth parameter is the level of specialization of regulatory transformations, which is similar to the third parameter. Both of these parameters look at the separation of tasks into smaller sub-tasks. The difference is that the third parameter looks at the operational structure, while this sixth parameter looks at the control structure. High levels indicate that regulatory tasks are divided into many separated sub-tasks, while low levels indicate that regulatory tasks are mostly integrated into one task.

The seventh parameter is the level of differentiation of regulatory transformations into aspects. This parameter refers to the three different aspects of regulatory tasks (or transformations) that exist in De Sitter's theory. These three aspects are Operational regulation, which has the function to steer teams and activities on an operational (day-to-day) level, Design regulation, which has the function to adapt the infrastructure, and Strategic regulation, which sets, monitors and adapts the goals. High levels of this parameter indicate that these three regulatory aspects are strictly separated, while low levels indicate that all these aspects are integrated into the same tasks.

Lastly, De Sitter discusses the level of differentiation of regulatory transformations into parts. Regulatory transformations can be separated into Monitoring, which is about measuring the current value of some variable, Assessing, which is about comparing the observed values to the desired values, and Acting, which is about taking measures when there is a discrepancy between the observed state and the desired state. Again, high levels indicate that these tasks are very separated, while low levels indicate that these three tasks are mostly integrated into one function.

De Sitter uses these eight parameters normatively. In his view, organizations are better off with low parameters, as this would decrease the amount of interactions that are necessary for

an order to be completed and thus the risk of disturbances, potentially propagating through the whole network, would be minimized. We will make use of this normative approach by using the theory to compare with the actual situation.

2.1.2 The Configurational Approach

In discussing Mintzberg, we will focus on what he calls the Design Parameters of the configurational approach. Mintzberg defines much more, but most of it is not necessary for the scope of this study. The Design Parameters offer enough to compare the organizational models in practice to the configurational approach of Mintzberg.

First, Mintzberg defines Job Specialization as the number of tasks and the breadth of these tasks in a given position and the control the employee has over these tasks. A parallel can be drawn to the MST, in which De Sitter focuses on operational control (how broad tasks are) and regulatory control (how much control the employee has over how his job is designed).

Second, Mintzberg describes Behavior Formalization as the degree to which work processes are standardized. Examples he gives are rules, procedures, policy manuals, job description and work instructions. The core idea of this parameter is that in some organizations, tasks are strictly defined and formalized, while in other organizations tasks are more open to own interpretation and judgement.

Third, Training and Indoctrination is a parameter that describes the degree to which skills and knowledge of employees are standardized. Often this is based on the level and type of education that is required from employees. Mintzberg notes that these skills and knowledge are usually gained before beginning the job, outside the organization.

Next, Unit Grouping is used to describe with which method employees are grouped into units and units into departments and so on. Unit Grouping focuses on why the groups are as they are, which makes it a distinctly different parameter than Unit Size, which focuses on how big these groups are.

Planning and Control Systems are used by Mintzberg to describe how standardized the outputs are of an organization. He further divides this into two types. The first one is Action Planning, which determines how certain actions are to be executed. Examples Mintzberg gives are that holes should be drilled with two centimeter diameters or that new products should be introduced in September. Second, he describes Performance Control as “after-the-fact measurement of performance of all the decisions or actions of a given position or unit over a given period of time. An example for Performance Control from Mintzberg is the sales

growth of a division in the first quarter of the year. Both these types are concerned with controlling whether the goals of the organization are reached, albeit in a different way.

A sixth parameter of Mintzberg is Liasion Devices, which means in which ways mutual adjustment across units is possible in the organization.

Finally, Mintzberg discerns two types of decentralization: Vertical and Horizontal decentralization. Vertical Decentralization concerns how much formal decision making power lies lower in the hierarchy. Horizontal Decentralization concerns how much and which power flows exist informally in the organization, without regards to the official hierarchy.

2.1.3 The theory of Christensen

The theory of Christensen is based on his earlier ideas of *disruptive innovation*, which he described in his book named 'The innovator's dilemma: when new technologies cause great firms to fail' (Christensen, 1997). Since then, Christensen, along with various co-authors, has written books on the application of his theory on education in general (Christensen & Horn, 2008) and on universities (Christensen & Eyring, 2011). In addition, and most importantly for our research, he wrote a book on the application of his theory on healthcare (Christensen et al., 2009). The social district teams act in the domain of healthcare and the theory should thus fit to these teams as well.

In his book, Christensen (2009) separates three business models. First, the Solution Shops are businesses that focus on solving complex problems. The nature of these problems is unknown beforehand. The solutions to these problems are different for every case and require specific expertise and, for every case, a unique approach. Second, Value-Adding Process Businesses (VAP's) are businesses that take some input, transform it with a standard procedure into an output. Examples Christensen gives are restaurants, automobile manufacturing and specialized clinics (such as eye-lasering clinics). The procedure is always the same, the input and output might differ somewhat, but not by much. Christensen further specifies that often the diagnosis, determining what a client needs or wants for his problem, has already occurred when the client arrives at a VAP. Finally, Christensen describes Facilitated Networks. These businesses create a platform on which a network can operate. This network can exist of patients and doctors, of only patients who can help each other or of individuals trying to sell their second-hand books to other individuals. The business thus makes sure (facilitates) that the group of people (the network) can interact with each other.

These three models are general models. They are not yet linked to healthcare. Christensen uses these three models to separate three types of healthcare: Intuitive medicine, empirical medicine and precision medicine. These types of medicine are described as a spectrum, with intuitive medicine on the one hand and precision medicine on the other. Diseases over time move from the intuitive to the precision medicine. This starts when a disease is discovered and barely anything is known yet. Doctors have to use their intuition to device a treatment and continuously monitor and experiment to see what treatment is effective for this unknown disease. Over time, research will be done, more knowledge will be gained and scientists and doctors will be able to more reliably apply treatments to diseases. These treatments are known to work and will reliably help the patient.

Christensen (1997) describes intuitive medicine as "care for conditions that can be diagnosed only by their symptoms and only treated with therapies whose efficacy is uncertain". Intuitive medicine is thus mostly clients being a case their doctors have never or barely ever seen before, and for which no treatment is available. The doctor will then, based on his intuition, have to find out what works and what does not work. Christensen (1997) describes this type of healthcare as an "art": there is no science to back it up, so the patient has to rely on the instincts and pattern-recognizing of the doctor to be treated.

Precision medicine is defined as "the provision of care for diseases that can be precisely diagnosed, whose causes are understood, and which consequently can be treated with rules-based therapies that are predictably effective" (Christensen, 1997). Diseases that are well-known and for which treatments are available that cure almost every case of that disease are precision medicine. The doctor is tasked with noticing the symptoms and making the proper diagnosis, which should be possible based on the available scientific knowledge. Then, when the doctor knows which disease is present, he can prescribe a treatment of which the doctor knows it will work. This is what Christensen (1997) described as a "science": based on written literature, and following the prescriptions said literature provides, a doctor can easily solve the problem of the client.

Finally, empirical medicine is in-between these two types of medicine. When scientists see patterns and have treatments that are often, yet not reliably, effective, it is to be called empirical medicine. This is a stage that every disease will be in at some point. Often, diseases that are known for some time, yet the causes are still somewhat unclear, are example of empirical medicine. Some treatments exist with some success, and the task of the doctor is to apply these treatments and find out what works and what doesn't. An important role for the

doctor is observing, which is why it is called *empirical* medicine: observe what the treatment does and adjust based on what the doctor notices. In some cases, the problem can be solved quickly, but in other cases the problem cannot be solved until more research is done.

With the three business models and the three types of medicine, Christensen now combines the two. He observes that currently, the healthcare sector combines all types of medicine in various institutions, such as hospitals. These hospitals are supposed to solve difficult intuitive medicine cases, but also more precision medicine, such as fractures. This combination makes sense from a historical point of view, where almost every disease was to some extent a mystery, but in the modern times, an ever increasing amount of diseases is rules-based: the causes are known and the treatments are known. There is no need for a skilled specialist to look into the case when the solutions can be found in the literature.

Christensen (1997) instead suggests that the types of medicine and the business models should be linked and separated. He describes healthcare solution shops, which in his mind would serve clients with an intuitive disease, such as asthma, by concentrating specialists on asthma in one clinic. These specialists together devise a treatment plan. Currently, these asthma patients have to go to a hospital and see each specialists individually. The specialists barely work together, because that is not the structure of the hospital. The patient is transferred to a different doctor, while in solution shops all doctors work together for a single patient. Key is that these solution shops should have a specific specialization and employees that are committed to being specialists and knowing everything there is to know on that specific specialization. An example can be a cardiovascular clinic, which houses specialists on everything that has to do with heart-problems. This type of organization would thus be responsible for intuitive medicine: no clear solutions, but the instincts and knowledge of the best doctors who combine their expertise to increase the chances the patients can be helped.

A different kind of clinic Christensen (1997) proposes is the value-adding process clinics. These clinics are supposed to solve the simple healthcare requests. The diagnosis is already clear, the treatment is too. The only thing the client needs is a clinic that can effectively and efficiently perform these routine surgeries. An example is an eye-lasering surgery. In the domain of healthcare, the surgery is relatively easy, as well as the diagnosis. The only thing the clinic has to do is to efficiently organize their organization to allow specialists to perform a limited range of surgeries in quick succession.

Finally, Christensen (1997) foresees facilitated networks in the form of online communities where doctors and clients come together to discuss everything there is to know about a disease that cannot yet be cured. Doctors can help each other by sharing new knowledge, they can help clients by spreading this new knowledge and prescribing medicine that can solve some problems (such as pain-relief or medication that negates symptoms) and finally clients can help each other by sharing day-to-day tips on how to make life with that disease easier. These are diseases that fall firmly into the intuitive medicine category, where no (effective) treatment is available and doctors cannot yet help much.

2.2 Synthesis

In order to adequately compare the literature to the predicted models and the models in practice, it is useful to create a framework that fits all three of the theories we have selected to use. In this synthesis, we will therefore describe how our framework was established and why we think it can be useful to compare the social district team models with.

We have searched the literature for existing frameworks in organizational design. Christis & Soepenberg (2014) already created a framework that fits the Modern Sociotechnical Design Theory as well as the Configurational Approach of Mintzberg. Christis & Soepenberg argue that, while Mintzberg categorizes four types of design parameters in the Configurational Approach, specifically design of positions, design of superstructure, design of lateral linkages and design of decision-making system, these four can be categorized in two types: design of the production structure and design of the control structure. This categorization aligns with the Modern Sociotechnical Design Theory, whose design parameters fit this categorization as well.

Christis & Soepenberg (2014) also argue that the organisational design in healthcare should be organized differently. They see that healthcare is now fragmented, because this should lead to efficiency. However, they argue that this increases cycle-times due to long waiting and that these cycle-times could be reduced drastically if healthcare was reorganized to not fragment care, but to make care paths for similar patients that flow. An author they cite for this is Christensen, of whom we also have taken inspiration in this chapter.

Christis & Soepenberg (2014) name two types of ordering these care-paths can take: Product-based (“grouped around patients/clients with the same medical care conditions as in a migraine centre, asthma centre, cancer centre, hip street, etc.”) or customer-based (“grouped around similar patients/clients with different medical/care conditions as in the district teams

of Buurtzorg Nederland and the social district teams many Dutch Municipalities are experimenting with") (citations from Christis & Soepenberg, 2014 p.17).

To conclude, Christis & Soepenberg (2014) have come up with a framework for the MST, the configurational approach and the disruptive innovation approach of Christensen. They conclude that there are two types of organizational design: design of the production structure and design of the control structure. In addition, based on Christensen, they state that these can be organized in three ways: fragmented (non-sociotechnical), product-based and customer based.

We will use this framework in our analysis. This framework has been visualized in figure 4.

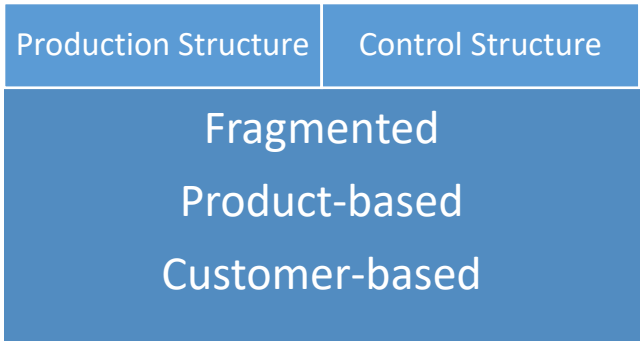


Figure 1: Visualization of the Christis & Soepenberg (2014) framework for Organizational Design

3. Methodology

3.1 Type of research

This study was of a normative nature. This means that we have described the current designs in use, compared them to the predictions made before the decentralizations and compared them to the academic literature. We have tried to discern trends from the data and through these trends recommend certain design choices based on what works for which municipality. We also take a look to what extent these design choices correspond to organizational design theories and make recommendations to further improve the organizational design of the social district teams. For this, normative studies are appropriate (Vennix, 2011).

The goal was to create a comparison based on the existing organizational structures. The study was qualitative, since it encompassed interviews to obtain a thorough picture of how the teams are structured. We also made use of a survey to compare the trends we find in the interviews to a more representative data set. This way we made sure that the insights we gained from the interviews are representative for the entirety of The Netherlands.

3.2 Research Design

For this study we have examined a number of municipalities and how they handle their social district teams. We have interviewed five to gain an insight in how these teams are organized. The interviews were semi-structured, with a number of topics to lead the interview, but also the possibility of going off-track if the interviewee gave any interesting leads. The prepared topics were based on the academic literature and can be found in appendix 1.

Our aim was to use these interviews to more clearly define how the teams are organized, based on the MST, the configurational approach and the disruptive innovation approach of Christensen. Through the interviews we have gained insight in whether designs in practice correspond to the designs in the theories. This helps us not only in defining how social district teams are actually organized, but also provides opportunities for further research into the effectiveness of altering the parameters.

In addition, we wanted to gain information on what design choices have been made by the municipalities and what is working for them. They have had approximately three years to experience the decentralizations and have thus had time to evaluate their initial design choices and possibly alter course to increase effectiveness. Through the interviews we have gained knowledge on these processes.

In essence, this means we have conducted multiple case studies. We have analyzed the specifics of the design of the social district teams of a limited number of municipalities. Swanborn (2013) argues that a case study is a good fit for research aimed at finding out either what happened during a specific timeframe or how something happened. We were focused on the first option: what has happened since the decentralizations in 2015? For this reason we thought a multiple-case study approach fitted best to our primary research goals.

After this first analysis, we wanted to gather the major differences in design and which designs are useful for which municipalities. We then set out a survey to find out if the information we gathered from the interviews is also present when we ask all municipalities. Although we would appreciate a high amount of municipalities taking the effort to return the survey to us, a minimum should in our opinion be a 100 municipalities (out of 380 total (VNG, 2017). This would give us a reasonable representation of the Dutch municipalities. It turned out that we had a response rate of 108 municipalities. This means that between a third and a quarter of municipalities responded. The average amount of inhabitants is slightly higher than average. This means that on average, the responding municipalities are slightly bigger than the average municipality of The Netherlands.

From the above, we can conclude that our survey is quite representative. It is not perfect, but we do have a lot of respondents compared to the total population and the divergence of the average amount of inhabitants is slightly off, but not by much. We also gave priority to finding a diverse palette of municipalities for the interviews. Because we intentionally asked municipalities of differing size, location and urbanization, we improved representativity of the interviews. Of course, we had to do a survey to further improve this, but it did give us more clues as to why certain choices were different. We used these to more accurately formulate the interim conclusions.

3.3 Data collection

We have made use of two data collection tools: interviews and a survey. We discuss the methodological aspects of these two in this paragraph.

3.3.1 Interview

For this study a total of five interviews have been held and 108 surveys conducted. The aim was to interview people in municipalities who work with social district teams on a daily basis, such as managing directors of social affairs. Important was that the interviewees have extensive experience with their social district teams, know how they work and how they are supposed to work on paper. This reflects the demand for quality, as Symon & Cassell (2012)

describe. To make sure the interviews had the necessary quality for answering the research question, the interviewees needed to have enough knowledge of the subject at hand.

The interviewees should also be representative of the field, or representativeness (Symon & Cassell, 2012). This means that they should not all be managers, for example, but also some people who actually work in the social district teams. The representativeness makes sure that the interviewees do not provide a single view of the matter, but provide a varied and diverse view of the social district teams.

These five interviews are spread across the country, with the goal to have at least one interview in the north of The Netherlands (Friesland, Groningen, Drenthe), one in the east (Overijssel, Gelderland, Utrecht), one in the west (Noord-Holland, Zuid-Holland, Flevoland) and one in the south (Zeeland, Noord-Brabant, Limburg). We managed to conduct one interview in the North, one in the east, one in the west and two in the south of The Netherlands. In addition, the aim was to have at least two interviews with a city in the municipality (>50.000 people) and two interviews with municipalities that can be characterized as the countryside (<50.000 people). We managed to conduct interviews in two municipalities with >50.000 people and three municipalities with <50.000 people. This spread enables us to generalize our research to the whole of The Netherlands.

In addition to these parameters, we also suffered from pragmatic limitations. Pragmatic limitations already limit the amount of interviews, which we set at five. Five interviews is not much compared to the total amount of municipalities, but for a case study it is quite extensive (Swanborn, 2013).

We analyzed the interviews by coding the interview notes made during the interviews. For the analysis, we used the Charmaz approach to coding as described in Bryman (2016, p. 574). This means we started off with initial coding, during which data was compared with data from other interviews to find out what common themes emerged. During the following process of focused coding, in which a selection was made of the most important codes, related to the subject at hand and both theoretically and practically relevant. Finally, the process of theoretical coding related the focused codes to theoretical constructs and theories we described in chapter 2. Finally, we turned these codes into the Results chapter (chapter 4).

3.3.2 Survey

We further improved on this pragmatic limitation by conducting a short survey after the interviews to confirm whether the findings we distill from the interviews is actually

representative of all the Dutch municipalities. The survey thus has the goal of confirming whether the findings from the interviews are representative of municipalities in general.

For this survey, we have transformed the findings into three main interim conclusions, theses that we could distill from the interviews. In the survey, these interim conclusions will be transformed into the survey questions. This way, the survey will have a clear connection to the interviews.

3.4 Operationalization

Through interviews we wanted to gain an overview of the prevalent organizational structures in the social district teams in Dutch municipalities. We could not assume that the interviewees would have adequate knowledge of the Organizational Design theories to discuss their district team-structure based on the parameters of those theories. Instead, we used the reports advising municipalities on how to organize their social district teams from before the decentralizations (chapter 2.2.1) and used these visual aids to compare the social district teams the municipality has to the social district teams that are described in these reports. This made it easier for the interviewee to describe their own structures, by describing the similarities and differences with the models.

3.5 Reliability and validity

Reliability and validity are important metrics for researchers that we have been giving attention to. First, reliability is defined as whether the same results would be obtained if the study was repeated in the same way (Vennix, 2011). We support our reliability by describing our methodology as extensively as possible. This will enable others to not only criticize our methodology, but also replicate it. In addition, we discuss the models from the reports from before the decentralizations (chapter 2.2.1) in the interviews. The interviews can thus be reasonably replicated in future studies. This increases reliability.

Our reliability is limited by the fact that, while we did ask the same leading questions, we could divert from our predetermined topics if we thought this would improve our data collection. This could not be written down in advance and thus limits reliability. In addition, since the social district teams are fairly new, their structure can undergo changes relatively often, especially in the first years. This might mean that future research does not find the same results, since the environmental factors have changed, due to new decisions.

Validity can be separated into content validity and construct validity (Vennix, 2011). Construct validity means that whether a certain concept correlates with other concept that

appear in the theory. For measurement to be valid, it should reflect the same correlations as those present in the literature. This type of validity does not seem relevant to our research, since our research applies current theories to a specific type of teams/organizations. We could not compare our measurement to other measurements, as these did and do not exist to our knowledge.

Content validity means that the way of measurement should be representative of the concept that should be measured (Vennix, 2011). We based our interview questions on the Modern Sociotechnical Design Theory (De Sitter, 1994), the configurational approach from Mintzberg (1980) and the disruptive innovation theory of Christensen (2009). By doing this, we have tried to ensure content validity. We were limited by the fact that it is not possible to directly ask our respondents what the structure of their social district teams is in terms of the theories, since we have no basis to assume that the interviewees have any knowledge of those theories.

3.6 Research Ethics

Our research made use of interviews and surveys. The interviewees were relevant employees of municipalities who are active in or together with social district teams. We asked them about the design of their social district teams, but the effectiveness of their design also came up. This means that the participants were free to talk on an anonymous basis. Although we have tried to keep the participants anonymous, there is still the possibility that colleagues of the participant will know that we conducted the research. That is why we chose to keep the names of the municipalities anonymous as well. We only describe the characteristics of the municipalities, such as how big it is and if it concerns one city or multiple villages in that municipality. Other than that, we refer to the municipalities as Municipality A, B, C, etc. This way, we have tried to ensure full anonymity for the participants.

Another possible ethical issue is that the social domain involves many personal stories. Participants might give examples of cases they know to give a better description of their social district teams. These examples might include some personal details of clients of the social district teams. We have tried to exclude these examples from this paper.

Other than that we focused on organizational designs, not on individuals. We did not focus on any personal details and have tried to keep those out of this paper. In addition, all participants will receive a copy of this paper and were free to back down from participation at any moment, if they wanted to do so. However, we have received no such requests.

4. Results

First, we will discuss the results from our interviews with various municipalities. For each municipality, we will discuss wat their structures are and what experiences they have. This will be concluded with a synthesis on what the main findings are throughout the interviews.

Next, these results will be transposed into a survey, which is set out among all Dutch municipalities. This will allow us to confirm or debase the findings we had in the interviews. We will conclude this part of our research with a concise description of which findings we can not only base on the interviews, but also on quantitative data.

With these findings, we will start the comparison to the advised structures from KPMG and Movisie and to the organizational design theories, in that order. After this, we will finalize with a comparison between the advised structures and the organizational design theories.

In the last paragraph of the results we will summarize what we have learned from all of the steps above.

4.1 Consultancy Configurations

We start with discussing the consultancy configurations. In the synthesis in paragraph 2.3 we established an overarching framework based on Christis & Soepenberg (2014), as shown in figure 5. Each organization, regardless of which theory is used to look at it, is build out of a production structure (how the input becomes an output) and a control structure (the way the hierarchy is designed). Based on these two aspects, three possible organizational designs in healthcare can come forward: A fragmented organization, where all types of problems and clients are grouped and handled without any division, a product-based organization, where clients are grouped based on the product or service they need, or customer-based, where clients are grouped based on one or more similar characteristics of the clients.

The social decentralizations were aimed at one type of healthcare. Municipalities are now responsible for ‘first-line’ and ‘zero-line’ care, meaning the first healthcare professionals you get into contact with (such as a general practitioner, the first-line) and prevention (such as programs against obesity and the promotion of volunteers, the zero-line). Social district teams are thus a type of (light) healthcare service.

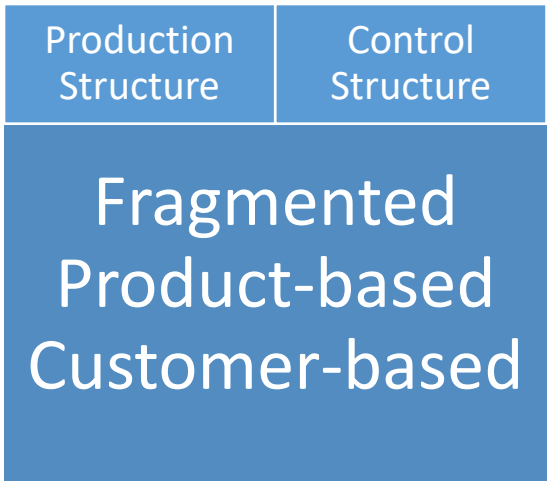


Figure 2: Theoretical framework of organizational designs in healthcare

4.1.1: Suggested social district teams

We have analyzed reports made before the decentralizations were in effect. Not many organizational models were proposed beforehand. One main cause of this is that the national government made a conscious choice to not set up many restrictions or limits for municipalities: it would be decentralized and thus their choice how they would want to organize it (Van der Steen et al., 2013). One of the main arguments for decentralizing was that municipalities were supposedly able to deliver better care for lower costs. The way they would organize their care would be location-specific and could be different for each municipality. This argument would be impeded if the national government would proceed to limit the degree to which municipalities could organize their own district teams.

However, two organizations, KPMG Plexus and Movisie, have done research on what municipalities were planning to do before the decentralizations were in effect. They concluded that three models were prevalent. We will use these models as the proposed models beforehand, as these are indicative of what municipalities were planning beforehand without any experience.

KPMG Plexus (2013) defined two typical models that have been found in social district teams. Their second model can be further broken down into a second and third model (Van Arum & Schoorl, 2015). We will use the vocabulary of Van Arum & Schoorl, but note that the original typology is based on KPMG Plexus.

First, Model A is one broad team to which all clients can turn and which can handle all types of requests for care. Even more specialized care is as much as possible handled within this one team. Teams can therefore solve most issues on their own, without the need for external

parties to support them. It is possible that more teams exist, but they all handle all care requests. They can, for example, have different geographical areas where they are active. Still, they handle all types of requests for care.

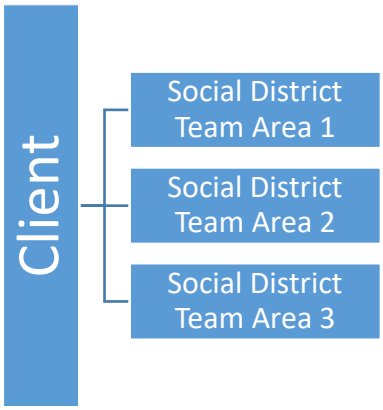


Figure 3: Visualization Model A

Model B encompasses multiple teams with clearly defined domains where they are active. These teams coexist, but should not interact, as their clients should not overlap. An intake procedure determines in which team a client belongs. Van Arum & Schoorl give the examples of a youth-team, a family-team and a team for complex interrelated problems.

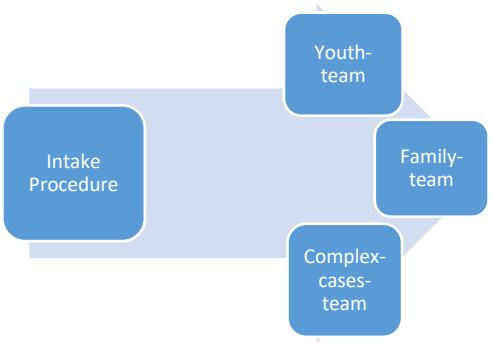


Figure 4: Visualization Model B

Finally, Model C uses the social district teams as entryways to more specialized teams. Clients come in and are diagnosed by the social district teams. These teams then determine which specialized teams are most appropriate for the specific case. In this model, social district teams only handle the simple care requests. Anything more complex is separated into specialized teams.

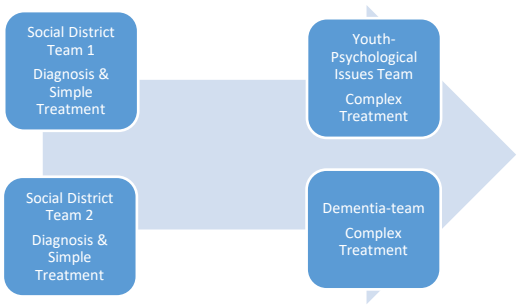


Figure 5: Visualization of Model C

These models are specifically made for social district teams. They are less general than the theories we will discuss next. Nevertheless, these models have been made prior to the decentralizations and while these may have been logical at the time, we do not know if these models are still prevalent in the municipalities more than three years after the decentralizations took place.

4.1.2 Comparison of Model A to the literature

Model A thus features one tier of social district teams, which are often based on geographical location. A client can, based on this simple distinctive characteristic, directly contact the appropriate team. The team then handles the problem regardless of what it entails.

	Production Structure	Control Structure	Type of organization
MST	Production process is concentrated in one team, handling the entire process from admission to end. In line with high scores on the first three parameters.	The control structure is not set in stone, but leaves open the possibility for high scores on the control parameters. Coordination can happen within the team, following MST recommendations.	Model A has the potential to be fully in line with the MST. If the control structure is made to empower the professionals in the teams and give them regulatory tasks, model A would be an example of the MST in practice.
Configurational Approach	In model A, there is not a lot of Job Specialization, since the teams are required to complete the entire process themselves. The units are grouped in a geographical way. Due to the independent nature of the model, professionals have to be skilled and willing to work in a self-steering team.	The teams in model A mostly regulate themselves. Since all actions happen within the same team, coordination is reduced to a minimum. Clients are assigned based on geographical area, reducing complexity and decision making before entering the process.	Model A is a self-steering organizational model, which it not only applies to control, but also applies to the production structure, where all workfloor decisions are to be taken by the team. The teams therefore have a lot of responsibility. Their team members have to be skilled to be able to work in such an environment.
Disruptive Innovation Approach (DIA)	From the Disruptive Innovation perspective, the task of the teams in Model A are too vast. They are expected to do everything, yet Christensen argues that this leads to loss of efficiency. Model A teams will handle depressions and dementia, but also easier cases.	The coordination tasks are assigned to the teams, but Christensen finds this too big of a task to assign a single team. The team consists of expensive professionals, who should be used to treat the difficult and complex cases, not the simple and straightforward ones. Yet they have to coordinate both in this design.	The Disruptive Innovation Approach does not compare to Model A well. Model A assigns all cases to a single team, where the DIA would advise to group certain procedures together in teams/organizations. Model A thus does not fit the DIA.
Conclusion	The MST and Configurational Approach are positive about Model A, since it allows for self-steering teams to work within a flexible environment. Model A does not fit the DIA, since that theory advises separation of certain types of treatments to improve efficiency and specialization. Model A does not separate, except for their physical location.	The MST retains the possibility for high scores on the control parameters, signaling that Model A's control structure fits the MST well. The Configurational Approach emphasizes that the control and production structure should fit and be congruent. In Model A, that is the case, since the self-steering teams are allowed space for self-regulation and self-coordination. The DIA advises to separate control and production tasks to improve efficiency. Model A does not separate the control and production structure.	Model A is customer-based, since it is only separated from other teams based on the characteristics of the customers, in this case geography. Model A receives the support from the MST and the Configurational Approach, but is advised against by the DIA.

Production Structure

First, we will discuss the production structure of this model. The production structure is as simple as it is complicated. A client comes in with a problem, either through their own initiative or because they were redirected by the municipality or another professional, such as a general practitioner. The client with the problem is the input. Depending on the problem, the social district team assembles a group that has enough expertise to solve the problem. Because of the wide variety of problems being handled, these teams either need to be very big or their composition has to be flexible to accommodate for varying problems.

The teams are not divided up based on the type of care that is needed. We can therefore exclude the product-based model. The teams are divided geographically, for example by town or by neighbourhood. This suggests a customer-based organization.

Control Structure

Next, we will discuss the control structure. In Model A, teams are responsible for all clients from within their allocated area. This leaves a wide variety of care that may need to be delivered. Cases can vary wildly, which also means every team needs to have access to a lot of expertise.

How this expertise is embedded can differ. In general, there are two options: a fluid team with a core of municipal civil servants assisted by case-specific professionals with additional expertise on an ad hoc basis or a large team of professionals from as many fields of profession as possible discussing cases together.

For the control structure, four questions can be formulated: who decides where a client should be allocated, who decides which team formation handles which case, who decides when a case is closed and who is responsible for the actions of the social district team?

First, the allocation is clear in this model: Based on geographical location or an otherwise objective and simple characteristic of the client. Second, the formation can vary, but who decides is not properly documented. This can be the core group of civil servants, however they may not be able to get the necessary expertise from outside the team on a continuous basis. How external expertise can be guaranteed for proper handling of cases is a question that was not formulated beforehand. In practice, municipalities had to find their own answer to this. Of course, for teams with a large group of professionals this was not a problem, but that might lead to extremely large groups of people involved, which also does not contribute to quick care delivery.

The same can be said about the third question. An external professional may consider the case closed, but the municipal core group may think otherwise. Who decides? The model does not specify this. The final question also alludes to this: who is responsible? When a group of municipal civil servants without sufficient expertise are tasked with solving a case, who is then responsible for the actions of the social district team? The control structure is unclear in this regard too.

Type of organization

We can determine that Model A is a Customer-based model. The teams are separated based on a characteristic of the customer/client: often their geographical location. The control structure is mostly unclear, which means we have to rely on the production structure, which is better defined. How the hierarchy is organized remains open however, which means municipalities have to think of their own solutions.

4.1.3 Comparison of Model B to the literature

Model B features a two-tiered approach: first, clients go through an intake procedure, after which they are assigned to a team that fits their case. Examples are a Youth-team, focused on clients under 18 years old, and a Family-team, focused on cases which concern not one individual, but a whole family.

How the intake procedure is organized is not described. Different interpretations can be possible. Examples are a single civil servant doing some sort of intake or a separate team primarily focused on new clients.

	Production Structure	Control Structure	Type of organization
MST	Two-tiered approach leads to separation of tasks and the need for coordination between tiers. This results in lower parameter scores on the first three parameters.	Depending on the intake procedure, model B can be very compliant to MST recommendations. Lighter intake procedures fit the MST reasonably well, although it would prefer to have this allocated to the teams themselves. The coordination can lead to separation of regulatory tasks, which is not advised in the MST.	The MST fits this model somewhat. While model B is far from the worst offender to the recommendations of the MST, it is not fully compliant with them either.
Configurational Approach	The two-tiered approach leads to some Job Specialization, as the intake process is separated from the rest of the process. How the units are grouped is up to the municipality, but in general the possibilities seem to be based on geographical location or on type of care needed.	While the control structure has not been specified for this model, the two-tiered approach does ask for more coordination than in model A. The two tiers have to communicate with each other, for example when redirecting a client to a team or when giving feedback to the intake process. There has to be more mutual adjustment, increasing the need for Liaison Devices.	This model is still quite vague, leaving a lot of decisions to the municipalities. However, the need for coordination is apparent, since the two-tiered approach means a client will have to be transferred. This process needs some degree of coordination, therefore increasing regulatory complexity. Important for the configurational approach is that this necessity is understood and acted upon, fitting with the chosen system, to ensure fit.
Disruptive Innovation Approach (DIA)	The DIA advises not to group precision medicine (treatments with a known cause and solution, able to be delivered quickly and accurately) and intuitive medicine (treatments with an unknown cause and without a known solution, relying on the intuition and trial-and-error of a specialist). In Model B, some distinction is already made, by separating “product groups”, in this case types of clients. This already fits better in the DIA than model A, but how well it fits still depends on the execution, since the model is only described in general terms.	The coordination tasks are less intensive than in Model A. The DIA advises not to group too many tasks in a single unit, since this can lead to efficiency loss and less experience gain. In Model B, some coordination is lifted from the team to a higher level, coordinating the two tiers in the model. This relieves the teams and allows them to focus on their primary tasks.	While Model B is still vague and a lot depends on the individual choices a municipality makes, it does seem to fit DIA better than Model A. Model B has the potential to fit DIA well.

Conclusion	Model B fits the MST less than Model A, because the tasks are split with the intake procedure. This leads to lower scores on the production parameters. The Configurational Approach cannot add much insight, since Model B is quite vague and the Configurational Approach emphasized the importance of fit. The structure has to fit with the goals. Model B is too vague to analyze this way. Model B fits the DIA better than Model A, since some tasks that are not concerned with healthcare are taken out of the tasks of the specialists, leaving them with their core tasks.	Model B requires more coordination, since the intake procedure is separated from the rest of the process. This complicates the process for the MST, because it prefers to concentrate all tasks (including coordination) into the team itself. The Configurational Approach does not have a preferred structure, but does advise to make sure all elements fit with each other. The DIA advises to lift coordination tasks from the specialists to allow them to focus on their clients and treatments.	Model B is a mix between customer-based and product-based. Customers can be separated based on their own characteristics (such as age) or on product (such as whether the problem is a family-wide issue). The intake procedure has to make this choice.

Production structure

The production structure is slightly more complicated than in Model A. Whereas in Model A a client could contact a team directly, Model B opts for a two-tiered approach. The severity of the intake procedure can be very different. A client calling their municipality and having to answer a couple of questions can already count as an intake procedure, albeit a very light one. On the contrary, a separate team could also conduct an intake, analysing the case and trying to find out if there are any related problems or underlying causes before redirecting to a second, specialized team. This intake procedure would be much heftier.

Similarly, which teams exist and how they are formed can be different as well. Municipalities can have any number of teams and it is possible to form ad hoc teams, based on the specific case and which professionals and expertise is useful for that case. Which teams are responsible for which clients is also up to the municipality. Model B thus gives a lot of freedom and mostly differentiates itself from the other models with its two-tiered approach.

Although a lot of variety can exist in the entire production structure between municipalities, in general the procedure for a client would be as follows: first, the clients gets into contact with some sort of intake procedure. This intake procedure would make sure the client gets redirected to a team that is appropriate for their case. The appropriate team then handles the rest of the necessary care.

Control structure

In the previous comparison about Model A, we already formulated four questions: who decides where a client should be allocated, who decides which team formation handles which case, who decides when a case is closed and who is responsible for the actions of the social district team?

First off, the intake procedure decides where a client should be allocated. Which team formation handles which case is predetermined, because the municipality decides in advance which teams it is going to use, but can also be on an ad hoc basis. The teams themselves have

to decide when a case is closed. Finally, municipalities with predetermined teams have thought in advance about which cases belong where and have thus also created a hierarchy and responsibility structure. For municipalities with ad hoc teams, determining responsibility can be more difficult.

Type of organization

Model B is not clearly a fragmented, product-based or customer-based model, and most of that has to do with the leeway municipalities still have when choosing for Model B. For example, an ad hoc organized team structure can be geographically differentiated (customer-based), based on age (customer-based) or based on a group of frequently occurring problems (product-based). The example given in the figure of Model B is also a mix between customer-based (the youth- and family teams are separated by the amount of clients and by the age of the clients) and product-based (complex cases are separated from non-complex cases, which is a division based on the product).

4.1.4 Comparison of Model C to the literature

Model C is a variation on Model B. The similarity is mostly in the two-tiered approach, with diagnosis and treatment separated into two separate stages. However, as opposed to Model B, Model C features simple treatment additional to the diagnosis. A client would first address a social district team, which determines a diagnosis and provides simple treatment if possible. Most of the cases should be handled by this first team. In this sense, Model C somewhat resembles Model A. For more complex problems and treatment, the client is redirected after the diagnosis to a specialized team. Examples are a Dementia-Team and a Youth-Psychological Issues Team.

	Production Structure	Control Structure	Type of organization
MST	For clients with relatively simple needs, the production structure follows the recommendations of the MST and scores high on the parameters. However for complex issues there is a second tier, leading to more coordination issues and a separation of tasks.	Model C is very MST compliant in regards to simple treatments. Clients do not have to be transferred to a different team. For complex cases, model C does not score well on the control parameters. Due to there being multiple teams, more coordination is necessary and regulatory tasks are separated.	Model C is mostly MST-compliant in regards to simple cases. Complex cases are significantly less in line with the recommendations of the MST.
Configurational Approach	Model C describes the intake procedure as not limited to determining in which team a client belongs, but also treating clients with simple needs and only referring clients to the second tier of teams if their problems are complex. This means there is a degree of Job Specialization, especially in the specialized second tier of teams. These are fully focused on one type of treatment (such as dementia).	The way model C is organized leads inherently to coordination, since the intake team has to coordinate the client they refer to the other teams with those other teams. Also, because these other teams are very specialized, the intake team has to be aware of where the borders of the teams are drawn, that there is no overlap, but also that every client gets treated, even if a team focused on that specialty does not exist yet. This increases the complexity.	The need for Liaison Devices is very high here, since there is a lot of coordination to make sure teams are not overlapping, but also that all clients get treatment. Maintaining a reliable treatment procedure while minimizing teams doing the same is a difficult task requiring much coordination.
Disruptive Innovation Approach	Model C separates the issues that can be solved quickly from the complex ones. This is in line with the DIA, which advises to separate the precision medicine (in this case: quick issues) from the intuitive medicine (in this case: complex cases).	Model C requires some coordination to make sure all clients are able to be treated by a team and teams do not treat the same clients and create overlap. This coordination can be done by the intake-team or by a coordinating layer above the teams. In any case, it would be advisable following the DIA not to put this coordination in both teams, since this increases their workload and reduces efficiency.	Model C follows the DIA quite well. It clearly separates the straightforward problems from the complex ones and therefore allows for specialization. Especially if the complex teams are differentiated by product, such as dementia or loneliness. This improves specialization and concentration of specialists in teams.
Conclusion	Model C follows the recommendations of the MST when it comes to the clients that can be handled by the intake-team. For the clients redirected to a complex-problems team, the process is separated more, which is against	Model C is very MST compliant for the straightforward cases. Model C is less MST compliant for the complex cases. Here, the coordination tasks are much bigger and increase complexity. More complexity can lead to more possible moment a coordination problem can occur.	Model C is a mix of customer- and product-based, fully product-based in the second stage. The first stage is customer-based, but also handles a lot of straightforward problems, which means it is also product-based. The second tier of teams is

	recommendations of the MST. The Configurational Approach notices that some aspects of the theory, such as Job Specialization, are increasingly important when the choice is made to divide the teams in to these complex teams. Model C follows the DIA, which advises for the separation of complex problems (intuitive medicine) from straightforward problems (precision medicine).	Separation is therefore not recommended by the MST. The Configurational Approach notices an increase in complexity and emphasizes that it is important to recognize the possible overlap or gaps between teams. The DIA approves of this model, since it separates the teams into units that follow its ideal types very well.	completely product-based, since they are separated based on the type of problem a client has.

Production Structure

For Model C, the production structure is well documented and predetermined. A client will first contact a social district team, which sets a diagnosis and delivers simple treatments if possible. For most clients, this is the end of the process. For some, the problems are more complex and the treatment is also more complex. For these clients, specialized teams exist that the client gets redirected to by the primary team. Key of this design is that the involvement of specialized personnel is based on a scale-up approach, which means that specialists are only involved if it is clear that they are needed.

Control Structure

We will again revisit the same four questions: who decides where a client should be allocated, who decides which team formation handles which case, who decides when a case is closed and who is responsible for the actions of the social district team?

The primary social district team sets a diagnosis and determines whether a client can be treated by the team itself or whether more specialized knowledge is necessary and the client should be redirected to the specialized team. The primary social district team can thus also determine which team would be most appropriate to handle the case. The primary social district team determines whether a 'simple' case is closed, whereas a specialized team has that responsibility for complex cases. The hierarchy and responsibility structure is unknown.

Type of organization

Model C could be a mix between types as well, similar to Model B. This mostly depends on how the primary social district teams are divided over the municipality. If they are geographically differentiated then it would be customer-based. If the client can contact a team that the client deems most appropriate, then it could also be product-based. And finally a single overarching social district team would be fragmented.

However, the existence of the specialized teams which only handle cases with similar complex problems means that at least the second stage of the model is product-based, as the type of problem is key for determining which team should handle the case.

4.1.5 Conclusion

We have used the literature to determine whether the suggested social district team models fit in a theoretical basis and how they are different. We found that Model A is a customer-based model, due to the fact that teams are only separated geographically. The only distinction made is a customer-related characteristic: where they live.

	Model A	Model B	Model C
MST	Model A fits the MST. It is a self-steering model with high concentration of tasks, both production- and control-related.	Model B does not fit the MST well. It adds a coordinating task and separates a production task. This leads to more complexity, more interdependence and more possible miscommunication.	The straightforward cases in Model C follow the MST well. The complex cases do not. In essence, Model C combines a Model A approach for straightforward cases with a Model B approach for complex cases. The MST only fits partially.
Configurational Approach	Model A is a model with a production structure and a control structure that fit each other very well. The Configurational Approach does not advocate a single organisation structure; it looks for fitness of structures. In this case, the parts of Model A fit each other very well.	The Configurational Approach does not have much use for Model B, since a lot of the further implementation choices are left open. Therefore the fitness of Model B depends on the choices made by the municipality.	Model C follows the same logic of Model B, in that it leaves open some choices for municipalities to be made. Nevertheless, Model C has more details and allows the Configurational Approach to look at it from a fitness point of view. The approach concludes that there will have to be a focus on Liaison Devices to make sure the Mutual Adjustment of the teams is in order. There is significantly more coordination than in the other models, which means the models with the most fit are the ones with a focus on coordination.
Disruptive Innovation Approach (DIA)	Model A does not fit the DIA, since it does not differentiate between different types of treatment. The DIA advises to separate cases based on complexity. Model A is designed to handle all problems in one team. They therefore do not fit.	Model B is quite vague. Based on the separation of teams, the DIA might fit with the model. If the separation is based on treatment method (precision medicine or intuitive medicine), then the DIA fits well. If it is based on other factors, then de DIA does not fit.	Model C fits the DIA really well, because the straightforward cases are handled separately from the complex cases, which have specialized teams. This is exactly what Christensen envisions in his examples, where he has units for straightforward problems and units specialized in complex, not fully understood problems.
Conclusion	Model A is customer-based. It fits the MST and the Configurational Approach very well, but not the DIA.	Model B is a mix of customer- and product-based. It is too vague to give a clear conclusion, but it does not fit the MST as well as Model A.	Model C is a mix of customer- and product-based, fully product-based in the second stage. Model C fits the DIA best, but does not fit the MST well.

Model B and Model C are more difficult, since they are not described to such an extent that a full analysis is possible. Much space has been kept for municipalities to fit in their own vision on how the social district teams should work. There is therefore no clear answer to the question where these models would fit in the literature.

4.2 Interviews with Municipalities

Next, we will discuss our interviews with the municipalities. In order to preserve the anonymity of the municipalities, we will name the municipalities based on their characteristics. The most important characteristics will be named, such as the size of the municipality and how many cities or towns are in it. This will allow the reader to grasp the differences in context between the municipalities, while not naming the municipalities outright.

4.2.1 Municipality 1: The Big Central City

This city lies in the center of a region and is one of the largest cities in The Netherlands. The municipality is comprised of only the city. The city has chosen to divide its territory into 11 distinct geographical neighborhoods, with each neighborhood having their own physical office out of which the social district team works.

The municipality chose for what they call a development model: existing healthcare organizations were asked to deliver personnel for the social district teams. Initially, they remained under contract by the healthcare organization. When the teams were used to each other and the organizational structure was satisfactory, the personnel was taken over by the municipality.

The social district teams reside in an office in their neighborhood and handle almost all cases. Only the most complex cases are redirected to a different team. Aside from being a physical location for the social district teams, the municipality also aims to put as much local governmental services under these roofs, with the aim of creating a central hub in the neighborhood, which makes it easier for the social district teams to get people on their radar.

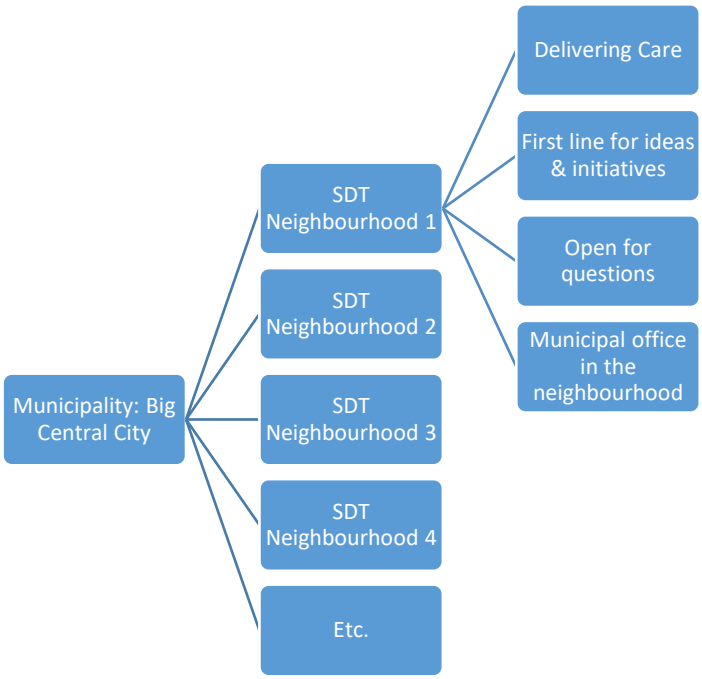
Interesting to note is that these social district teams have very broad tasks. Not only do they deliver care, but they also are the first line of communication for ideas or initiatives from the neighborhood. This allows the entire municipal organization to become more neighborhood-focused instead of city-focused.

Every neighborhood can have differences in what the teams look like. However, there are some aspects that are identical for all teams. First off, they have 30 to 50 members, with at

least a teammanager, policy advisor, practical supporter and a behavioral scientist. The other members can vary.

The municipality found that the decentralizations did not financially deliver up until now, but they did find that more signals from the community get heard in the municipal organization and that more people know how and when to contact the municipality. This is an important positive effect for them, even though it was not one of the goals put forward when introducing the decentralization.

Because of the earlier mentioned development model, the municipality emphasizes that their organizational structure is not sacred. It is inherent in their organizational vision that it can and will continuously change, depending on what the new developments in the field are.



4.1.2 Municipality 2: The Green Towns

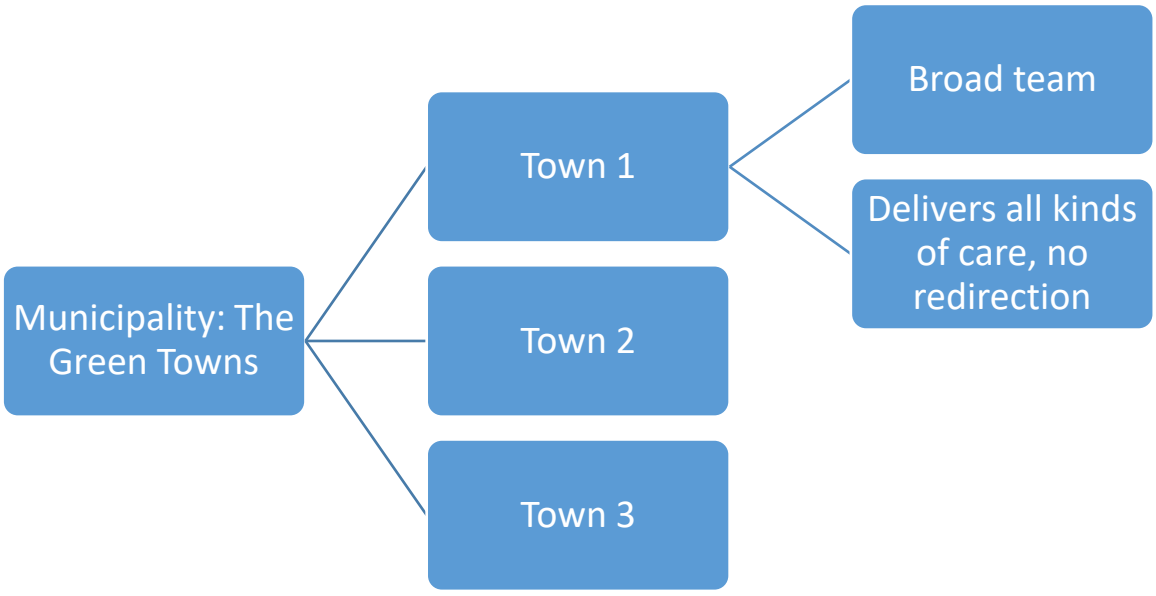
This municipality has 5 similarly sized towns with some smaller villages surrounding these towns. The municipality lies in a central location in the country in a green, forest-rich environment. At first, the municipality chose to dedicate a social district team to each town, meaning there were five social district teams.

The focus of these teams lie in servicing a broad group of people, meaning every inhabitant of the town should be able to get help from the local social district team. In the most complex cases, these teams worked together to gather the necessary expertise.

After some time and experience with the chosen structure, the municipality found that some towns were simply too small for a dedicated social district team. At the moment, there are three social district teams, but they are considering trimming this further down to only one team, which would physically visit the various towns throughout the week.

The municipality is not satisfied with the financial results of the decentralizations and finds that the idea of the national government to realize single case managers is not being met, because the healthcare organizations still maintain a strong competitive position. In addition, they think about their profits primarily, which sometimes means that the clients would be better off without (or with less) care, but the healthcare organizations do not accommodate this.

A positive note is that clients are satisfied with the service the municipality delivers. In addition, the municipality finds that more problems are found and more people can be helped. The downside is that this has a negative effect on the financials, but it does deliver societal value. The broad teams are working very well, because they are rooted in the towns and have the freedom to also sometimes create solutions or initiatives without resorting to formal care.



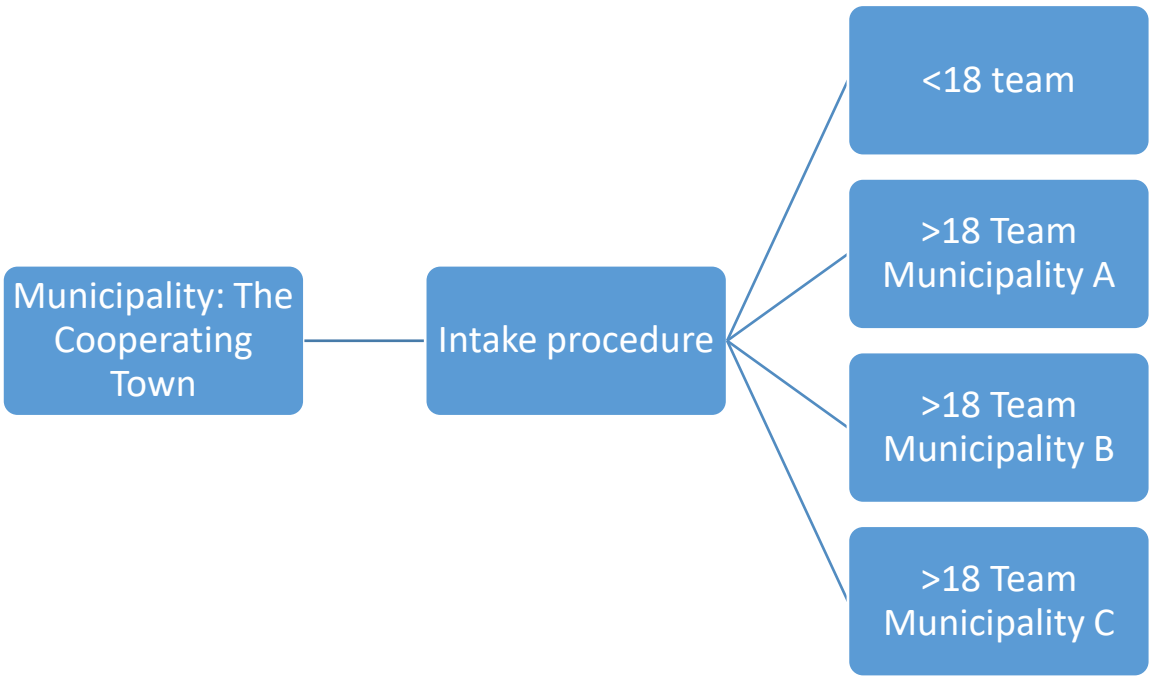
4.2.3 Municipality 3: The Cooperating Town

In the southern part of The Netherlands, we interviewed a municipality that works intimately together with two neighboring municipalities. So much so that their entire civil service is combined. It is therefore no wonder that their social district teams also work together in one system.

The three towns divided their social domain into two age-categories: 18- and 18+. The 18- category was first given social district teams. A year later the 18+ category followed. The youth teams are in cooperation with two other municipalities. These municipalities do not cooperate with the 18+ category.

In principle an inhabitant of the municipality can call a civil servant who will make a first assessment determining where that case should be handled. No strict rules apply, the expertise and individual situation is the primary concern. At first, the teams handled this first intake themselves, but the municipality quickly learned that placing this intake outside of the teams reduced the workload and did not have a negative effect on the intake procedure.

The municipality is not able to provide any measurable results, but they do state that they have a positive feeling about the entire endeavour, although the financial results with relation to youth care are not great.



4.2.4 Municipality 4: The City in the South

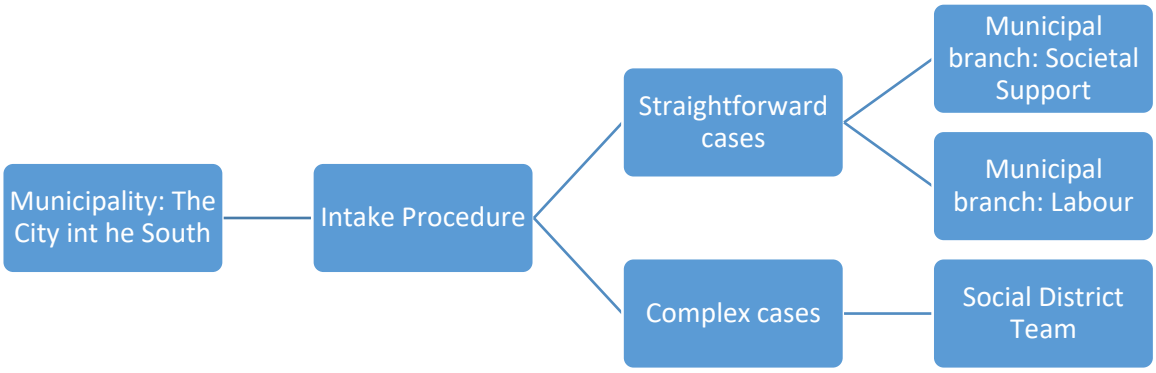
This municipality consists of one of the bigger cities in the south of The Netherlands. The city is divided into eleven geographical areas with seven physical locations from which the municipality works. The city has chosen to redesign their social district teams as per 1/1/2019. First, we will discuss what the teams looked like before 2019, then we will discuss them as they are now.

The city chose to combine five cooperating partners (the municipal health agency (GGD), the local branch of communal labor (Maatschappelijk Werk), the MEE cooperation (Stichting MEE) and the municipal agencies concerned with labor (Werk & Inkomen) and societal support (WMO)) into a new group. The idea was that people would be able to go to the people and organizations they already knew and that only the most complex cases would be handled by the social district teams.

Between 2015 and 2019, the municipality found the cooperation between the partners lacking, due to the different interests and managers that were involved. As per 2019, the city therefore has institutionalized the group into a cooperation, which handles the social district teams for the municipality, with the municipality as the ordering party. The management of the new cooperation consists of the managers of the five partners we mentioned earlier. The municipality expects this structure to be more clear, less divided in terms of interests and easier to steer.

In both timeframes, the teams handle all cases with the requirement that they are complex cases. If they are not complex, the case is handled by a municipal department.

In terms of the results of the decentralizations, the municipality mentions that they do reach more people who need help. More problems are on the radar. The downside is that the workload increases as well, which makes it difficult to find the right solutions for all individuals. One of the pillars of the decentralization was ‘maatwerk’, meaning a custom-tailored solution for all individuals that suit their specific needs. The high workload has made this a challenge.



4.2.5 Municipality 5: The Suburb in the Randstad

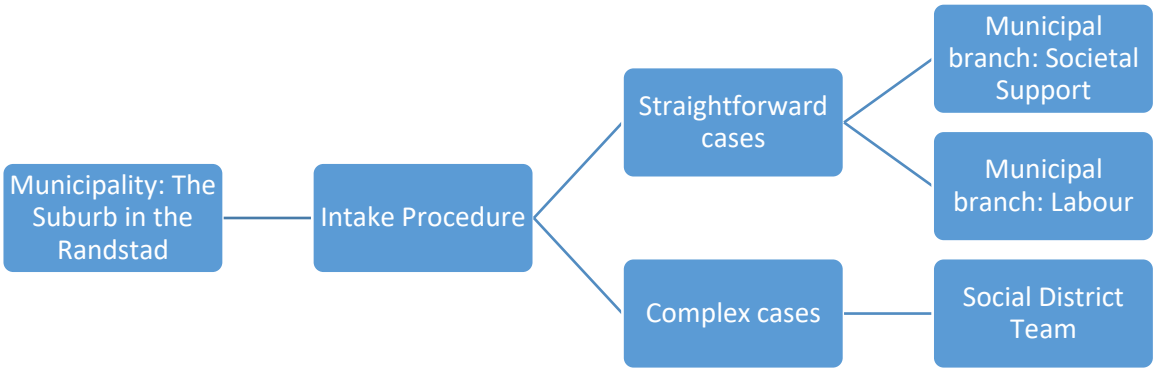
This municipality consists of one large town that is a suburb in the Randstad, the main urban area in The Netherlands, which also consists of cities such as Rotterdam, The Hague and Amsterdam. This municipality is not as big as those, but it is quite urban.

The municipality has one social district team, which is not physically in the neighborhoods but only at the town hall. The team only handles complex cases. Simpler cases are the responsibility of the municipal departments.

At the start, employees of the social district team were placed there while still under contract of the healthcare organizations. After one year, all these employees have been put under contract of the municipality, to decrease the risk of different interests.

Inhabitants of the municipality cannot reach the team by themselves. The team can only be contacted by professionals. However, by calling the municipality the inhabitants can immediately take a short intake and get redirected immediately if the civil servant deems the case to be part of the complex cases the social district team should handle.

The primary result of the decentralizations according to the municipality is increased clarity for the inhabitants. Who is responsible is clear now. The municipality has to take care of its inhabitants. This also helps inhabitants to contact the right organization quicker.



4.2.6 Synthesis of the interviews

All models are present in the five municipalities we interviewed. In the following paragraph we will discuss all municipalities and which model we can assign to them.

First, the Big Central City has multiple social district teams which handle a large variety of cases and problems, even those not necessarily limited to social healthcare. The teams are separated based on the neighborhood they are located in. This structure is reminiscent of Model A, with the addition that the teams are not limited to social healthcare, but handle all kinds of requests and questions from citizens. Model A was in line with the MST and the Configurational Approach, but criticized by the DIA.

Second, the Green Towns have multiple social district teams, which are separated depending on which town(s) they service. This is an example of geographical separation. The Green Towns are an example of a Model A structure, with multiple teams doing all different tasks themselves, only limited by their location. Model A was in line with the MST and the Configurational Approach, but criticized by the DIA.

The third municipality, the Cooperating Town, uses a system where there is a team for all clients aged over 18, organized together with two neighboring municipalities, and one team for clients aged under 18 for every individual municipality. Becoming a client of a social district team requires a short intake procedure, often by phone call. This structure, separate

teams behind an intake procedure, is an example of Model B. Model B is not supported by the MST or the DIA. The Configurational Approach reserves judgement due to the model being too vague to make conclusions on the fitness of it.

The City in the South and the Suburb in the Randstad both have nearly identical organizational structures for their social district teams. After an intake procedure, they separate the straightforward cases, which can often be solved quickly and routinely, from the complex cases, which require specialists and experimentation to find out what works for the client. This organizational structure is an example of Model C, although Model C does not specify exactly which types of teams should exist. The DIA supports this model, although it would prefer further specialization, for example by making a complex cases team specialized in dementia. The MST does not support Model C. The Configurational Approach reserves judgement.

Municipality	Which model(s)?	Conclusion
1: The Big, Central City	Model A*	Supported by the MST and Configurational Approach, not by the DIA.
2: The Green Towns	Model A	Supported by the MST and Configurational Approach, not by the DIA.
3: The Cooperating Town	Model B	Not supported by the MST and the DIA, no judgement based on the Configurational Approach.
4: The City in the South	Model C*	Not supported by the MST, supported by the DIA. No judgement based on the Configurational Approach.
5: The Suburb in the Randstad	Model C*	Not supported by the MST, supported by the DIA. No judgement based on the Configurational Approach.

4.3 Interim Conclusions

Based on the interviews, we can formulate a set of interim conclusions which we can test in our survey. There are a few main similarities that we found while studying the interviews. First, it seems like cities prefer to have various locations within their city out of which they like their social district teams to work. This could be because it is quite common for cities to actively and thoroughly work with neighborhoods already. On the contrary, the municipalities we spoke to with less inhabitants and more towns generally were decreasing their amount of

social district teams. While some spread physical presence seemed to be preferred, they did all mention reducing the amount of teams and the time that these teams were in different locations. Often the towns were deemed not big enough to dedicate a team to.

A second finding is that almost all municipalities find that the main result of the decentralizations is that they reach more people who need help. The municipalities all agreed that financially the decentralizations did not work as they all encounter financial deficits, mostly on youth care. Nevertheless, it is interesting to note that apparently the municipalities are better at signaling whether their inhabitants have problems. This was not hypothesized beforehand.

A third trend we noticed was the hiring process. At the start of the social district teams, most employees still worked for existing organizations and were placed in the teams. After some time, in most cases a year, the municipalities decided it would work better to place all these employees within the municipal organization.

We also looked at which types of cases the social district teams handle. This is different for all municipalities, with no clear characteristics that could be linked. One of our municipalities had very broad tasks for their teams, which also involved supporting initiatives from their inhabitants. Other municipalities let their teams strictly handle complex cases. Based on the interviews we are unable to explain why this difference exists and thus cannot test it in our survey, although we will ask for what all the other municipalities chose, combined with some basic characteristics, which might lead to a conclusion later on in our research.

To summarize, we will formulate the preliminary conclusions we have based on the findings from the interviews.

C1: The larger and more urban a municipality is, the larger the chance is that they have social district teams in different physical locations.

C2: The intake procedure most often takes place by contacting a regular civil servant outside of the social district teams.

C3: After initially hiring personnel from existing organizations, municipalities often hire personnel themselves.

4.4 Municipal Survey

The main goal of conducting a survey is to check whether the findings of the interviews are true on a bigger scale as well. Our interviews allowed us to find out what general trends are, but the survey also allows us to quantitatively back these findings up, or disprove them. We will first quickly discuss the main topics in the survey, based on the preliminary conclusions we formulated in paragraph 4.1.6. The complete survey can be found in Appendix 1. After this, we will discuss the results.

4.4.1 Topic 1: Social district teams in different physical locations

In our interviews, we found that the municipalities which were more urban in nature often had physically differentiated teams, with for example each neighborhood having their own social district team. Urban municipalities appeared to have more offices throughout their city in general, even before the social decentralizations. More rural municipalities often did not have physically differentiated social district teams or were scaling them back. This finding led us to formulating the first preliminary conclusion:

> ***C1: The larger and more urban a municipality is, the larger the chance is that they have social district teams in different physical locations.***

This conclusion has three main variables: Size of the municipality, degree of urbanization of the municipality and whether social district teams are in different physical locations. We will measure the size of the municipality by the amount of inhabitants a municipality has. The rationale is that more inhabitants means more people that could be helped by a social district team and thus more reason to have multiple teams. Because we rely on the amount of inhabitants, we will not feature this variable in the survey but base it on other data. The urbanization of a municipality has to do with the density of inhabitants living close to each other. A more urban municipality will find it easier to have meaningful spread out locations throughout its city, while a more rural municipality will, even with spread out locations, remain at a physical distance from their inhabitants. The attractiveness of being present in smaller towns is lower than being present in a dense neighborhood of a city. We will measure this by asking the municipality in the survey how many towns or cities are present in their municipality and how dense they find their municipality to be. Finally, these two factors in the interviews appeared to be the difference between municipalities with physically spread out social district teams and municipalities without these spread out teams. This final variable can be asked in the survey directly.

4.4.2 Topic 2: Intake procedures

The interviews gave us the idea that most municipalities did a first intake outside of the social district teams. This could be by a specialized civil servant, but some municipalities also relied on their regular reception employees who would pick up the phone and immediately start with a simple intake. In most cases, these intakes would decide a priori in which team a client would belong and what the problem was in general. The social district teams would then follow up on this with specialists who would try to find out the details and in some cases transfer the client to a different, more appropriate social team. Most municipalities already worked this way or were moving to an intake as we described above. We therefore formulated the following preliminary conclusion:

> ***C2: The intake procedure most often takes place by contacting a regular civil servant outside of the social district teams.***

For this conclusion, we have only one variable: whether the intake procedure takes place outside of the social district team or by the social district team. We did not find a trend in a certain type of municipalities preferring one way or the other, so we will stick to just finding out whether the a priori intake is indeed a general trend in municipalities.

4.4.3 Topic 3: Hiring personnel

Due to the speed which with the decentralizations were enacted, many municipalities were not ready for it. Some solved this by guaranteeing to finance the same care the clients received before the decentralizations for some time, after which they were able to handle all clients themselves. In our interviews, we found that many municipalities started by skipping a long and tedious hiring process by getting their personnel from healthcare organizations that already existed. These people would still be employees of the healthcare organization, but work for the municipality. While this was a quick way of getting people with the necessary expertise, it also resulted in social district teams with many different bosses. All these people were still employees of their healthcare organizations. When taking into account that some municipalities we interviewed have teams of around 30 people, this would mean dozens of healthcare organizations being involved.

It is no wonder that municipalities then started to put these people in their own municipal organization and take over the contracts from the healthcare organization. We are interested if this trend we encountered in our interviews is also present in general. We formulated the following third preliminary conclusion:

C3: After initially hiring personnel from existing organizations, municipalities often hire personnel themselves.

Two factors need to be asked in our survey: whether the municipality has hired the personnel in their social district teams themselves and whether this was different in the starting phase. We will ask these questions in our survey and based on this can determine whether this is a general municipal trend or whether our interviews were anomalies.

4.4.4 Results

We contacted all Dutch municipalities with the request to answer some questions about their social district teams, if present. Of the total of 355 municipalities, 108 responded and filled out the questionnaire. Not all 108 answered all the questions, which means the number of respondents can differ throughout the questionnaire.

The average amount of inhabitants of the municipalities which responded was 51.293, which is higher than the national average of 43212 (CPB, 2019). We therefore have to be cautious that our dataset is large (roughly one third of all Dutch municipalities), yet not completely representative.

We asked whether a municipality worked with social district teams. 67% of respondents answered that they use social district teams, compared to 33% who do not. In an earlier study, 87% of municipalities had social district teams (Van Arum & Schoorl, 2015). Another study, dated January 1 2016, found the percentage to be around 75% of municipalities, although this last study does not include all teams in its statistics (for example, municipalities with only a social district team aimed at youth are not counted as having social district teams) (CPB, 2019). We can therefore say that our first finding is that the amount of social district teams has decreased.

We have asked various questions to find a statistically more representative outcome with regard to the three interim conclusions we formulated. These interim conclusions were the following:

C1: The larger and more urban a municipality is, the larger the chance is that they have social district teams in different physical locations.

C2: The intake procedure most often takes place by contacting a regular civil servant outside of the social district teams.

C3: After initially hiring personnel from existing organizations, municipalities often hire personnel themselves.

Interim Conclusion 1

For Interim Conclusion 1, we need three variables: the amount of inhabitants of a municipality, the urbanization of a municipality and whether the social district teams were in different physical locations. We already discussed the first variable, as we also used it to compare our response set to the average Dutch municipality. The second variable is represented by the amount of villages were within the borders of a municipality. If a municipality has many villages, we assume it is not very urbanized, while a municipality with only one village is probably more urbanized. The reason for this line of thinking is that cities often are their own municipality and do not include other villages, while rural municipalities are often comprised of many different villages. We can control for the amount of inhabitants in the case of small municipalities which are comprised of only one small (and not urban) village. Finally, the third variable was included as a question in the survey.

	Differentiated	Centralized
Municipalities with >50.000 inhabitants	46,4%	53,6%
Municipalities with <50.000 inhabitants	31,7%	68,3%

Unfortunately, we did not get enough respondents to have a statistically valid conclusion to this question. We therefore have to rely on the observations made during the interviews and the (statistically invalid) responses we have received in our survey. These do indicate that larger and more urban municipalities more often have social district teams in different physical locations. In the interviews we found that the cities use offices throughout the city to divide the city into neighbourhoods with one team allocated to every neighbourhood. The responses to the survey indicate the same, with cities (municipalities >50.000 inhabitants, but only one town) relatively often having physically differentiated social district teams, while small municipalities and municipalities with many villages often choose not to physically differentiate the teams or to choose to hold consultation hours for a few hours per town. We did not count this as physically differentiated, as these consultation hours are only used for initial contact. All further contact and work happens when the teams are back in their offices, which were centralized. This method (having consultation hours in most or all villages) is popular, especially among smaller, rural municipalities (inhabitants <50.000, more villages than 5). We have to emphasize again that these findings are based on the five interviews and

the statistically invalid responses to the survey, and should thus be taken as an indication and not as a conclusive answer to the interim conclusions.

Interim Conclusion 2

In order to formulate a conclusion for the second interim conclusion, we need to know whether the intake procedure is done inside or outside of the social district team. We have asked the municipalities how they have organized this and gave them three options we encountered in the interviews: a civil servant outside of the social district teams (often some kind of receptionist) who answers the phone and performs a simple intake procedure to relay the client to the appropriate team, professionals (such as general practitioners) who can defer clients to the social district teams and clients having the opportunity to contact the team of their choosing directly. The fourth option was to explain a possible different way of handling the intake.

In 57,1% of the cases, the inhabitant can call a phone number and gets a simple intake by a civil servant outside of the social district team. In 69,6% of the cases, the client gets deferred by a professional. In 57,1% of the cases clients can contact the teams directly. 39,3% of the municipalities had a different method for taking in clients. These answers consisted, among others, mostly of civil servants/professionals on location (for example, teachers on schools) and consultation hours.

	A: Civil servant	B: Deferred	C: Direct contact	D: Other
Percentage of municipalities	57,1%	69,6%	57,1%	39,3%

Some overlap was expected, as there may be more than one way to get in contact with the social district teams. What is interesting is that there is no one way that is dominant. The options we found in the interviews were quite evenly used throughout the municipalities. We expected that most often municipalities would have a separate civil servant outside of the social district teams that could be contacted by the inhabitant of the municipality. This civil servant would then do a simple intake procedure and assign the citizen to a social district team. However, our finding is that only about one third of municipalities use this method, with the other two options being used slightly more. Accounting for the fact that we only asked one third of municipalities, we conclude that the interim conclusion has been rejected and that there is no one dominant way of contacting social district teams. Instead, there are

three dominant ways. The other ways municipalities brought in were not used often, mostly limited to just a couple of municipalities using that method.

Interim Conclusion 3

For our third interim conclusion, we need to know two things: whether municipalities hired personnel from existing organizations initially and whether they still do this. During the interviews we found that municipalities often chose to hire personnel from existing organization, "detaching" them in the social district teams while they were still on the payroll of the existing healthcare organization. This often led to difficult situations, where personnel had to answer to two different employers at the same time. The interviewees told us that this was the reason they now often hired the personnel themselves and put them on the municipal payroll.

In our survey, we asked what the situation in the other municipalities is and was to find out whether this was common for all municipalities or just happened to be similar in the municipalities we interviewed. In 23,6% of the answers, the municipalities responded that the personnel for their social district teams is employed by an existing healthcare organization. In 10,9% of the cases, municipalities started this way, but have hired the personnel by now. This is the case in the municipalities we interviewed. In 18,2% of the cases, municipalities have chosen a third option, where some personnel has been hired by the municipality, but there also remains personnel that is not on the municipal payroll. Finally, 7,3% of municipalities have always employed their own personnel for the teams and 40% chose the option that their method did not fall under the options, and gave various different methods. The most common "other" answer was that the personnel has a contract with a new organization, which was founded by the municipality in cooperation with a varying number of local organizations which are involved. The personnel is thus not employed by a market party or by the municipality, but by a third party.

	A: External employment	B: Start external, now employed	C: Combined	D: Always direct employment	E: Other
Percentage of municipalities	23,6%	10,9%	18,2%	7,3%	40%

We can conclude that the interim conclusion cannot be generalized to the municipalities in general, since only 10,9% of the cases reflect this interim conclusion. The other 90 percent has a different method of dealing with the staffing of their social district teams.

5. Conclusion

We have done an in-depth research on the organization of social district teams and how it compares to the organizational design theories and organizational design models which were advised before the decentralizations. We found two main organizational models. The first model has social district teams as main case handlers which handle all straightforward cases. Complex cases are redirected to a specialized team. The second model has the departments which also existed before the decentralizations. These departments do the work that the social district teams do in the first model. Complex cases are here handled by social district teams.

For the most part, we have found that the organizational design theory is well integrated in the current organizational design models. Based on the theory of Christensen et al. (2009), we can state that the two models fit his theory well, as they are either product-based or customer-based, but not fragmented. Using the Modern Sociotechnical Design Theory (MST), which urges organizations to strive for low parameter values on its parameters, we found that for the first model six out of eight parameters had a low value, while the second model had four out of eight parameters at a low value, with another two that could be lower depending on individual design choices of the municipalities. However, this also means that there is some room for improvement to bring the organizational models in accordance with the MST.

The first parameter which had a high value for both models was the level of differentiation of operational transformations, the separation of making, preparation and supporting. We concluded that these are currently separated by design. In order for a better fit with the MST, actions should be taken to allow the teams and departments to not only handle the care requests, but also have the responsibility on the preparation and supporting tasks.

The second parameter with a higher value is the level of specialization of operational transformations. This parameter, which is about dividing tasks into smaller subtasks, has low values for the first model, but potentially higher values for the second model. These higher values could be lowered depending on individual municipal choices. For a low parameter value it is recommended to not divide tasks into smaller tasks too much. In the case of the departments, this means that cases should not be divided and separated over multiple tasks, but condensed in one task. This should lead to less unnecessary interaction and potential communication issues, leading to better quality and less necessary time per case.

The third parameter is the first about the control structure, the level of separation between operational and regulatory transformations. Here the focus is on the second model, which on

average will have a higher value than the first model. The second model has less of a focus on self-steering teams than the first model and will thus on average have a higher value. To lower the parameter value we recommend to implement self-steering teams in the departments as well. This would mean that, aside from operational tasks, the civil servants also have regulatory tasks, lowering the separation of the two and thus the parameter value.

The final parameter that we feature here is the level of differentiation of regulatory transformations into aspects. Here, we separate Operational Regulation, Design Regulation and Strategic Regulation. We argued that due to the nature of a municipal organization, some degree of separation will always exist. The municipal council will always have the final decision making power in terms of Strategic Regulation. However, it is possible to delegate a lot of these decisions to the social district teams. More delegation means a lower parameter value.

When comparing the organizational designs in practice with the models that were suggested before the decentralizations, we found that none of the municipalities we interviewed could directly point to one of the models as their model. Each municipality had their own design with often some aspects of various models. One of the goals of the decentralization was to give municipalities the possibility to alter the design to their own local needs. We can conclude that municipalities made use of this.

In the Introduction chapter (Chapter 1), we named a number of problems about social district teams that were raised by various organizations, such as Rekenkamer Rotterdam (2018). The named problems are the financial results and the effectiveness of the social district teams (including problems such as long waiting times, inaccessibility for regular people and too much bureaucracy). The report of Rekenkamer Rotterdam (2018) points to the structure of the intake procedure as one of the main problems, as well as the members of the social district teams often still being under contract at care distributors instead of the municipality.

In our interviews, we found that all municipalities encountered financial problems, yet none of them relate it in any way to the structure of their social district teams. They agree that it is down to more people who make use of the decentralized laws and more people needing more expensive care. This coupled with a lower budget compared to before the decentralizations makes for an explanation outside of structural reasons.

The other problem, the effectiveness of the social district teams, does seem to be structure-related. Many municipalities are actively evaluating and changing their structure of the social

district teams, especially aimed at improving the efficiency of the intake procedure and the effectiveness of the team members. Many municipalities have taken or are planning to take all social district team members under contract, or a related solution to the problem of double employership that Rekenkamer Rotterdam also highlighted. We therefore conclude that these problems are related to structure, although we cannot yet conclude that they will be solved by the changes that are being made. For that, further research is necessary, especially after some time to give these changes the time necessary to sort out any effect.

6. Discussion

For this research, we have tried to come up with answers to important questions surrounding social district teams and the care they are supposed to deliver. We ran into several problems that we have tried to tackle. The interviewees were not aware of the organizational design literature and it was therefore hard to keep the interviews focused on organizational design without forcing the interviewees to in essence fill in a spoken questionnaire. We tried to use the topic list to stay within the realm of organizational design without forcing the interviewees to stick to restrictive questions, but some interviewees did have difficulties with this and went somewhat off-road.

We also encountered some difficulties with the survey. As with the interviews, we could not directly ask through the organizational design theories. We therefore opted for a series of interim conclusions that we distilled from the interviews that were suitable for a survey without extensive explanations. This restricted our possible questions and limited the amount of topics we could check through the survey, but it did allow for a survey that was filled in by many municipalities. This was a balancing act that we had to consider before distributing the survey. In retrospect, we might have been able to get away with a survey that was a bit longer, leading to a slight drop in response, but with more content.

All in all, we think we have come to some closure, yet during the writing of this research we also found new questions that could provide interesting new subjects for research.

First of all, we focused heavily on the structure of these social district teams and how they can be improved. We did not research the effectiveness of various approaches. Different approaches can adhere to theoretical norms, yet differ in how they are designed and implemented. For municipalities it can be interesting to find out what works when. In addition, many municipalities were in the process of changing their structure, partially as a reaction to their own evaluations, but also to evaluations from outside their own municipality. Critically analysing these changes and finding out what direction municipalities are moving in can be very useful knowledge.

A second point of interest is the financial problems many municipalities encounter with the decentralized tasks. Every interviewee told us that one of the main problems they had was the financial situation of these tasks. Often these finances trumped any other problems they had. We also quickly found out that structure was not really relevant for this problem. All interviewees pointed to demographic circumstances, budget cuts from the state government

and expensive healthcare. Some municipalities tried to partially solve these financial problems by looking at their structure, often removing access to the intake procedure for employees of healthcare companies that benefited more clients, since their profits would be higher. Yet, a large part of these problems were not associated with structure at all. For municipalities, the practical value of a thorough research into these financial problems could prove valuable.

Due to the time it took to write this thesis, it is important to check whether the findings are somewhat in line with the current situation. According to Koster (2020), it seems like the general findings they did in 2020 are similar to the findings in this thesis. The time that has passed does not seem to have had much of an impact on the situation of social district teams.

We are very interested to see where the social district teams are going and how they will develop. We hope the municipalities that supported this research found some value in our findings and in the stories of their fellow municipalities. We remain open for these municipalities to answer any questions or substantiate any cavities that they encounter.

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Appendices

Appendix 1: Interview topics

For each interview, we had the following topic list as a basis. Because it were semi-structured interviews, the topic list was not a definitive list for every interview. Interviewees were allowed to add topics they felt were important and the interviewer sometimes asked more questions about topics that were potentially interesting.

Topic list:

- Models (see chapter 4.3.1);
- Level of autonomy of the social district teams;
- Degree to which the teams are self-steering;
- Team composition;
- The physical location of the teams;
- Problems, advantages and disadvantages of the decentralizations.

Appendix 2: Survey questions

Welkom!

Bedankt dat u mee wil werken aan mijn Master Thesis onderzoek naar sociale wijkteams. Mijn doel is om, een aantal jaar na de decentralisaties, de stand van zaken op te maken over hoe de sociale wijkteams in Nederland georganiseerd zijn. Er zijn in veel gemeenten inmiddels aanpassingen gedaan, al dan niet na flinke evaluaties, waardoor het interessant is om te kijken naar de ontwikkeling op dit gebied. Graag wil ik u in deze enquête verschillende vragen stellen over uw sociale wijkteams en hoe deze zijn ingericht. Ook als uw gemeente geen sociale wijkteams heeft (of ze een andere naam heeft gegeven) hoor ik dit graag.

De naam van uw gemeente zal niet in het definitieve verslag genoemd worden. Indien gewenst kunt u later in deze enquête aangeven of u interesse hebt in het ontvangen van dit definitieve verslag.

Bij voorbaat dank voor uw deelname!

Thomas Eskes, Masterstudent Organizational Design & Development aan de Radboud Universiteit Nijmegen

Q1: Welke gemeente vertegenwoordigt u? (dit veld is niet verplicht)

A: [Open question]

Q2: Wordt er in uw gemeente gebruik gemaakt van sociale wijkteams?

A1: Ja

A2: Nee

If A2: Skip to end of survey.

Q3: Hoe veel inwoners telt uw gemeente? U mag afronden op duizenden.

A: [Open question]

Q4: Hoe veel kernen (dorpen, buurtschappen, etc.) telt uw gemeente? Wijken tellen niet als kern.

A: [Open question]

Q5: De manier waarop een inwoner bij het sociale wijkteam terecht komt kan verschillen. Hoe wordt bepaald of een inwoner in aanmerking komt voor een sociaal wijkteam en welk team dit zou moeten zijn?

A1: De inwoner kan een telefoonnummer bellen waar een loketmedewerker een korte intake uitvoert.

A2: Inwoners kunnen door professionals doorverwezen worden.

A3: De inwoner kan direct contact opnemen met een wijkteam waarvan hij/zij vindt dat bij zijn/haar probleem past. Dit team verwijst eventueel door naar een ander, passender team.

A4: Anders, namelijk: [Open question]

Q6: Gemeenten hebben in 2015 vaak met enige haast de 3 decentralisaties moeten verwerken. Tijdens verkennende interviews bleek dat dit ertoe leidde dat zelf personeel aantrekken om de wijkteams te bemannen vaak te lang duurde. Hoe is er in uw gemeente omgegaan met de bemanning van de wijkteams?

A1: Personeel is gedetacheerd uit bestaande zorgorganisaties. Dit is nog steeds het geval.

A2: Personeel is eerst gedetacheerd uit bestaande zorgorganisaties, maar vallen nu direct onder de gemeente als werkgever.

A3: Personeel is eerst gedetacheerd uit bestaande zorgorganisaties. Dit is deels nog steeds zo, maar deels valt dit personeel nu onder de gemeente als werkgever.

A4: In onze gemeente is het personeel direct na de decentralisaties onder de gemeente gaan vallen. Wij hebben geen personeel gedetacheerd uit bestaande zorgorganisaties.

A5: Anders, namelijk: [Open question]

Q7: Er zijn gemeenten die hun sociale wijkteams door hun gemeente verspreid hebben gestationeerd (bijvoorbeeld in een kantoor per wijk of dorp) en gemeenten die de wijkteams gecentreerd op één locatie houden (vaak het stadhuis/gemeentehuis). Zijn in uw gemeente de sociale wijkteams fysiek gecentreerd?

A1: Ja

A2: Nee

Bedankt voor het invullen van deze enquête! U kunt hieronder een mailadres invullen waarop u het verslag van dit onderzoek wil ontvangen. Indien u het tekstvak leeg laat zult u het verslag niet ontvangen. Het mailadres zal enkel worden gebruikt voor het versturen van het verslag en daarna vernietigd worden uit mijn adressenbestand.

Tevens wil ik u nog uitnodigen om eventuele opmerkingen over dit onderzoek en/of deze enquête in het tweede tekstvak te zetten. Feedback is uiteraard van harte welkom!

Dank voor uw aandacht en moeite!

Thomas Eskes, Masterstudent Organizational Design & Development aan de Radboud Universiteit Nijmegen

Q8: Wilt u het verslag van dit onderzoek ontvangen? Vul dan hier het mailadres in waarop u het verslag wenst te ontvangen.

A: [Open question]

Q9: Heeft u verder nog opmerkingen over dit onderzoek en/of deze enquête? Uw feedback is van harte welkom!

A: [Open Question]