QUALITY MANAGEMENT IN SOCIAL WORK IN THE NETHERLANDS: PRINCIPLES AND APPROACH

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Your Excellency, ladies and gentlemen, dear colleagues!

I felt very honoured by your invitation to address you here this afternoon and say something about quality in social work.

For your convenience, I have summarised the main issues of my speech in Lithuanian (or better I've asked others to do this) so that you may get an idea about what I'm going to say **(sheet 1).**

Quality as a cultural phenomenon

You may perhaps assume that in my country, The Netherlands, a great deal of experience has been gained regarding the furthering of quality in social work. That is not so though. The legal regulations in the field of quality in the care- and welfare sector date from the nineties. This does not imply though that there was no interest in the matter of quality previously.

In those days quality had an other meaning however. It was a static concept regarding the introduction of standards and rules by the authorities and the checking if people complied with them. Institutions that complied with the rules were officially recognized. And recognition meant quality. This filling in of the quality concept reflects the society of that era. The citizen and the employee resigned to what the authorities or the employer had arranged. This was the case in the industrial sector and in the sector of care- and welfare alike.

In the seventies the image began to shift. In The Netherlands as well as in other Western European countries. The increased prosperity also enlarged the choices of people. Gradually quality was not longer taken for granted fact, but as something that had to be proven. First when buying a radio, a tv set or a car, gradually with regard to health care, the education system and the social care sector also. The emerging of all kinds of consumers' – and clients' organisations in those days may illustrate this. At the grassroot level, at the shop-floor, the imposed way of acting became less and less accepted. The method itself was being questioned. First in the industrial sector, then in the service sector and the administration. The concept of quality gradually gets a dynamic meaning including everything and everybody.

In the care and welfare sector in The Netherlands since the last few years we have been with the term of *integrated quality care* concept. In the industry, not just in The Netherlands but abroad also, this concept may also be known under the name of *total quality management*, or *TQM*.

Quite recently the *European Organisation for Quality* published a concise but fascinating report under the title *'Towards a European vision of Quality – The way foreward'*. In it the Organisation unfolds a quality development policy based on a *'Charter of European Values'*, i.e. 'dignity, equality, diversity and (....) spirituality'. TQM is considered as a means to meet this objective. Values and norms attached to it are:

- customer focus;
- continuous improvement;
- engagement of all employees;
- management based on facts;

- senior management leadership for quality;
- focus on processes and prevention, rather than reliance on inspection;
- documented, auditable systems for key processes;
- teamwork built around processes;
- training and education.

Although the report addresses to the industrial sector in the first place, the ideas could in my opinion easily be implemented in social work as well. It is a challenging story anyway.

Legislation on social care in The Netherlands

As I said before it took until the nineties until The Netherlands got its first laws regarding the quality aspect in the care- and welfare sector. Until then the authorities set rather detailed quality requirements which institutions had to meet in order to obtain official recognition. Due to the increasing complexity and the specialisations in the care sector in particular, the idea of a self-governing system for the institutions received increasing support. The authorities would then reduce their role to the setting of some general guidelines. The institutions, insurers and clients' organisations were expected to ensure quality by mutual agreement from then on.

For the elaboration and implementing of this policy a *quality consortium* was formed by all the parties involved. Eventually the agreements set by the consortium led to the Law on the quality of care provisions *(Kwaliteitswet Zorginstellingen*) which became effective in 1996. This law holds articles about the way 'care producers' should guarantee the quality of the care rendered. The most important of these are:

- The care producer guarantees care of an adequate level, which shall be implemented effectively, efficiently and client oriented and which shall be adjusted to his or her actual needs;
- Care producers are obliged to maintain in a systematic way, the monitoring, controling and improvement of the quality of the care rendered.

Implicitly the regulations refer to an overall quality system which an institution should maintain and to a continuous, cyclical quality control. I will return to both later.

How quality is seen from different angles

Quality can be looked at from very different angles. The product or service which is good for the one need not necessarily be good for the other. Just an example:

Dordrecht is one of the oldest cities of the Western part of The Netherlands, also known as Holland. Some years ago an independent survey on the feelings of well-being among the citizens was conducted in one of the neighbourhoods of the town by some university researchers. This particular neighbourhood had but few green areas and in it lived a rather large number of immigrants and therefore it had been declared a 'problem area' by the municipal authorities.

There was some commotion among the local politicians and civil servants when the outcome of the investigation showed that the residents thought otherwise. In contradiction to the municipal assumptions, the citizens didn't really care about the lack of greens and the number of immigrants. They appeared to be much more interested in their homes and their social contacts within the family instead. As a result the plans for some new public parks and the reduction of the number of immigrants in the neighbourhood became superfluous.

The research showed that it can be rather risky to simply project one's own expectations regarding quality on others, in this case the citizens of that particular district. It may also illustrate the importance of involving the clients or users (in this case the citizens) when determining the quality of products and services that is needed. In the example it was the public authorities who missed this point, but it might also happen to care- and welfare institutions and individual social workers.

According to research by Nivel, the Netherlands research centre for the health care sector, patronizing and arrogant behaviour of caring professionals is the complaint most mentioned by their clients.

The concern of the social worker with quality differs from that of clients. He or she wants to practise his or her profession as well as possible. This implies the wish and the ability to apply one's experiences and skills, a vision on how to organise one's work and to treat one's clients in a respectful way. This may sometimes lead to conflicts, for example if the opinion of the professional and that of the client are opposite. The Dordrecht case I just mentioned was a good example of this.

Other parties, such as the management of the institution or the financier or insurer, will experience the quality aspect their own way. You may not believe this, but although in a rather rich country the social care sector in The Netherlands is struggling with a continuous shortage of places in nursing homes and home care provisions. There are waiting lists and sometimes people have to wait for half a year or more until they are assigned a place in nursing home or a home care assistant. This makes great demands on the management of the institutions concerned. Managers try everything possible to increase the outflow of clients in order to create room for new customers. Under such circumstances 'have vacancies' and 'quality of the provision' are, though incorrectly, easely seen as identical by those managers. Moreover, paying attention to other important aspects of quality, such as the care for a proper coaching of employees and the availability of client-friendly surroundings disappear from sight all too easily.

The insurers who, together with the authorities, are the main financiers of the care- and welfare provisions, play a curious double role in the story on quality. On the one hand together with the clients' organisations they represent the people for whom the care provisions are meant. And in that role they may only demand the best for the insured persons. On the other hand however, as financiers, the lower costs are, the better their interests will be served. Thus quality in their eyes is an optimum in the ratio between price and quality: as many and as good services as possible at the lowest possible price. The consumer does not always benefit from this attitude. To my mind, the fact that many of these insurance companies now have become for-profit organisations has not enhanced their quality consciousness.

To summarise: Quality is a very subjective concept. What quality is depends on the circumstances and on who is defining. For the consumer or client quality may be something different than for the social worker, the manager, the financier or the authorities. Sometimes one may notice a sliding scale of more or less quality which challenges one to find the best quality under the prevailing circumstances.

The diagram, made by my colleague Gabriëlle Verbeek, may illustrate the various positions of the parties involved and the norms and values they may refer to (Table 1).

Table 1. ***Some norms and values regarding quality perception in social work (Gabriëlle Verbeek)***

PRIMARY CARE PROCESS	***CARE INSTITUTION***	***CARE MARKET***
Clients:	**Management:**	
Individual care provision	Internal coherence of organisation	
Quality of life	Continuity of institution	
Client-oriented services	Product-oriented	**Authorities/politics:**
Individual choices	Market-oriented	Level of public welfare & health
		Economic situation
Social workers:	**Insurers:**	Civic awareness
Profession-oriented	Market-oriented	Accessibility of care
Quality of methods used	Insurance package	
Co-operation with clients	Efficiency of care	
Co-operation with colleagues	Costs of care provisions	
SOCIETY		

Modern ideas on furthering quality are based on a multidimensional filling in of the quality concept. As a consequence the different angles which we just discussed are linked up and combined in a so called quality system. I will return to this later.

To close off this part of my speech I'd like to confront you with some statements about quality you may be especially interested in (Table 2).

Table 2. ***About quality***

- Quality is ballet, not soccer. (Crosby)
- Quality is the use of allocated means by care providers in a way which is useful, efficient and in accordance with the objectives. (Commission for the restructuring of social care)
- Quality is the extent to which all the qualities of a product, process or service meet the expectations attached to it resulting from its purpose. (Council for the Certification)
- Social care quality is the level of social support for people trying to integrate, to reintegrate these people into social life and to help/teach these people how to care for themselves. (dr Gintaras Razaitis, Savanoriu Centras)
- Quality is the extent of concurrence between the objectives of (health)care and the care delivered. (Donabedian)
- There is no disputing about tastes. (saying)

Some quality principles

Before continuing on the quality system I want to draw your attention to some what I would call important preconditions for quality in the care- and welfare sector everyone in The Netherlands will agree upon. If quality development is the course we want to go, then the following aspects may be called the buoys that keep us on the right track (Table 3).

Table 3. ***Quality principles in social Work***

- Client in the centre
- Right to information
- Right to complain & right to appeal
- Accessibility of care provisions
- Effeciency & effectiveness
- Professionalism
- Accountability & transparancy

The client is in the centre. The interest and needs of citizens, consumers or clients are the starting point for social work. This implies that the client has a very important say in determining the nature of the care and the way it is rendered. The interest of others should not stay out of sight however. But the interest of the others is always seen in relation to the client's interest in particular.

The right to information. Clients should have the opportunity to collect information that is of importance to them, e.g. on their rights on social care and where to find the according provisions. In The Netherlands we have an extended network of social counsellors and a variety of information centers. As a supporting means my institute publishes an update of a fist-thick almanac containing over a thousand pages of information on social issues every six months. This almanac is now also issued as a cd.

Accessibility. To know where to turn to as a client is one thing, being able to actually use these facilities and services is yet another. Provisions should be in or near the area where the client lives, they should be accessible by telephone, they should also be accessible physically -e.g. by wheel chair and the price of their services should be at a reasonable level. Accessibility also means the absence of waiting lists and alike and as you already know by now, in The Netherlands that is a tricky issue.

Effectiveness & efficiency. This means as little bureaucracy as possible, the abolishing of superfluous rules and procedures and a cost-effective management that aims at arriving at an optimum in the ratio between price and quality. The starting point is that as a rule institutions themselves may know best how to work efficiently. Thus efficiency also implies a policy of decentralisation and the throwing overboard of top-down management.

Professionalism. Social workers' educational level should meet the tasks they have to fulfil. This also applies to the other employees of social institutions and to the volunteers alike. The institution has the obligation to organise adequate additional schooling and in-service training of its employees.

Accountability & transparancy. The organisation of the social care and services should be such that it is clear to all parties who is responsible for what. Procedures, protocols and rules should be clear, simply formulated and

standarized if and where helpful. Monitoring and controlling of their effectiveness should be easy. This also applies to the financial aspects of the institution.

The right to complain. A client should have the right and the possibility to complain if he/she thinks the care or services rendered are not meeting the standards or if he/she disagrees with decisions. In The Netherlands this has been arranged by law quite thoroughly: institutions have their internal commission for complaints and apart from that external commissions of independent experts exist to which complaints may be presented. In the ultimate case complaints may be sent to the courts or to a special disciplinary committee. If the public authorities are at stake, one might appeal to the national ombudsman.

A similar rule should apply to the individual social worker. He or she should also have the right to appeal if disagreeing with a client's complaint.

Quality system and quality policy

Care producers in The Netherlands are obliged to implement a systematic monitoring, managing and improving of the quality of the care they offer. I already mentioned this while discussing the legislation in my country. An important instrument for the execution of this obligation is the so-called quality system.

A quality system is in fact nothing else but a set of managing rules. The objective is to guarantee constant services of good quality and to prevent mistakes and failures as much as possible. In the business sector this should lead to a smooth functioning organisation with clients that are satisfied. In essence this is the aim of the quality systems that have been introduced in the care sector also.

The characteristics of a quality system are threefold:

- *Client's needs*: a first characteristic is that the client's needs should be known, so that the services may be accordingly. In the present jargon this is what is called 'demand oriented' (opposite 'supply oriented', in which the institution determines what is good for the client!). A good quality system has procedures to map these demands for care continuously, e.g. by enquiry among (potential) customers, by consulting clients' organisations, other care providers and institutions involved.
- *Evaluation by the clients*: the satisfaction of the clients is a standard for quality. Their judgement is important in order to establish where quality falls short and where to make improvements. A quality system therefore always includes procedures for evaluation by the users of care services. E.g. by evaluating enquiries, by exit-interviews, by consulting a board of clients or judging by external experts. In this way a feedback-mechanism will be built which renders it possible to implement improvements continuously.
- *Measuring of results*: in business and industry the entire quality system is about the measuring of results as a basis for improving the organisation and the work processes. You do need registrations and statistics to be able to follow the quality of the work performed. On the basis of the feedback-information the work process can be fine-tuned in an ever better way. In the practice of Dutch social work measuring is becoming increasingly popular. Uni-interpretable indicators for quality are still being developed however.

In a quality system various angles and principles of quality development are brought together (Table 5).

Table 4. ***Quality development approaches***

➢ Policy- and strategy development
➢ Furthering employees' professional quality
➢ Developing of protocols & procedures
➢ Developing of quality sub-systems (e.g. interfraternel examination among colleagues)
➢ Involvement of clients
➢ Coherence and chain-quality

By *chain-quality* we aim at the quality of the entire route of the client in the care system and the people and institutions that are involved (e.g. the family doctor or GP, social worker, nursing institution).

As practice will show us a quality system will emerge step-by-step fromthe coming together and integration of existing examination practices and

sub systems. There sometimes may already be a good performing examination and monitoring system for internal care, while a similar system for external care is still lacking. As such this is not a problem, as long as it is kept in mind that eventually one integrated system is the ultimate objective.

From research it appears that the development of a quality system is a process in phases in most institutions. First comes a period in which the idea is discussed and considered (orientation), to be followed by a phase in which preparation of concrete measures (e.g. the training of employees) takes place, then implementation of single projects will follow and finally a systematic, all-over approach will be implemented.

So-called *quality models* have been used in industry for years to assess the quality of the entire system. A well-known example of these is the so called *ISO-model* (*International Standards Organisation*). In such a quality model the entire process of care and services provided will be reduced to a few main aspects, e.g. (ISO) the client's satisfaction, the efficiency of the organisation and (since only recently) the preventing of negative influences on society and the environment. A thorough management of the production- and servicing process with the help of standarized procedures is the central objective.

Furthering of quality in care practice

For the final part of my speech I'd like to pay some attention to how in practice quality could be furthered.

The first and most important thing I guess is for a team of management and workers to discuss together what quality is or should be and why it is so important to work on it. I summarize this in the formula $\mathbf{Q = MC^2}$ in which M stands for motivation, C of consciousness for being aware and 2 for the fact that one should work on quality together, as a team (with thanks to Mr Einstein). Once affinity with the concept of quality has evolved, the developing of a joint vison on a quality policy is not that difficult anymore. The expliciting will be a matter of perseverance mainly then.

As a basic model for a strategy of systematic quality improvement we may use a step-by-step approach consisting of the following elements :

1. drawing up of criteria and norms to be met by the care provider; which is the situation desired?;
2. investigation of the situation in practice and registering, using measurable data as much as possible;
3. planning of activities that should improve the situation;
4. implementing improvements according to the planning ad 3;
5. evaluating the results and re-start of improving activities if necessary.

'*circle of quality* or *cyclic approach*, indicating that quality improvement should be an ongoing process of planning, action, check and feed-back, readjustment, etc.

Now, if we apply practice to the steps just mentioned, we may find

1. home care should be available 24 hours per day instead of the current 12 hours maximum provision;
2. investigation shows: most 24 hours home care is needed in a district where many old people live;
3. we make a plan for altered work-shifts for present social workers; we recruit volunteers to help us by taking over some simpler tasks;
4. we inform the clients involved, we instruct the volunteers and we start working according to the altered scheme;
5. we ask clients if they are satisfied, we ask the volunteers about their experiences and we process our conclusions.

Methods and instruments

In the care and welfare sector a large number of methods and systems have been developed which in one way or another are focusing on quality improvement. Some of these methods are perfectly suitable for the social workers, either as an individual or in a team of colleagues, other methods are better to be used when involving clients in the process, some are meant for management purposes in particular. In the overview which I will show you now, you will find a number of these methods mentioned (Table 5). To some of them I'd like to add a few words.

Table 5. ***Overview of some methods and working procedures for quality improvement in social care (From: Kwaliteit als Werkwoord)***

Individual employee	*Colleagial teams*	*Worker & client*	*Employees and organisation*
self assessment	Intervision	handling complaints	assessment meetings
on-the-job coaching	client discussion	panel of clients	career counselling
in-practice counselling	methodical job- coaching	feedback from clients	visitation
supervision	interfraternal examination among colleagues	mystery client	market research
intervision	quality circles	counsellor	program evaluation
documentation	care plan	council of clients	data bases
ind. learning protocol	team learning	council of parents	quality circle

Self-assessment, supervision and intervision. To have an understanding of one's individual functioning as a social worker is a pre-condition for quality. If you are not aware of your own opinion regarding important issues in life, if you have no idea about your strong and weaker points, your capacities and shortcomings, then it may be a hard job to identify with someone else's situation and to understand his or her need and to respond in an adequate way.

In this respect *supervision and intervision* could be useful methods to improve one's own professionalism or/and that of the team. *Supervision* stands for the counselling by more experienced coleagues of newcomers in the profession -students, volunteers- or those who have to apply to another task. Supervision consists of three interrelated elements:

- experiences that should be reflected upon;
- the expliciting of those experiences;
- to re-comment on the experiences from a wider angle, e.g. by using experiences of others, by refering to literature, etcetera.

We speak of *intervision* if two or more professionals comment the way each of them fullfils his or her tasks. Good intervision results in a two- or multi-sided learning process. Both supervision and intervision are rather easy to arrange within almost every organisation. If assistance is needed one could apply for it at one of the social work schools or university departments. There are special protocols available that might be of help when implementing systematic supervision training.

The last few years the *self-assessment method* has become rather popular in The Netherlands. In this method so-called competence-profiles are used in which it is described what under certain circumstances is to be expected from a social worker. For instance such expectations as:

- to be able to identify and analyse needs of clients
- to be able to draw up a plan of action
- to be able to execute activities according to plan and systematically
- to report and to evaluate
- to co-operate in the team
- to be able to function within and contribute to the organisation
- to have an idea about the developing of one's profession.

According to the profile description the social worker may indicate to what level he or she thinks to meet the requirements, e.g. by filling in a score form. The result may be hey discussed with another team member. From that discussion it may be established whether additional schooling is necessary or that some exchange of tasks were to be recommended.

A variation to this method is the use of the so-called c*ompetences self-managing teams method*. In this method it is not just the individual employee but the entire team that puts itself on the dissecting table. A description of this method in English will be available for all of you tomorrow.

Standards and protocols. These are guidelines for how social workers or care providers should act under certain conditions. As an example of such protocols I could mention the protocol that is used in The Netherlands on how teachers should act if there is the suspicion of

incest or sexual child abuse in a family. For the drawing up of standards regional or national consensus meetings may be organised.

Consultation of clients. In The Netherlands in 1996 and 1997 laws have been introduced that made it compulsory to consult the clients of care- and youth care provisions. The law speaks about so called *boards of clients*, but does not give detailed instructions on how these boards should be arranged in practice. The boards should be representative however for the clientele of the institution concerned. The board must be consulted in all cases that are of collective importance to all clients.

Apart from this legally imposed form, there are of course many other possibilities to involve clients in the improving of the quality of services. One might consider executing an enquiry or installing a *con-sumers panel*, a sort of forum of experts that may act as a discussion partner for the management or the team of the organisation.

Yet another possibility to increase the client's involvement is appointing a *counsellor* clients can turn to anonimously if they have complaints or the use of a *mystery client*. The last method concerns a disguised person who acts as a client having the objective to check the quality of the services without the management's being aware of it. This might be done by order of a con-sumers organisation.

Conclusion

Ladies and gentlemen, I'd like to come to a conclusion.

In my speech I've tried to tell you something about the development of quality management in the social care sector in The Netherlands. I have indicated how in Western society the perception of quality has changed from a static towards a dynamic concept; I have also said something about the subjectivity of the quality concept and stressed how important it is to know who sets the standards and norms.

In addition I have mentioned the legislation on quality in our country and the implicit obligation for care institutions to establish an allover, integrated quality system. Finally I have shown how in practice quality may be furthered and I discussed several methods and instruments that might be of use here.

Of course there is much more to say about quality but I think I'd better not do so right now. In the working groups that have been scheduled for to-morrow we will all have another chance. For the diehards among you I have brought a checklist which may enable you to establish the quality of your institution's shop-floor. You may ask me for one later today or to-morrow. It's in English I'm afraid.

Thank you for your interest, thank you for your attention and for your patience.

References

1. **Verbeek G.** *Kwaliteit als werkwoord.* NIZW, 1997.
2. **Haarsma L.** *Gebruikers aan het woord.* NIZW, 1999.
3. **Haterd J. and Keijsers G.** *Competentieprofiel agogish medewerker Stichting Vertizontaal.* NIZW 2000.
4. **Verbeek G.** *Het spel kwaliteit en zorg.* Lemma, 1996.
5. **Sluijs E. M. and Wagner C.** *Kwaliteitssystemen in zorginstellingen.* Nivel, 2000.
6. *Towards a European Vision of Quality.* European Organisation for Quality, 2000.