Dignity first – priorities in reform of care services (Sweden, 26-27 September 2013)

Comment paper- European Social Network[1]

Lisa Schönenberg
European Social Network
Alan Baird
Scottish Government

Introduction

ESN is delighted to be involved in a peer review that is focused on quality, person-centeredness and efficiency in care services for older people. ESN members, public authorities at local and regional level, manage social work and care services. They play an important role in the design of efficient and effective care services in terms of service planning, provision and local cooperation with other stakeholders.

ESN provides a Europe-wide learning and networking platform for social directors and senior professionals in local and regional government. Through our various projects we bring local and practice-based experience into European policy-making, drawing on our members' knowledge and expertise.

Ageing and care for older people has long been a priority for ESN's mutual learning and policy development work. In 2008-2009, ESN explored the strengths and weaknesses of long-term care models through a working group. This was followed by a research study on "Contracting for Quality". During the ESN Autumn Seminar 2012 'Retaining and Regaining Independence and Inclusion in Later Life', we looked at how social services, health services and other partners can promote prevention and rehabilitation.

ESN members in Austria (City of Vienna), the Czech Republic (Association of Czech Municipalities), Germany (German Association for Public and Private Welfare), Spain (Provincial Authority of Biscay), Poland (City of Wrocław), Serbia (Gerontology Centre Belgrade) and the UK (Scottish Government) as well as two care regulators in Finland (Valvira) and England (Care Quality Commission) responded to the following questions.

1. What are the current situation and the recent trends in the countries of your members in relation to home care?

Are innovative approaches similar to the Swedish case already applied (e.g. free choice systems, person-centred approach)?

National long-term care systems are very complex and different actors (financers, regulators, planners, case-managers and providers) influence the quality and the efficiency of care. The availability of home care, residential care and other support services for an older person at the point when s/he becomes dependent was probably determined several years previously. The provision of services is driven by national and local polices, as well as by the supply and demand in the care market. Approaches like **care management** or **commissioning** put public authorities in

1 Prepared for the Peer Review in Social Protection and Social Inclusion programme coordinated by ÖSB Consulting, the Institute for Employment Studies (IES) and Applica, and funded by the European Commission.

charge of the **social planning** process which includes the assessment of local needs and the regulation of services. As purchasers of services, local authorities can incentivise providers to offer quality care.

The Scottish government is currently working on a legislation that supports joint commissioning between the health and social care sector to improve community planning by introducing integrated budgets. However, service contracts are a complex and overlapping set of governance arrangements and the influence on the life quality of the service user is not easy to assess.[2] Into this very complex model, steps the frail older person and his or her family. It is important that each older person has access to the best care in the right setting for her/himself.

In many European countries the biggest share of home care is provided by informal carers, especially in Poland and Serbia. In *Serbia*, local governments have started to develop formal home care, but the share of older people receiving the service is at 0.9%. However, some recent national legislations put a greater emphasis on the provision of home care and aim to **increase the service users' choice by providing them with funds**.

In *Spain*, the Dependency Act in 2008 introduced cash allowances to increase home care. In the Basque Country, currently half of the dependent older people still receive institutional care (nursing homes or day-care centres). In Finland, the 2013 Act on Care Services for Older Persons regulates responsive home-based services for older people with increasing care needs. *Scotland* is transforming its public health and social care services. The Scottish Social Care Act 2013 will ensure that service users and carers can decide between different care options. A Self-Directed Strategy to support the legislation introduces a programme of activities that are focussed on assessment, review and commissioning, assessing individual budgets and cooperation between local and national government.

The government in *Poland* has started to work on a new Dependency Act that aims to support informal carers and to increase choice between formal public and private service providers. As in other European countries, the intention of this legislation is to stimulate the care market, to improve the quality and accessibility of services and to increase self-determination of service users. In terms of this approach, the question is which measures allow service users to self-direct their support as much as they wish. Benefits in kind often allow service users a choice between different providers, but not much choice between different services. Certain services may only be available with certain service providers.

A good way to overcome the information barrier about different care options is **integrated case-management** that assesses multiple needs of a service user and makes a mix of services accessible. It is important that it is provided by professionals who have the authority/skills to pull different resources together. In Vienna (*Austria*), community-based case managers visit older people at home and offer them access to care services, housing, domestic help, support for family carers, etc. This approach might also lead to a delay of the need for extensive care.

Another preventative approach exists in the *Czech Republic*, where inter-professional home care teams monitor the physical or mental health status of the service user. It is important to stress the medical and the social aspect of prevention. A close cooperation between social and health services, housing (shared assistive living, barrier free housing) and civil society organisations may

[2] Contracting for Quality, P. 101.

prevent social exclusion and loneliness. The Scottish government programme "Reshaping Care for Older People" 2011-2021 aims to improve services for older people by shifting care towards anticipatory and continuous care, prevention and co-production. The programme is being supported by a Scottish Government Change Fund that has allocated £70 million in 2011/12 and a further £80 million in 2012/13.

The **involvement of service users** in service design is essential. In some countries, service users already play an active role in the care management and decision making process. Local structures, such as older peoples' committees or older peoples' councils involve older people in the planning, preparation and monitoring process of services. In *Finland* and *England*, the service user and the provider agree together on an individual service plan.

Another important issue in relation to home care is the **shortage of formal workforce** in the care sector. The workload and motivation of staff is a key factor for quality services. Retention strategies, health prevention for staff, job breaks and local volunteering projects can help to relieve carers. An example of this is the Carers Strategy by the Scottish government. £1 million was invested in 2010-11 to provide more short breaks to be delivered by the voluntary sector as well as £281,000 in carer training this year.[3]

2. **What is the experience of your member countries regarding the use of technology in home care?**

Some ESN members stressed the lack of data and evidence in terms of the use of technology in home care. Nevertheless, there are promising results of evaluations in *England* and in *Scotland*. An English evaluation of the impact of telecare and telehealth for people with long term conditions living at home showed amongst other things the following results: a 5% reduction in A&E visits, a 20% reduction in emergency admissions and a 14% reduction in bed days. Scotland is very engaged in this area. The National Telehealth and Telecare Delivery Plan for Scotland (2012-2015) aims to support 300,000 people through telehealth and telecare and to stimulate innovation by cooperation. An earlier Telecare Development Programme invested £20m from 2006-2011. The results were (amongst other things): 44,000 people (including 4,000 people with dementia) receiving a telecare service, 2,500 hospital discharges being accelerated, 8,700 emergency admissions to hospital being avoided and 3,800 admissions to care homes being avoided. Already 80% of people receiving support at home in Scotland now benefit from telecare.[4]

However, there is still a discrepancy between the high potential of technology and its low usage in many countries. Currently, there are no strong purchasing powers for "Ambient Assistive Living" products because these products are not covered by the social welfare system. For many service users, technology is therefore not affordable. "Ambient Assistive Living" pilot schemes in *Germany*, *Austria*, *Finland* and *Spain* aim to implement new technologies into the living environment, such as electronic alarming systems or senor systems. The use of technology should be accepted by service users and carers and should cater the needs and habits of the service users. Technology is also used for service coordination between different sectors. In the Basque country (*Spain*), there are promising examples of pilot tele-assistance systems that are implemented by the social and the health care sector.

[3] Caring Together: The Carers Strategy for Scotland 2010 - 2015 http://www.scotland.gov.uk/Publications/2010/07/23153304/5.
[4] Scottish Government's Joint Improvement Team Annual Report 2012/2013.

However, different administrative levels (social services at local level, health services at national level) often make systems not compatible with each other.

3. How is the quality in the provision of services monitored in the countries of your members (e.g. quality registers)? Which information / indicators are being used?

In many European countries, public authorities have introduced **certain minimum standards** for care services. The indicators are mainly quantitative data such as the staff ratio, qualification of staff and physical requirements (number of rooms and beds, use of technology). These standards are used for the accreditation of non-profit or for-profit service providers and/or to inspect the acknowledged organisations.

In some countries, there are **national guidelines** that support local authorities to regulate the service provision, such as the new Finnish Act on care services that gives national recommendations on different aspects of quality. However, there is no national register in *Finland*. The regulation of service quality is organised at regional level (*Spain*, *Austria*), or at municipality level (*Poland*, *Finland*) or at national level (*England*, *Scotland*). England's Care Quality Commission and Scotland's Care Inspectorate inspect service providers and monitor how local authorities develop and deliver services within their communities. The two regulators allow for self-assessment of services, unannounced and announced inspections and targeted activity on poorly performing services.

In various countries, quality can be also monitored by care providers. In Finland, less than 40% of the providers use indicators derived from the RAI assessment, which gives the possibility of benchmarking for over a third of municipalities/ organisations. Two ESN members also noted the discussion about **quality monitoring for home care**. Often only the organisation providing formal home care is monitored, but not the service itself. There is also a discussion about the monitoring of informal home care in Germany.

Our members also stressed that **professionals** play an important role in managing the quality of the service. Professionals have to be qualified in order to provide quality person-centred services. In most countries there are mandatory occupational qualifications. In *Scotland* all professionals are registered with the Scottish Social Services Council (SSSC). SSSC has responsibility for staff conduct and has a range of powers that include removing workers from the register, thereby preventing them from working in the care sector. Furthermore, the quality of formal care services can be improved by moving away from a traditional task-based approach to supporting people to do everyday tasks themselves.

In addition, some countries (England, Scotland, Germany, Finland) use **transparency and user involvement** as a tool and publish the results of inspections or/and results of service user feedback. In England, a new strategy by the Care Quality Commission aims to involve the feedback of service users at national and local level.

4. What kind of impact have the related policies on the different actors involved in the care process – users, carers, health professionals – for example in terms of independent living, quality of life or work-time savings? In which ways can quality and accessibility of care services be balanced with sustainable finances?

The response to questions 1-3 provides some early indications that at a local level service redesign around the needs of users, shifting care into the community, minimising bureaucracy to speed up decision-making processes, increased integration of health and social care, early intervention, a focus on enablement and harvesting the benefits of technology are already delivering improved experiences for service users and their carers, as well as creating more sustainable services. A report was commissioned by the Scottish Government in order to improve care service quality whilst supporting the long-term sustainability of services. The report found that 40% of public spending was on interventions that could have been avoided by prioritising a preventative approach.

However, there are not many evaluation systems that measure the quality, effectiveness and efficiency of implemented measures. This would be necessary to identify further developments at local, regional, national and European level. Nevertheless, we would like to present some examples that have potential to balance quality and accessibility of care services and sustainable finances:

- The Scottish reform agenda is being driven through strong **strategic partnership working** bringing together various stakeholders from national and local level, the health sector and the Third Sector. At a local level, collaboration is already delivering innovative and sustainable solutions that translate into national statistics: rates of emergency bed days for people aged 75+ are down by 7.2% in 2 years from 2010 to 2012 and in 2011 there were around 6,500 fewer residents in care homes than forecasted.
- **Integrated local strategies:** the German county Siegen-Wittgenstein assesses the needs of older people by care management and provides individual support by case management. The local authority works in cooperation with care service providers (home care, day care, short term care), housing organisations, volunteering projects and household services. With this model, the relation between people in home care and in residential care increased to 1,16 in 2011 (overall German rate was 0,82 in 2011) and the estimated savings for the local authority were 30 mio Euro between 2007 and 2012.
- **Accessibility of services and service planning:** In the Czech Republic, service planning is the responsibility of regions and municipalities. They are required to develop a medium-term plan in cooperation with providers and user groups. The regions should first research needs of social services provision to different groups of users and are also required to monitor and evaluate fulfilment of social services development plans and report to the Ministry. If a municipality identifies a gap in service provision, it can either set up or expand new services itself or invite providers to apply for a grant to develop in line with the municipality's plan.
- **Technology** should be accepted by service users and carers and should cater the needs and habits of the service users. Assistive Technology Practitioners (ATP) in Norfolk County Council (UK) combine the technical understanding of the equipment with the ability to work together with service users in a person-centred approach. This approach resulted in a reduction of hospital costs and 28% of the service users needed lees home care, creating an average saving of £139.21 per week.

- **Training of formal workforce:** At Bennett House, a care home in the UK, social care workers were trained to perform certain medical tasks, such as blood pressure monitoring, urinalysis, blood glucose monitoring and pulse checks. This training led to a higher motivation of staff and there was a significant reduction in A & E attendances and hospital admissions, with a total cost saving of £67,332 in 2010-2011.
- **Involvement of service users:** Services in the Danish municipality Kolding cooperate actively with service users. Formal carers agree together with the service user on a plan about what they wanted to achieve. This change in the provision of care led to a 20% decrease in the provision of home care.

Conclusion

ESN members, public social services, play an important role in supporting older people to stay at home and to maintain a social and family network. In many countries, regional and local authorities are responsible for the funding, planning and delivery of preventative, community-based and coordinated services. The availability of services for a dependent older person is determined to some extent by national policies based on free choice systems and market governance or a social planning process by public authorities. Different planning and funding models of long-term care also influence tools to monitor quality.

Older person (and their family) may experience a very complex system, when they come to need care and support. It is important that each older person has access to the best care in the right setting. Person-centred approaches with the involvement of service users are important to provide information and make services accessible, especially in long-term care systems based on free choice.

ESN members acknowledge the high potential of care technology. However, assistive technology is often not affordable for service users. One example is the national Scottish strategy for Telehealth and Telecare which has already shown very good outcomes.

Practice examples of our members show that local service redesign around the needs of users, shifting care into the community, early intervention with a focus on enablement contribute to older people's wellbeing and have a positive impact on public budgets. ESN thinks that a mutual learning process is crucial to discuss how services for older people can be (re-) designed in different European care systems.