Achieving excellence in social services provision

Stephen Barnett / Heike Hoffer / Alexis Jay
European Social Network

1. About ESN

ESN is the independent network for social services in Europe. Our mission is to help change the lives of the most vulnerable in our societies through the delivery of quality social services. With **Members in local public social services across Europe**, we bring together the people who are key to the design and delivery of vital care and support services to learn from each other and contribute their experience and expertise to building effective social policy at European and national level.

ESN has been focused on the promotion of person-centred services since its foundation in 1999 and this remains central to our vision of quality. We appreciate this opportunity to contribute to policy development in Romania. ESN co-organised the first **two national social services conferences in Romania** in cooperation with the City of Cluj in 2009 and 2010. These conferences brought together 150 professionals from the field with a number of guests from across Europe to share good practice on many areas including child protection to disability.

A more recent working group on long-term care for older people led to a project called "Contracting for Quality" whose aim is to investigate the **potential for different types of relationships in the sector to support quality improvement**. ESN has previously organised seminars on "Access to Quality Services" on which it also produced a policy paper and on "Commissioning for Quality" which considered the links between area-based social planning and the procurement of quality services. ESN has been consulted on the evolving voluntary quality framework and is active in the debate on social services of general interest at EU level.

2. Introduction

This paper begins with a description of the Romanian accreditation model, drawing on some additional information from ESN Members in Romania. It then considers the strengths and potential areas for improvement in the quality principles and standards themselves, then in the methodology of the accreditation system. We take the view that **achieving excellence in social service provision is about more than a sound system of provider accreditation**, it is about the whole system. A final section therefore looks at aspects of social planning, access and choice for users and the long-term sustainability of social services in Romania.

Throughout our review, we highlight areas of strength in this model, but also point to some potential areas for improvement. We also recognise that people working day to day with this system will have the necessary knowledge to weigh up our comments and suggestions carefully. This draft paper is a contribution to a peer review process, which we hope will provide food for

thought for policy-makers and stakeholders in Romania and **have input into future policy reforms and developments**.

3.   Romanian accreditation model – summary

Romania has introduced an accreditation system for all service providers in order to improve the quality of life of service users. It has been in effect since January 2005. A "County Agency for Social Benefits" administers the system in the 41 counties. Within the agency, accreditation is overseen by a "commission" made of representatives of different central ministries, county councils and service providers; user representatives may attend as observers. **Accreditation is required in order to receive any public funding** (local, county, national, European and international) for the delivery of services.

Accreditation depends on **compliance with a set of standards** organised under the heading of nine quality principles (there are five standards per principle):

1.   Organisation and administration (e.g. agreement of a 3-5 year strategic plan);

2.   Rights (e.g. existence of a charter of rights for each service which is provided);

3.   Ethics (e.g. measurement of beneficiaries' satisfaction with the service provided);

4.   Comprehensiveness (e.g. presence of a multidisciplinary team capable of assessing needs);

5.   Person-centred (e.g. development and implementation of an 'Individual Intervention Plan');

6.   Participation (e.g. involvement of beneficiaries in the local community);

7.   Partnership (e.g. existence of partnership agreements with other providers);

8.   Results orientation (e.g. achievement of objectives and implementation of policies);

9.   Continuous improvement (e.g. staff training and continuous staff improvement).

These principles are based on EQUASS, a quality accreditation model designed and administered by the European Platform for Rehabilitation. It was originally designed for the disability sector, but Romania **applies it to all categories of social services** (disability, foster care, elderly care, domestic violence, day care for children with disabilities, residential care for children).

In order to receive accreditation, a provider must **submit an application** to the County Agency for Social Benefits for each type of service it wishes to provide. The application must comprise the following:

1.   Accreditation Application Form and Description of Services
    1.1 Accreditation Application Form
    1.2 Description of each service

2.   Supporting Documents
    2.1   Statutory documents confirming the establishment of the applicant

2.2 Fiscal Registration Certificate

2.3 Regulation on the organisation and functioning

2.4 Organisation chart

2.5 Curricula vitae and list of staff with positions, qualifications and years of experience

2.6 Copies of the documents that prove the qualifications and training of the staff

2.7 Financial statement

2.8 Balance sheet

2.9 Confirmation Legal status of all 'immobile' properties

2.10 Sanitary Certificate issued by the Sanitary Directorates for each location where services are provided

2.11 Environment certificate

2.12 Prevention of fire certificate

2.13 Other certificates

3. <u>Self Assessment Form</u>

3.1 Self Assessment form

4. <u>Supporting Documents</u>

4.1 3-5 years Plan

4.2 Model Care plan

4.3 Code of Ethics

Two assessors employed by the County Agency **evaluate compliance with the given standards** under the heading of the nine quality principles through the "self-assessment form" (3.1) and relevant associated documents. For each standard, the provider must "describe elements" and "aspects complied" and the (two) assessors give a score between 0 (no compliance) and 5 (full compliance). The assessors are obliged to make field visits for each service provided, to make sure it meets the standards.

The full dossier with a report by the assessors is then passed to the "Accreditation Commission" within the County Agency which **decides whether or not to confer accreditation** – this is decided on the basis of the application and on site visits to the head office and/or services. The commission meets once a month, to establish the various applicants' eligibility. It is possible a provider may get accreditation for only some of the services they applied for.

Decisions at county level may be **appeal**ed to the "Superior Commission", a body of the Ministry of Labour, Family and Social Protection, within 30 days. If a provider is accredited and later found to be in **breach** of its accreditation, the County Agency can decide to suspend or withdraw accreditation or limit a provider's field of activities. The County Agency accepts reports on poor compliance.

The certificate of **accreditation is issued for three years** and the whole documentation must be elaborated again to renew it. As an exception if the service is new and there is no certainty that the provider will be able to maintain the standards, the certificate is issued for one year. After that the service is reassessed and the provider may be issued a certificate valid for three years.

4. Implementation: the municipalities' experience

ESN has gathered **feedback from two municipalities** in Romania on how the accreditation system works in practice. They say that the system is widely implemented and that the certificate of accreditation stands as a guarantee for the quality of the social services provided. They have experience of accreditation not only as service providers, but also as financers, and members of the accreditation commission.

Both municipalities which responded **make funding of providers conditional on accreditation** – they raise awareness about the process in early discussions with NGOs seeking funding. In the case of public providers, accreditation is compulsory for functioning. One municipality publishes its priorities on the web and local newspapers in September for the following year depending on the social needs locally.

Accreditation is seen as a good thing because it compels public and private providers alike to maintain standards and develop the services. Though it was **difficult and time-consuming** to bring all the service up to standard, they report that it was **a worthwhile exercise**. One municipality provides the example of taking over ten nurseries formerly run by the health department: it had to renew the 35-year old furnishings and correct under-staffing in infant care and education in order to meet the standards. It was challenging to report against generic standards – there is a suggestion that standards should be differentiated at least between children's and adult services. Several colleagues had to be involved in order to obtain all the documents required.

The biggest challenge is the **qualification of human resources**, although this concerns mainly small towns or villages communes) where one person has several duties (minimum income, marriage register, disability enquiries). In some services, it can be a problem that a social worker must be a member in the National College of Social Workers.

They report that there are a small number of providers, which do not have accreditation, usually small NGOs. However, they have to **assume all the consequences** which follow: limited access to funding, to partnerships with public authorities and they could be subject to Social Inspection controls (which can apply penalties).

5. The Quality Principles: strengths and areas for improvement

The nine quality principles and associated standards form a good stimulus to a provider organisation to seriously consider its vision for how it wishes to support (potential) beneficiaries.

Some of the **strengths** we have identified are:

- the development of a strategic plan and clear objectives for further development (I.1.)

- the recognition of the importance of provider-based quality development (including the internal development of a Charter of Rights – II. 3. – and a Code of Ethics – III.1.)

- the sharing of good practices and results of innovation (I.5);

- transparency as an overarching goal (e.g. I.2.; VIII.4.)

- the way rights and responsibilities/duties are balanced under II;

- the insistence on the care continuum and on partnership under IV and VII;

- the insistence on participation of users in terms of the organisation itself and in the design of the 'Individual Intervention Plan'; the person-centred approach that is taken (V.) and the focus on outcome-focused quality criteria

- frequent references to the wider 'community' around the service itself and the people receiving it (I.4, VI.4 and 5, IX.3) as well as the goal of an inclusive society

These are some of the potential **areas for improvement** in future reforms:

- *Principle I. Leadership*

  This actually refers to strategy and organisational development, whilst quality of **corporate leadership and management** within an organisation is largely omitted. Senior managers have a vital role in implementing the 3-5 year strategy and objectives required under Standard I.1., managing human and financial resources, negotiating partnerships with other stakeholders, and ensuring continued compliance with quality standards.

  In Germany, there are minimum qualifying standards for senior managers of social services, and in France special qualifications for managing social services. In the UK, all residential care home managers have to be registered separately, besides the institution they run. Whilst staffing standards in terms of numbers and minimum qualification are an important issue, too, **minimum qualification standards for senior managers** of social services are of great importance, particularly in implementing a quality strategy that strongly relies on internal quality development.

- *Principle IV. Comprehensiveness and Principle VII. Partnership*

  While the emphasis on the continuum of care and partnership is very important, it is doubtful whether the service provider alone can "ensure" this by cooperation with all kinds of partners. The German experience shows that cooperation and integration of services with the purpose of a continuum of care only works best where all parties involved **understand the necessity of a continuum of care** and see it as inherent to their own separate professional standards.

  Other countries have various models of **taking the lead** in promoting cooperation among providers, but leadership and initiative often lies with the municipality. In Belgium for example, local public social welfare centres (CPAS/OCMW) have a duty to promote cooperation at local level. Other peer reviews (UK City Strategy 2009) also regarded partnership as important and asked who should take the lead. Interestingly, it was found that it did not as much who took the lead as long as someone did so.

- *Principle V. Person-centred*

The standards on "**initial and complex assessment**" and the Individual Intervention Plan appears to rely on needs assessment by the service provider and user, rather than by an independent assessor, as is the case for example in Germany, where the Care Insurance Regulator's[1] care specialists make the assessment and the municipality can advise through care advice points (*Pflegestützpunkte*) on what services to put in place.

In other sectors in Germany, users of services for disabled people or youth services will often be assessed in a **comprehensive assessment** ("Care Conferences") including e.g. staff from the municipality, medical specialists, social workers and the user and his/her representatives; together they define objectives for care based on the user's preferences. This multi-professional approach is prevalent and successful in other countries as well. In the system under discussion, the assessment of needs begins once the user is inside the door of provider X, whereas provider Y or Z may have been a better option for him/her. We develop this point further on page ("Access and Choice for Users").

- *Principle VI. Participation*

This is a very important issue, **not just at individual but also at collective level**. Here, user committees can be established by the law which are vested with certain rights regarding the service provider, e.g. the right to information or the right to have a vote in certain decisions affecting all users/residents (e.g. quality development, as laid out in IX.2.). In Germany, these "beneficiary committees" (*Heimbeiräte*) may include external "ombudspersons" as well and the local community as well as the service provider are obliged by law to support their information and effective work. In France, the "*conseils de vie sociale*" are compulsory in every residential home and, as in Germany, must be consulted on every decision affecting the lives of residents, notably the institution's internal regulations and its budget.

- *Principle VIII. Results Orientation*

The differentiation between outputs and outcomes is unclear and the lists of 'outcomes' in fact mix inputs, outputs and outcomes. ESN's understanding of the **difference between outputs and outcomes** is as follows:

- Outputs tend to be about *quantity*: how many people live in residential home X, how many people are supported by home-care provider Y, etc.

- Outcomes tend to be about *quality* and how someone's life is improved by the inputs into a service: what is the user's experience of the service, has his/her health improved, are they able to do more for themselves, are they taking part in more social activities?

It is mentioned several times that quality assessment should be "results-oriented" and take into account such aspects as quality of life, user perception, social inclusion. Experiences from

---

[1] Medizinischer Dienst der Krankenkassen (MDK).

other countries, including Germany and the UK, show that these **outcomes are difficult to measure**. The relevant criteria and methodology are subject to an ongoing debate in international research. More guidance and good practice examples might perhaps be offered to service providers in this regard – ESN can contribute existing work, but it is at an early stage in other parts of Europe too.

Where measurement of outcome criteria is meant to lead to **public reporting** (as is to some extent suggested here), benchmarking requires particularly well-designed criteria to ensure comparison of like with like. A new public reporting system was implemented in Germany in 2009 based solely on criteria agreed by the provider and the payer, but legal actions stopped the publication of results. People who use services should be able to access information about the provider's performance against set criteria, including nature and volume of complaints made about the service, and whether these were upheld on investigation.

Because the measurement of outcomes, especially of quality of life criteria, in an "objective" way is difficult, it might be worth considering as **a first step a revision of the Individual Intervention Plan**, so that users could jointly with the service provider and possibly a municipal social worker define personal standards for quality that could be used to measure user satisfaction. This could both empower users and help them engage in the quality process and ensure that needs are met within a community care approach.

Overall, the emphasis of the standards is on minimum requirements, which are a mixture of inputs and outputs, against which a provider is graded. This is **a good starting point** and it is where most quality models begin. However in the longer-tem the weakness of this approach is that it is not sufficiently aspirational to encourage providers to go beyond minimum standards. Several countries have developed their systems further, to include quality *indicators*, which have the potential to show change over time. For example, standard I.1 requires there to be a 3-year strategy in place. An indicator might ask (every time accreditation was renewed) what % of staff know an aspect of its content (e.g. what are the values of this service) or at least whether s/he knows where to find the strategy document. This could change over time, indicating how aware of and committed to the organisation's vision the staff are.

The main emphasis here in the present system appears to be on **fixed minimum standards**, but there are elements in each standard which could develop into clear **quality indicators**. As elsewhere in Europe, there is some way to go until the system is clearly focused on **outcomes for people** using services and confident in how it is going to measure them.

6.   The methodology: strengths and areas for improvement

The methodology for approving or denying accreditation for providers has a number of strengths and potential areas for improvement.

In our view, these are some **strengths** of the accreditation model:

- Self-assessment can provoke a useful evaluation of the strengths and weaknesses of a given set of services.

- There is a clear process for application, decision and appeal.

- Responsible bodies have been designated at county level to administer the system. The bodies consist of a variety of stakeholders which helps balanced assessment.

- The methodology is based on a model from the disability sector – this is a good model because of its focus on user empowerment.

- The comprehensive approach used for all social services (with specifications) promotes even development across categories in the area of quality and should facilitate transitions within the system.

- The methodology emphasises the internal development and controlling of quality and professional development which have both been shown to be important elements of an overall quality strategy.

- The methodology emphasises social inclusion as an overarching goal for all social services – this is innovative in particular for the area of elderly care.

However, experience in the UK of self assessment of social services shows this to be an area which needs considerable improvement to be rigorous and reliable, even within relatively well developed systems. Further, the tendency is for the poorest performing services to be the worst at accurate self assessment, therefore compounding risks to the service user, who has to rely on such self reporting.

Some areas are unclear from the papers provided and may be **areas for improvement** in future reforms:

- Do the two assessors work and score independently, i.e. the second assessor scores without seeing the first assessor's score?

- Are the two assessors required to make site visits to the services before issuing/recommending an accreditation? Are they announced or unannounced?

- If visits are made, do the two assessors speak with staff, users and families to ensure compliance with the relevant standards or must they rely solely on self-reporting by the provider?

- The quality strategy is based on a mix of internal quality development and inspection to check the accuracy of self-reporting. Both are important as inspection against minimum standards alone cannot guarantee quality, but at least reduce the chances of abuse and negligence of vulnerable people. Inspections should be constructive: together with other sources of external advice, they should incentivise and support internal quality development in a dynamic way, rather than being a punitive process. However, for the small minority of providers whose services fall well below minimum standards, there ought to be a formal legal process in place to terminate that service and alternatives to be found for the users. The protection and wellbeing of vulnerable adults and children must be the first consideration.

- Is accreditation possible if a provider scores the minimum of 108 points? If so, this would mean it would be possible to be very inconsistent in which standards are met, and at the extreme, to score full points on 22 standards but 0 on the other 23 standards? This may mean that major quality differences are "disguised" because all providers are accredited which achieve 108 points, thus undermining the goal of having a "similar" quality of social services.

- It is unclear whether the rights and ethics written down by the providers exist elsewhere in Romanian law and what options users have in reality to hold providers accountable (e.g. through legal process)?

- What is the procedure for the suspension or rescinding of accreditation?

- Why are user representatives not obligatory members of the accreditation commission?

- Can it arise that a representative of provider X is a member of the commission assessing his/her own employer's application for accreditation?

- Are inspections unannounced?

In case of limited resources for inspections, a **County Agency might decide to prioritise high-risk services** (e.g. child protection, mental health), to make a random sample of 10% of all the accredited services in each category or to focus on one service category per year. There is also the question of what supporting evidence might be required to back up the self-assessment form, for example an independent survey of users to see how their situation changed over time.

The accreditation model is a good system on its own terms but in order to "achieve excellence in social service provision", we need to consider some wider issues – which we do in the next section.

7. Beyond accreditation

Local area planning

The accreditation system, if operated in isolation, puts the **provider at the centre of the system**. As long as a provider meets the legal criteria and quality standards, and is successful in applying for funding, it can operate.

This **risks being a supply-driven model,** especially as it is not a required standard (as far as we can see) that the provider applying for accreditation proves there is demand for the services it wishes to supply where it wishes to supply them. It may be that it needs to do so in order to receive public funding.

Local authorities in the UK are seen as "commissioners": for a given local area, they **make an assessment** of the needs of the population on the basis of demographic and socio-economic data, assess what services are being provided now and what gaps there might be, then **plan in order to meet the identified needs** of the population and fill the gaps in supply. This is depicted in the diagram above. A provider can also be accredited nationally under this system, but would also have a contract with the municipality to operate in its area, at least if it is to provide services to users who are part-funded by the municipality. Diagram credit: Surrey County Council

The Flemish Region in Belgium also has a provider-driven model, not in terms of quality accreditation, but funding. The Flemish care infrastructure development fund (VIPA) requires an organisation applying for capital funding to **demonstrate that there is demand for its services** in the area it wishes to serve.

The present system has the potential to raise standards, but in the medium-term, a reform which commits to local area planning with clear accountability should be considered. There is always a risk that a market-based system will become entrenched and difficult to reform. **Municipalities should have a key role to play in local area planning** and in working with providers to put in place services to meet clearly identified needs.

Access and choice for users

Needs-assessment, advice and case management in this system appears to be carried out primarily by providers. The quality model begins once the user is already inside the door of provider X, whereas provider Y or Z may have been better placed to provide appropriate care and support. There is no mention of an **independent organisation or community body that helps users choose** between a number of services or to move easily between services when their needs change. For many countries, the principle of separating the assessment of need from meeting the identified needs is paramount. Combining the two processes within the provider sector increases the tendency of assessing only for the type of service which individual providers have on offer, especially if it is a for-profit organisation. In a social care market, independent advice and unbiased information are important factors in making the market perform well and in getting good outcomes for the person.

There are numerous models which not only attempt to provide independent advice but actually give people the money with which they buy the services. Nacka municipality was a pioneer of this approach in Sweden (see diagram opposite). In this system accreditation is managed by the municipality, which also sets prices for particular services, and helps people choose from a local list of providers. The Romanian model appears to be taking steps in the right direction with the open register of accredited providers.

Independent needs assessment could perhaps be an area for development, so that **a person's needs are assessed before s/he chooses a service** and can be advised on which service(s) and provider(s) might suit them best and help improve their quality of life.
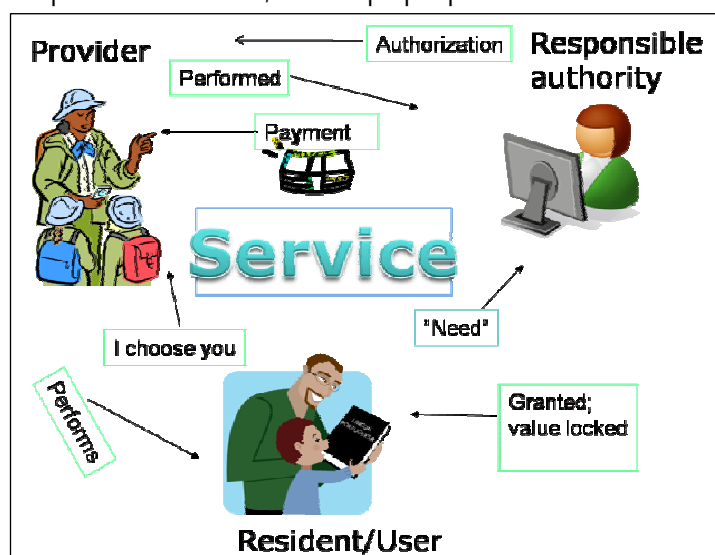
Sustainability and investment

There is a question about how the accreditation model fits in with the wider context of long-term social policy development in Romania. It is not clear how this model might help in deciding **what types of services should be developed in the long-term**, e.g. to promote the transition from institutional to community care. In the UK model, accountability for public funds was the driving force of early quality reforms in the 1980s and the local authorities have been able to shape the market in their area through their role as commissioners.

8.   Conclusions

Overall, the accreditation model has some strengths and weaknesses. In this paper, we have identified a number of areas for potential development which could be considered in future:

1.   Moving from quality standards to indicators based on outcomes for users and show change over time.

2.   Reinforcing verification of self-reported compliance with quality standards.

3.   Supporting the development of local area planning to ensure that accredited services meet real needs in their catchment area.

4.   Developing independent needs assessment and clear information and advice for users on which services would help meet their needs, drawing on individual evaluation and performance information about the quality of different services, where this is available.

5.   Making sure that the accreditation system is linked to a long-term vision for social services and how they are to be financed.

The shift to defining quality in terms of outcomes for people is an ongoing challenge across Europe and could perhaps be the subject of a future Peer Review.

Stephen Barnett, Heike Hoffer, Alexis Jay
European Social Network

Stephen Barnett is senior policy officer with ESN.

Heike Hoffer is policy expert for long-term care at Deutscher Verein für öffentliche und private Fürsorge e.V., the umbrella organisation of public and private social services in German

Alexis Jay is Chief Executive of the Social Work Inspection Agency (Scotland), UK.

Deutscher Verein and SWIA are members of ESN.

stephen.barnett@esn-eu.org