

Achieving quality long-term care in residential facilities

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Statements and Comments

The quality of care in residential services has long been an issue of concern for local public social services and has often been discussed in the ESN. These discussions have also considered the broader context of the diversification of service provision and the changing governance arrangements in the sector.

The way residential care is provided has changed over the years: local public social services are developing new relationships with independent residential care providers. These relationships, which may involve contracts or grant-funding, need to be well-managed so that older people get a better quality of services. While this should be a welcome stimulus for improvements in quality, if not well-managed, it can have detrimental effects. To ensure better quality of care, service developments driven by project-based funding, e.g. for home-care, should be carried out on the basis of local strategic planning.

ESN Members also understand that the role of municipal actors is changing: 'I see the ULSS (local social service agency) as an important facilitator, shaping the care systems and building community capacity, facilitating networking and investing in cooperatives,' Teresa Spaliviero from Veneto Region in Italy has emphasised. Luc Kupers, chair of the Flemish association of social directors agreed: 'While the public sector role in direct provision of services is shrinking, our new role is to ensure that quality services are available.'

In Germany care providers and institutions are registered with the long-term care insurance regulator and may face additional inspections by a regional or municipal agency. In the Veneto Region in Italy, a regional agency registers service providers. In Sweden meanwhile, private service providers are registered with the county authority as well as with any municipality in whose area they operate. In Belgium, registration and inspection happens at federal level through the health insurance regulator (National Institute for Health and Disability Insurance) and – additionally in Flanders – through the regional government's care agency (VAZG). In Spain, registering providers is a regional responsibility, but based on countrywide minimum standards (currently being introduced). Over time, the Spanish regions may choose to exceed the national standards. In the Czech Republic, meanwhile there is a uniform national system of standards implemented by regional agencies.

In many countries, public and private providers alike are seeking additional quality marks such as ISO or TQM or sector-specific marks like EQUASS or E-Qalin over and above the national standards for registration. There is certainly still a debate around in social services, particularly in residential care, about whether the relative importance of an external quality regime required by a public agency or a funding authority versus an internal quality regime developed (or at least, managed) by the provider itself.

Even from these few examples, it should be apparent that registration processes and requirements vary widely between countries. There are very different trains of thought about who should be responsible for quality. In some countries, the predominant view is that service providers should be responsible for quality assurance internally. In others, the view is that national or regional agencies must assure service quality on behalf of the public or that municipalities must take the lead in defining standards and ensuring they are respected by providers they work with locally.

Older people are receiving services from a growing range of organisations and from social and health services. Despite the different welfare state models and histories, the public sector has a vital role in coordinating different local actors and service providers. This may imply a correspondingly important responsibility for municipalities to ensure not only that citizens receive services that they need and want but is able to ensure that they are of the highest quality.

This paper goes on to look specifically at the UK model in some detail, which is interesting for comparison with the Peer Review model for its high degree of public-sector-led regulation.

1. How is the national dialogue on key issues of long-term care discussed or organised in the countries of your members? What are the related challenges?

1.1 In keeping with many other European countries, the national dialogue about long-term care within the UK has at its centre the projected increase in the numbers of older people over the next two decades, and particular the 'oldest old' (85+). This has led to long-term care being a significant political issue because of questions of affordability and sustainability of current models. Funding of long-term care in the UK is extremely complex, involving pensions, benefits, assessment of capital and income, and differential systems of charging for non-residential long-term care across municipalities.

1.2 The four countries of the United Kingdom operate under the same legislation for the arrangement and provision of residential care for adults, but since the devolution of relevant statutory powers to Scotland, Wales and Northern Ireland over the last ten years, important differences in some aspects of funding have emerged. For example, in Scotland there is state provision of Free Personal and Nursing Care in care homes, whilst in England there is Free Nursing Care in care homes. These two provisions were intended to address the continuing public concern that older people have to sell their homes to pay for care, however, with the current financial crisis, these measures are coming under significant political scrutiny about whether or not they are affordable.

Key issues

1.3 While the debate about long-term care attracts considerable attention, almost all of the commentary has been about how to pay for care, both now and in the future. Very little debate has focused on what older people themselves want, and the often accepted nature of embedded ageism and discriminatory practices.

1.4 Residential care, however high quality, is more often a last resort than a positive choice.

- 1.5 An important recent research study about residential care for older people concluded that 'At an individual level, human rights need to be better understood and applied. So many of the shortcomings of current care derive from the failings to approach people as individuals with a right to express their needs and preferences' (Joseph Rowntree Foundation, 2009).
- 1.6 The impact of the recession on the debate is still to be fully understood, but there is general pessimism about the future position for adults needing long-term care, whether in care homes or in their own homes. Municipalities, who commission (i.e. plan and fund) these services, are preparing for significant reductions in expenditure.
- 1.7 The government commitment is to protect the most vulnerable. With current budgetary pressures the priority for most municipalities in these circumstances will be vulnerable children and we see across the country investment in children's services being partly funded from resources notionally allocated to older people. A significant aspect of this problem is the continuing level of parental addiction which is the main cause of children being taken into public care.
- 1.8 The key issue of choice for older people needing long-term care is therefore likely to become more restricted.

2. What approach to external quality assurance has been chosen in the countries of your members?

- 2.1 In the UK, all providers of care services, whether public or private, must register these individual services with the regulator for their country. The provider is charged a fee for initial registration and an annual fee for the continuing process of inspection. The regulator carries out both announced and unannounced inspections of individual services. The regulatory body in each of the four countries has formal, legal powers of enforcement when services fall below the required standards. This occurs infrequently, since providers are usually given opportunities to improve. De-registration of a service may be challenged by providers through the courts.
- 2.2 Details of the regulatory bodies in the UK are given below.

ENGLAND - An independent organisation, accountable to government, licenses all care services for adults if they meet essential standards. They monitor these services to ensure they continue to meet the 28 prescribed outcome standards. Regulated services include:

- Medical and clinical treatment given to people of all ages;
- Care provided in residential homes, in the community and in people's own homes, with a focus on the most vulnerable, including those with mental health problems, learning disabilities, physical disabilities, and older people;
- Services for people whose rights are restricted by mental health legislation;
- Care provided by the National Health Service or independently.

SCOTLAND – An independent organisation, accountable to government evaluates services against National Standards, which were given to them by government, and grades individual services on a six-point scale, from Excellent to Unsatisfactory. Regulated services include:

- Care homes for adults and children;
- Early years;
- Hospice care, nursing agencies and independent hospitals;
- Care at home and day care.

WALES – An agency within government, with safeguards to ensure independence, which regulates and inspects the following services:

- Care homes for adults;
- Domiciliary care agencies and nursing agencies;
- Residential, fostering, adoption and early years services for children.

NORTHERN IRELAND – An independent organisation accountable to government, which monitors and inspects the quality of health and social care services, based on minimum care standards. Regulated services include:

- Care homes for adults and children;
- Independent health care and nursing agencies;
- Early years;
- Care at home and day care.

Key issues

- 2.3 Strong support for regulation but concerns over cost and burden on providers.
- 2.4 Government and providers across all sectors are now seeking a more proportionate and risk-based approach from regulators.
- 2.5 Focus is shifting towards self-evaluation and self-reporting by providers.
- 2.6 General concern by politicians, user organisations and others about the accuracy of self-reporting and whether this will increase risk to vulnerable people.

- 2.7 Relationship of inspection to improvement.
- 2.8 Minimum standards versus quality indicators and outcomes; one is static, the other dynamic.
- 2.9 The same standards are being applied across public, private and voluntary sectors. This is an important and accepted principle.
- 2.10 Regulation provides a benchmark for providers and commissioners of services to compare quality.
3. **What types of quality management in residential long-term care facilities have been applied in the countries of your members? Please describe the experience gathered so far with reference to stakeholder participation, quality indicators and the regulatory framework (e.g. accreditation standard).**
- 3.1 The use and type of quality assurance systems varie amongst providers. Many use models based on EFQM, Charter Mark (ISO 9000) or Investors in People which can be applied to single residential units as well as to bigger organisations.
- 3.2 There are strong similarities in the key themes in different quality assurance systems. These include:
- Strong leadership and accountable staff;
 - Safeguarding people who use services from abuse, respect for human rights and treat with dignity and respect;
 - Health and wellbeing are improved by the experience of residential care;
 - Information is effectively used and communicated.
- 3.3 The regulatory body in England asks all care home providers to complete an annual quality assurance assessment, which is used as evidence of delivering good outcomes for residents. This has two parts. One is a self-assessment which asks providers to say how well they think they are meeting the needs of their service users. The second is the production of a data set to give basic facts and figures about the service involved. The other UK countries operate a similar form of self-evaluation.

Key issues

- 3.4 The increasing focus on self-evaluation and self-reporting as described above demands consistent and well developed competence in quality assurance and performance management on the part of providers. There is little evidence that this currently exists, except in a patchy way.

3.5 As indicated above, strong concern that public assurance about social care services, and particularly residential care, will be weakened by this approach.

4. What kind of training measures for staff and managers exist to develop skills in quality management/assurance in the countries of your members?

4.1 Each of the four countries of the UK has an independent workforce regulator for social work and social care. The English regulator covers only qualified social workers and social work students. The Welsh, Scottish and Northern Irish regulators include a range of other social care staff, including residential staff. These three regulators have made individual registration available to residential staff, but it is not compulsory. Since 2009 the Scottish workforce regulator has made it compulsory that managers of care homes for adults must be registered with them. This requires them to demonstrate a range of competencies.

4.2 There is no single approved scheme of general training for residential staff and managers within the UK. Much relies on the approach of individual providers. The service regulator will check the training and development opportunities made available to staff as part of the process of registration of the service. There is compulsory training for a range of care workers so that they qualify for registration but quality assurance does not feature strongly in this.

Key issue

4.3 For these systems to work, the whole staff group needs to be committed to quality and needs to be trained in a total quality system. Such training in use of accredited quality assurance systems can be very expensive.

5. Is there a discussion about the future role of residential care facilities and about public vs. private care service providers in the countries of your members?

5.1 The UK operates a mixed economy of public, private and voluntary provision of residential facilities, with the majority of residential care for older people being provided by the private sector. Many municipalities have actively divested themselves of their adult residential provision, sometimes contracting the private sector to run it on their behalf, or selling it off entirely. Some authorities still retain their own care homes, but have substantially reduced the number of units they run.

5.2 The debate in the UK about the future role of residential care focuses on two key areas: future funding and affordability of older people's services in general, as indicated in section 1, and the known preferences of the majority of adults to live independently in their own homes for as long as it is safe to do so. This latter issue has led to a rebalancing of investment in care away from residential facilities towards intensive care at home.

5.3 Scotland is the only one of the UK countries which has a nationally agreed fee structure for places in residential homes for older people, including nursing homes.

Key issues

- 5.4 Whilst there remains a significant amount of usage of residential care, there is a slow decline overall. For example in Scotland, there has been a 2% drop in the numbers of older people in care homes over a five-year period. The current rate of usage is 36.5 per 1,000 over the age of 65. Residential care is seen by purchasers or commissioners of services as expensive and generally not what people want.
- 5.5 Many buildings cannot meet the required physical standards of regulation without significant capital investment, or the buildings themselves are not capable of being modernised.
- 5.6 The running costs of local authority homes are considerably higher than those provided by the private sector – sometimes almost double. This is usually accounted for by much higher pay and conditions of employment.
- 5.7 There is a trend throughout the UK for larger private providers to buy up the smaller private units and then close them down.
- 5.8 There continues to be a debate about the size of individual residential units (i.e. how many places the unit provides) versus financial viability. Questions surround whether large-scale units (of fifty plus places) can deliver high quality personal care in a homely environment.
- 5.9 There has been welcome diversification in some parts of the private sector in particular. For example, some care homes specialise in specific conditions such as dementia, or in end-of-life care. Others have expanded into different forms of support such as day care, care at home or short breaks, retaining a proportion of residential care and using their buildings as a base for other services.
- 5.10 The impact of the current economic climate, as noted above, will almost certainly mean a reduction in the amount of care home places purchased by municipalities across all sectors.

Conclusions

There is a real diversity in residential care regulation and quality management across Europe and the UK is an exponent of a high-regulation model. There is probably no one-size-fits-all model that would work across the EU, but there is something to learn from other models. It is also worth noting that, even with the highest quality residential care, the coming generation(s) of older people are unlikely to want to live in this setting, but remain at home and in control of their care and independent lives for as long as is possible.