Disability-relevance of quality assurance systems in social services

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1 Executive summary

1.1 Definition and framework of the quality of personal social services

There is a good legal basis for quality assurance in Germany. Quality assurance applies to public, non-profit and private/commercial social services in accordance with Book IX of the German Social Code (Rehabilitation and Participation of Persons with Disabilities – SGB IX) as well as to long-term care services under Book XI of the Code (social long-term care insurance – SGB XI).

The quality of these services, as well as the protection of the people depending on them, is mainly regulated at three different legal levels: at the contractual level *(Leistungserbringungsrecht)*, under regulatory law *(Ordnungsrecht)* and under consumer protection law *(Verbraucherschutzrecht)*.

Contractual relationships between rehabilitation service providers and social services are subject to the requirements in SGB IX and the extensive regulations in the individual laws governing the competent rehabilitation provider. The public contractual relationships between long-term care insurance and social services and facilities are harmonised by framework agreements at *Länder* level.

Secondly, there are regulatory provisions at *Länder* level on the protection of persons in housing and long-term care situations regarding housing, care and participation, the strengthening of self-determination and the promotion of the quality of care.

The third level concerns the protection of persons with disabilities who use and depend on social services. The contracts between social services and persons entitled to benefits are subject to the service contract regulations in the Civil Code (*Bürgerliches Gesetzbuch* – BGB). Contractual relationships in in-patient care are the subject of a separate protective law, the Federal Residential and Care Contract Act (*Wohn- und Betreuungsvertragsgesetz* – WBVG). In addition, there are general consumer-related provisions in social law, such as the right to seek and choose benefits and rights and obligations to information, counselling and advice.

1.2 Evaluation of the quality of social services

There are many quality assurance procedures for social services in Germany. These mainly relate to the internal quality management of the facilities – however, legal requirements in connection with funding often require external audits, sometimes in combination with internal quality assurance. Legislation has laid down many provisions for quality assurance. The general legal framework for social services and the quality regulations are implemented at federal level, but it is largely put into effect and supplemented at *Länder* level. The legal basis is found in § 37 SGB IX (rehabilitation and participation) and § 113 SGB XI (long-term care). The federal working groups play a central role in the development of quality assurance.

1.3 Impact of quality assurance mechanisms

The Federal Participation Law (*Bundesteilhabegesetz* – BTHG),[2] acting as a legal basis for quality assurance in Germany, is considered to fulfil the criteria of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). Therefore, the equal, full and effective participation of people with disabilities in political, social, economic and cultural life, with an independent and self-determined lifestyle, was strengthened and has been taken into account in assessing the quality of services and facilities.

The legal basis for the quality assurance of social services is located in Book IX of the German Social Code (Rehabilitation and Participation of Persons with Disabilities – SGB IX).[3] However, this is not a holistic model of quality assurance. While it is often defined as a cross-cutting issue in organisations and as being relevant in all areas, quality assurance is not comprehensively integrated into the education and training of staff.

1.4 Recommendations for Germany

In Germany, the legal basis for the quality assurance of social services should be reformed through the comprehensive integration of quality assurance for the education and training of staff.[4]

The *Länder* should establish common definitions of the criteria for effectiveness, in accordance with § 128 SGB IX.
Rationale: The regulations on the criteria for effectiveness are still vague in most of the *Länder* framework agreements regarding integration assistance, and the views on determining the criteria differ.

Germany should implement the right of integration assistance providers to carry out random audits in addition to occasion-based audits under SGB IX.
Rationale: So far, there is only an opening clause for the *Länder* to carry out audits without a concrete cause.[5] This measure is hence not binding and is not used nationwide.

Germany should establish a requirement for a certification procedure for out-patient rehabilitation services and facilities to prove the successful implementation of quality management at regular intervals.
Rationale: The requirement for a certification procedure is only binding in in-patient rehabilitation facilities according to § 37(2) s. 2, (3) SGB IX.

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2 Law on strengthening the participation and self-determination of people with disabilities (Federal Participation Act – *Bundesteilhabegesetz*) v. 23 December 2016.

3 Social Code Book IX (SGB IX), Rehabilitation and Participation of Persons with Disabilities *(Sozialgesetzbuch Neuntes Buch, Rehabilitation und Teilhabe von Menschen mit Behinderungen)*, v. 23.12.2016. See, e.g., § 37 SGB IX or § 113 SGB XI.

4 See, e.g., § 37 SGB IX or § 113 SGB XI.

5 § 128 (1) s. 7 SGB IX.

1.5 Recommendations for the European Commission

It could be envisaged to transfer quality assurance systems that exist in European countries to internationally recognised test procedures by means of higher-level quality criteria. As a result, comparability could be established throughout the EU, while (legal) quality assurance is maintained in each country.

A European certification for quality schemes could be considered.

The European Commission could set qualitative as well as quantitative targets for high-level quality assurance schemes.

If European quality certification is introduced, funding could be linked to successful implementation. In any case, beyond compliance with the quality criteria, it is important to ensure that funding is made dependent on compliance with the implementation of the requirements of the UN CRPD.

2 Conceptualising quality of essential services provided directly to the person: framework, definition, and research in the European States

2.1 Definitions and frameworks

Quality assurance applies to public, non-profit and private/commercial social services in accordance with Book IX of the German Social Code (Rehabilitation and Participation of Persons with Disabilities – SGB IX) as well as to long-term care services under Book XI of the Code (social long-term care insurance – SGB XI).

The quality assessment schemes laid down in the SGB IX apply to rehabilitation and participation services and facilities. These services are linked by the purpose of providing participation services that prevent, eliminate, alleviate, or compensate for disabilities. Depending on how strongly the service is orientated towards the functional limitation or more towards the individual or social contextual factors, the service is marked by generally strong medical, nursing, psychological, educational, assistive or technical components. Often, services for participation are multimodal and interdisciplinary and require correspondingly equipped and oriented services and facilities.[6] The spectrum ranges from medical rehabilitation facilities managed and characterised by physicians to homes or workshops managed and characterised by pedagogues, to assistance services.[7]

The quality assurance for long-term care insurance applies to long-term care facilities as well as out-patient care facilities.[8] Under the legislation in this area, care facilities are defined as independently operating out-patient and in-patient care units under the permanent responsibility of a trained care professional. The term ‘facilities’ includes care services (i.e. the out-patient services of home care), and care homes (full and partial in-patient care facilities). The facility must be orientated towards operating as a care facility. In-patient facilities that focus on providing services for preventive medical care, medical rehabilitation, participation in working life or in life in the community, schooling or the education of persons who are ill or persons with disabilities are not long-term care facilities, and neither are hospitals and certain residential premises for people with disabilities.[9]

The quality of these services/facilities and the protection of the people depending on them are regulated through a set of multiple provisions at different legal levels.

1. Contractual level *(Leistungserbringungsrecht)*

Firstly, there are contractual relationships between the public rehabilitation service providers (according to § 6 SGB IX these are the statutory health insurance, the Federal Employment Agency, statutory accident insurance, statutory pension insurance, providers of public youth welfare and integration assistance providers) and the social services. The social services and facilities are in most cases not operated by the rehabilitation providers themselves, but by public, non-profit or

[6] See § 42 (2) and (3) SGB IX.
[7] See Igl & Welti (2022), *Gesundheitsrecht* (Health Law), A. § 22 recital 2.
[8] § 71 (1), § 71 (1) a SGB XI.
[9] § 71 (4) SGB XI.

private/commercial services.[10] There are some general regulations on the requirements of these contracts including regulations on the quality of the services in the SGB IX[11] and extensive regulations in the individual laws governing the competent rehabilitation provider.[12] The contracts with the social services are to be concluded according to common principles, which are to be agreed in framework agreements or at least joint recommendations from the rehabilitation providers.[13] All suitable services and facilities should be able to provide services for all rehabilitation providers, and the services shall be based on common quality standards.[14] However, such a joint contractual practice for rehabilitation providers has not yet been achieved across all providers, since the law does not provide the quality standards themselves.[15]

In order to ensure the quality of social services, the contracts are only concluded if the social service is professionally suitable. For example, in-patient rehabilitation facilities require certification[16] and sheltered workshops require recognition.[17] In the contract itself, the quality requirements for providing the services, the staff involved and the accompanying specialist services occupy a central position.[18] The provisions on quality assurance apply to services that are provided by the rehabilitation providers themselves through their own facilities and to public, non-profit or private/commercial services.[19]

Within the framework of the Federal Association for Rehabilitation (BAR), rehabilitation providers[20] have agreed on joint recommendations to ensure and further develop the service quality and to carry out comparative quality analyses as a basis for effective quality management.[21] The aspect of barrier-free service provision is particularly emphasised and, thus, it has been made a feature of service quality.[22] Service providers must provide for quality management in which the quality of care is guaranteed and continuously improved through targeted and systematic procedures and measures.[23] The law does not specify this, however. In other words, the public rehabilitation providers (state, communities and social insurance) define the standards and the service providers (public, non-profit and private enterprises) are tasked with achieving them.

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10 See § 28 (1) s. 1 No. 3 in conjunction with § 36 SGB IX.
11 § 37, 37a, 38 SGB IX.
12 §§ 111-111c SGB V; § 15 (2) SGB VI; § 34 (8) SGB VII; § 123 SGB IX. Insofar as these provisions concern rehabilitation services, they are to be understood as supplements and special provisions to §§ 37 to 38 SGB IX.
13 § 38 (3) SGB IX.
14 § 37 SGB IX.
15 Igl & Welti (2022), *Gesundheitsrecht* (Health Law), A. § 22, recital 5.
16 According to § 37 (3) s. 3 SGB IX.
17 According to § 225 SGB IX i.V.m. § 17 WVO i.V.m. § 219 SGB IX.
18 In accordance with § 38 (1) No. 1 SGB IX.
19 See § 28 (1) No. 3 in conjunction with § 36 SGB IX; jurisPK-SGB IX 3rd ed. / O'Sullivan, recital 1.
20 § 6 (1) n. 1-5 SGB IX.
21 See *Bundesarbeitsgemeinschaft für Rehabilitation* (BAR), 2018, *Qualitätssicherung nach § 37 Abs. 1 SGB IX. Gemeinsame Empfehlung* (Joint recommendation on quality assurance), Qualitätssicherung I Bundesarbeitsgemeinschaft für Rehabilitation.
22 BAR (2018), Joint recommendation on quality assurance (§ 4), § 37 (1) SGB IX.
23 BAR (2018), Joint recommendation on quality assurance (§ 4), § 37 (2) SGB IX.

In addition, service providers are obliged to develop and implement a concept for protection against violence. In relation to a particular facility or service, this means suitable measures to ensure protection against violence for persons with potential forthcoming disabilities, in particular for affected women and children.[24]

Contract law for integration assistance specifies the content of written agreements between the integration assistance providers (public authorities on the local and regional level) and the social service provider.[25] As a rule, integration assistance providers may only authorise social services if there is a written agreement between them.[26] The written agreements regulate the service content, scope and quality. Under the Federal Participation Act (*Bundesteilhabegesetz* – BTHG), the effectiveness of the integration assistance services and their remuneration is to be specified explicitly in the contract.[27] This is flanked by *Länder* framework agreements which create conditions that apply to all agreements. The principles and standards for efficiency and quality, which include the effectiveness of services, as well as the content and procedures for conducting efficiency and quality audits, are determined here.[28]

Within the framework of long-term care insurance (SGB XI) there are very far-reaching regulations on quality assurance. No other healthcare and social sector in Germany has such a high quantitative and qualitative density of regulations for quality requirements. The public contractual relationships between the long-term care insurance and the social services and facilities are harmonised by framework agreements at *Länder* level.[29] Contracts may only be concluded with in-patient or out-patient care facilities if the care services at the facilities concerned are provided under the permanent responsibility of trained care professionals.[30] A general basis for quality assurance is set out through the agreement of standards and principles for quality, quality assurance and quality presentation in out-patient and in-patient care and for the development of an internal quality management system in the facility which is geared towards the continuous assurance and further development of quality of care.[31]

2. Regulatory Law *(Ordnungsrecht)*

In addition, there are regulatory provisions at *Länder* level on the protection of persons in housing and long-term care situations – in some *Länder* also for out-patient services – for example on housing, care and participation, the strengthening of self-determination or the promotion of the quality of care. Examples include the Care and Quality of Living Act *(Pflege- und Wohnqualitätsgesetz)* in Bavaria and the Hesse Act on Support and Care Services *(Hessisches Gesetz über Betreuungs- und Pflegeleistungen)*. Thus, in addition to provisions regarding the purposes of the law, there are notification obligations, quality requirements, opportunities for the residents to participate, consultation obligations and regulatory powers of intervention, e.g.

[24] § 37a SGB IX.
[25] § 125 SGB IX.
[26] § 123 (1) s. 1 SGB IX.
[27] § 125 (1) SGB IX.
[28] § 131 SGB IX.
[29] The requirements of these framework agreements are regulated by §§ 71-75 SGB XI.
[30] §§ 71 (2) and (3) as well as 72 (3) s.1 No. 1 SGB XI.
[31] In accordance with § 113 (1) SGB XI.

imposing an operating ban or an employment ban. These Care Acts can be applied to both services and facilities in accordance with SGB IX and SGB XI.

3. Consumer protection Law *(Verbraucherschutzrecht)*

The third level concerns the protection of people with disabilities who use and depend on social services. The service contract regulations, generally, are relevant to the contractual relationships between social services or facilities and persons entitled to benefits.[32] Contractual relationships in in-patient care are the subject of a separate protective law, the Federal Residential and Care Contract Act (*Wohn- und Betreuungsvertragsgesetz* – WBVG). The WBVG takes special account of the situation of people in need of care and creates a balance of interests between consumers on the one hand and entrepreneurs on the other, paying special attention to possible dependency and need for protection due to age, care or nursing needs. The agreed care and support services must be provided in accordance with professional medical and nursing standards, taking into account the expert standards.[33] This includes a requirement that the services are provided by qualified persons.

In addition, there are general consumer-related provisions in social law, such as the right to seek and choose benefits[34] and rights and obligations to information, counselling and advice.[35] In SGB IX, rehabilitation service providers are obliged to set up contact points that provide information services for persons entitled to benefits, employers and other rehabilitation providers. In addition, the federal Government promotes supplementary independent participation counselling *(Ergänzende unabhängige Teilhabeberatung)*, which is primarily to be provided on a peer-to-peer basis.[36]

There is a good legal basis for quality assurance in Germany, with strong overlaps with the principles laid down in the European Quality Framework but without referring to the framework directly (probably since the development of high-standard quality assurance systems started prior to the introduction of the European Quality Framework). The quality schemes take into account the main criteria of the UN CRPD. Under the Federal Participation Act (*Bundesteilhabegesetz* – BTHG), integration assistance, in particular, was aligned with the requirements of the CRPD, and the person-centred provision of social services was strengthened. However, even though there is a good legal basis for quality assurance in Germany, the new report on monitoring the implementation of the BTHG shows that there are implementation deficiencies in practice.[37] Within the framework of integration assistance, this report addresses provisions to define criteria for effectiveness, which vary in the different regions of Germany. There is a lack of capacity and of professionals to provide more

[32] § 611-630 BGB.
[33] According to § 113a SGB XI, § 7 (1) WBVG and § 11 (1) SGB XI.
[34] § 8 SGB IX.
[35] §§ 13-15 SGB IX.
[36] § 32 (3) SGB IX.
[37] *Bericht zum Stand und zu den Ergebnissen der Maßnahmen nach Artikel 25 Absatz 2 bis 4 des Bundesteilhabegesetzes, Bundestags-Drucksache 20/5150* (Report on the status and results of the measures under Article 25 paragraphs 2 to 4 of the Federal Participation Act), 23 December 2022, pp. 175-177.

intensive service and quality audits, however.[38] Moreover, there is a lack of scientific evidence for person-centred services. Exchange at the EU and international levels could be useful for the production and collation of such evidence.

2.2 Research studies and national debates

A range of quality assurance of social services is presented below on the basis of three areas of action – as specified through selected examples of projects and publications.

1. Rehabilitation and participation

The *einfach teilhaben* (‘simply participate’) portal of the Federal Ministry of Labour and Social Affairs (BMAS),[39] which is responsible for social policy in Germany, provides an overview of projects, initiatives and examples of participation and inclusion of people with disabilities.[40] The Project Compass[41] tool summarises vocational rehabilitation and participation projects by institutions (including research institutions), scientific studies and evaluations, model and implementation projects and international collaborations.[42] The category ‘Classifications, Processes and Analyses’ contains projects and relevant publications on quality assurance and quality assessment in rehabilitation and participation, on quality indicators and standards, on quality comparisons of institutions and on the implementation of quality management systems.[43]

One example is the study on the ‘Quality of the Provision of Medical Aids in Statutory Health Insurance’ by the Federal Social Security Office (BAS).[44] The starting point is that the provision of high-quality aids, e.g. wheelchairs, hearing aids or prostheses, is a basic prerequisite for social participation for many people – especially for people with disabilities and elderly persons. The health insurance funds have a legal obligation to conclude contracts with providers of medical aids and to present these aids as transparently as possible to the insured. In this regard, the ‘Special Report on the Quality of the Provision of Medical Aids in the Statutory Health Insurance System’ (2022) highlights some major deficits: a lack of contracts and of transparency, a lack of structured and random checks of the quality of medical aids, and limitations in the counselling services offered. The report summarises proposals for the further development of the legal framework. For example, regulations should be made on how quality audits are carried out, sample size and the audit cycle. Insured persons should be able to contact the Medical Service of the Health and Long-Term Care Insurance (MD) directly if they have questions about the quality of medical aids. The

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[38] Report on the status and results of the measures under Article 25 paragraphs 2 to 4 of the Federal Participation Act (2022), p. 177.

[39] See Federal Ministry for Labour and Social Affairs: Bundesministerium für Arbeit und Soziales (BMAS).

[40] See Projektkompass | einfach teilhaben.

[41] The tool is provided by REHADAT, a service of the Cologne Institute for Economic Research.

[42] See REHADAT-Forschung.

[43] See Quality Assurance: Qualitätssicherung | REHADAT-Forschung.

[44] Federal Office for Social Security (Bundesamt für Soziale Sicherung) (2022), ‘Sonderbericht über die Qualität der Hilfsmittelversorgung in der Gesetzlichen Krankenversicherung’ (Quality of the Provision of Medical Aids in Statutory Health Insurance), Hilfsmittelversorgung I Bundesamt für Soziale Sicherung.

strengthening of patient and user sovereignty in all matters concerning the provision of medical assistance – including personal counselling – is given great importance in the recommendations for action.[45]

2. Health promotion

Because of demographic change, the number of people with care needs and/or disabilities is growing. This implies increased demands on staff in these areas. This is the starting point for the project ‘Quality-oriented prevention and health promotion in institutions for integration assistance and care – QualiPEP’, which is conducted by the Federal Association of the AOK (*Allgemeine Ortskrankenkasse* – General Local Health Insurance) and funded by the Federal Ministry of Health (BMG) (2017-2021). The goals that were formulated as part of this project involved the development and implementation of a quality framework for prevention and health promotion in partial and full in-patient facilities for people with disabilities and for people in need of care, strengthening the health competence of residents and staff, and the quality-assured expansion of workplace health promotion. Based on qualitative studies, two manuals were published as implementation aids in practice. The development, testing and implementation of the quality frameworks and concepts took place in a participatory manner, which included the use of surveys among residents.[46]

3. Inclusive education

The Index for Inclusion can serve as guidance and support for educational institutions and their opening processes. Initial approaches can be found in Booth and Ainscow (2003), which was translated, adapted and expanded for German framework conditions by Hinz and Boban.[47] In the meantime, the guidelines are no longer only orientated towards school institutions; they can also be applied in other educational sectors. The development and expansion of inclusive cultures, structures and practices should promote the development of attitudes and the formulation of goals. The guidance is a tool for analysing the status quo as well as for process support and implementation. It looks at a total of 70 quality indicators on diversity (e.g. accessibility, a welcoming culture or support for educational processes), and it involves all stakeholders – covering the learners themselves and their opportunities for participation. The aim is to stimulate dialogue on inclusion and to raise awareness among people in educational institutions. The Index for Inclusion can serve as a guide for the design of inclusive places of learning, and it can also be used for other areas of life, e.g. for day-care facilities for children,[48] in sports[49] or in children’s and youth work.[50]

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[45] Federal Office for Social Security (2022), ‘Quality of the Provision of Medical Aids in Statutory Health Insurance’, Hilfsmittelversorgung I Bundesamt für Soziale Sicherung.
[46] See QualiPEP | Engagement | AOK-Bundesverband.
[47] The new edition (2016) focuses even more intensively on the importance of inclusive values for school development.
[48] See Index für Inklusion I Kindertageseinrichtungen.
[49] See Index für Inklusion I Sport.
[50] See Index für Inklusion I Kinder- und Jugendarbeit and Index für Inklusion | Aktion Mensch.

3 Evaluation / assessment of quality assurance for social services

3.1 Types of quality assurance

There are many procedures for the quality assurance of social services, mainly related to internal quality management of facilities. However, legal requirements, combined with funding allocations, often require external audits, sometimes in combination with internal quality assurance (e.g. § 37 SGB IX or § 113 SGB XI). Three sample selected procedures are presented below, which are applied in work with people with disabilities or care needs.

Concerning rehabilitation and participation, a classic and widely used quality management standard (including in Germany) is DIN EN ISO 9001 (currently DIN EN ISO 9001:2015). This internationally recognised model defines minimum requirements for a quality management system that an organisation should meet to fulfil customer expectations and legal requirements in equal measure. The goal is the safeguarding and optimisation of processes. This is associated with an increase in the transparency of operational processes, an improvement in customer satisfaction and an early reduction of errors and the possible consequential costs. The quality management system requires defined processes and procedures, cooperation and clear responsibilities.[51] External certification is carried out by recognised inspection bodies.[52] Certification is of great importance, including in sheltered workshops (WfbM), for the formal recognition of the vocational training area by the funding agency, the Employment Agency. The framework is provided by the Accreditation and Licensing Ordinance for Employment Promotion (AZAV). Providers of employment promotion measures such as the WfbM require approval, and one of the prerequisites is a quality assurance system. This includes external certification of a quality assurance system such as DIN EN ISO 9001 or association certification.[53]

Another model that is often used is self-evaluation based on EFQM (European Foundation for Quality Management) guidelines.[54] The concept has a high process orientation and can be used as a partial evaluation instrument. The EFQM model differentiates between enabler criteria and result criteria. Enabler criteria indicate how an organisation implements its main activities. Instruments can include regular staff appraisals, target agreements, team and case supervision and concept days – instruments that are often used in the social services sector anyway. Result criteria, on the other hand, focus on the results of the quality already achieved by a facility. Among the central questions are what results the institution has achieved regarding its own goals, the needs and expectations of the donors or expectations in the political arena, whether the legal requirements have met and whether there has been not just economic success but also substantive success, such as a successful vocational preparation measure. The goal of the self-assessment is a quality management system that is individually tailored to the institution. The core of the EFQM model is

[51] See Qualitätsmanagement | Beuth.

[52] Certification bodies can be found on the website of the German Accreditation Body (DAkkS), the national accreditation authority of Germany (see Deutsche Akkreditierungsstelle).

[53] See AZAV I Bundesministerium für Arbeit und Soziales; Federal Ministry of Labour and Social Affairs.

[54] See European Foundation for Quality Management (EFQM).

the self-reflection of one's own actions with strong inclusion of the environment, e.g. customers or collaboration partners.[55]

Concerning long-term care, due to demographic change, there are more people in need of long-term care – and ageing implies an increased risk of sensory impairments (hearing, vision or mobility) as well as cognitive impairments, e.g. as a result of dementia. The Medical Service of the Statutory Health and Long-Term Care Insurance (MD) and the Inspection Service of the Private Health Insurance (PKV) are responsible for regular quality inspections once a year (regular inspection) on the basis of medical and nursing standards under the Social Code (SGB) XI in out-patient care services and nursing homes.[56] The introduction of a new quality system for full in-patient care, with a focus on the quality of outcomes, took place in October 2019. Meanwhile, development and practical tests were also carried out for out-patient care. This is a combination of internal and external procedures (see Section 3.5). The primary question of the audits is how well the people in need of care are cared for in the facility. Indicators concern the support for residents of the home in their mobility and self-care, in dealing with special requirements and burdens (diseases), in shaping their everyday life and maintaining social contacts, in special care situations and situations of special need (settling in or behavioural problems), as well as professional requirements for addressing different needs. The results of the quality audits can be viewed on the web portals of the long-term care insurance funds as well as at the facility concerned.[57]

3.2 Types of services

In principle, all rehabilitation and participation services fall within the scope of the quality assurance schemes (see Section 2.1). The assurance schemes set out in SGB IX as well as those specified in the individual law governing the competent rehabilitation provider apply to both services and facilities provided by the rehabilitation providers themselves and to contractual social services and facilities (including public, non-profit and private/commercial services).[58]

However, when it comes to personal assistance as a social participation benefit, people with disabilities can hire an assistant outside the quality structure of social services.[59] Here, in the interests of the person in need, professional expertise is consciously renounced in favour of an orientation towards the right of self-determination.[60]

For certain social services there are extra requirements. In-patient rehabilitation facilities in the field of medical rehabilitation, for example, require a special certification procedure to prove the successful implementation of quality management at regular intervals. In-patient rehabilitation facilities can only be considered suitable if they are

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[55] See EFQM I Fachinformationsportal I Wirtschaftswissen.
[56] The interval can be extended to two years in the future for full in-patient care facilities with a high level of quality.
[57] See Qualität und Transparenz in der Pflege I Bundesministerium für Gesundheit; Gemeinsam für gute Qualität I Medizinischer Dienst.
[58] § 28 (1) s. 1 No. 3 in conjunction with § 36 SGB IX.
[59] § 78 SGB IX.
[60] See Igl & Welti (2022), *Gesundheitsrecht* (Health Law), A. § 22 recital 2.

certified.[61] Only then can the rehabilitation providers conclude contracts to provide services. In accordance with their obligation, the rehabilitation providers concerned have concluded a joint agreement within the framework of the Federal Association for Rehabilitation (BAR).[62] Sheltered workshops require recognition.[63]

Out-patient medical rehabilitation under the responsibility of statutory health insurance provides the basis for quality assurance in accordance with agreements by the Association of Statutory Health Insurance Bodies (*Spitzenverband* – GKV) and the associations of rehabilitation service providers, but without a certification procedure.[64]

The provisions on quality assurance apply to the services and facilities which provide long-term care insurance benefits (see Section 2.1). In-patient facilities in which the services for preventive medical care, for medical rehabilitation, for participation in working life or in life in the community, schooling or the education of persons who are unwell or persons with disabilities are at the forefront of the purpose of the facility, as well as hospitals and certain residential premises for people with disabilities, do not constitute long-term care facilities.[65] Hence, the quality assessment schemes under long-term care insurance do not apply to them. These services fall into the scope of rehabilitation and participation quality assurance schemes.

The provisions on quality assurance apply to the services and facilities, regardless of whether they are public, non-profit or private/commercial services.

3.3 The formal bodies

The legislator has set out many provisions on quality assurance at different legal levels (see Section 2.1). The general legal framework for social services and the quality schemes are implemented at the federal level, but these are largely put into effect and supplemented at *Länder* level. The federal working groups play an important role in the development of quality assurance.

Rehabilitation service providers agree on joint recommendations to ensure and further develop the quality of (accessible) services and the implementation of quality analysis as a basis for the quality management of service providers.[66] Service providers must ensure quality management that guarantees and continuously improves the quality of care through targeted and systematic procedures and measures. The Federal Association for Rehabilitation (BAR) (2018) states in its joint recommendation (*Gemeinsame Empfehlung Qualitätssicherung* – GE QS) that, in order to verify the information provided by the service providers on the quality of structures, processes and outcomes, the rehabilitation providers or those commissioned by them should conduct random examinations (quality audits). This also applies in the context of visits,

[61] § 37 (3) s. 3 SGB IX.
[62] ‘Agreement on the Internal Quality Management of the Various Social Insurance Institutions’, in force since 1 October 2009: Vereinbarung | Qualitätsmanagement.
[63] According to § 225 SGB IX i.V.m. § 17 WVO i.V.m. § 219 SGB IX.
[64] § 137d SGB V.
[65] § 71 (4) SGB XI.
[66] § 37 SGB IX.

inspections etc. (§ 16 GE QS).[67] According to § 17 GE QS, rehabilitation providers or their representatives shall carry out comparative quality analyses on the basis of routine and special data on the quality of structures, processes and outcomes.

The Federal Participation Act (*Bundesteilhabegesetz* – BTHG) has significantly strengthened the steering responsibility and obligations of integration assistance providers. This relates to a paradigm shift from focusing on services to a person-centred focus, and to ensuring greater participation, involvement and self-determination of people with disabilities. If there are factual indications that a service provider is not fulfilling its contractual or statutory obligations, the integration assistance providers examine efficiency and quality, including the effectiveness of the agreed and provided service, to ensure the quality of integration assistance.[68] The integration assistance provider does not have to announce the audit in advance. The *Länder* are allowed to enact regulations that require the integration assistance providers to carry out random audits in addition to occasion-based audits.[69] However, only some *Länder* make use of this opportunity, so an important instrument for determining actual compliance with quality standards is not used.

The practical implementation of the optimised control options varies greatly from region to region. Local providers in particular say that they lack both the capacities and the professional competences for more intensive performance and quality audits.[70]

Concerning long-term care, in no other area of social services is the monitoring of compliance with quality requirements regulated in such detail by law as under SGB XI.[71] In addition, there are sub-legal regulations in the guidelines on inspecting the quality of services provided in long-term care facilities.[72] There is a quality committee consisting of representatives of the long-term care insurance providers and the service providers.[73] The Federal Medical Service – as well as the relevant organisations at federal level for the representation of the interests of persons in need of care and persons with disabilities and for ensuring their self-help under § 118 SGB XI – participate in an advisory capacity in the meetings and decisions of the Quality Committee for Care. The Quality Committee for Long-Term Care is charged, among other things, with the development of new procedures for quality assessment and quality reporting in long-term care. In order to ensure a scientific approach to the Quality Committee's tasks, the parties to the contract commission scientific institutions and experts, in particular for the development of inspection tools.[74] The *Länder* associations of long-term care insurance funds are responsible for initiating quality audits. They issue an inspection mandate to the Medical Service of the Statutory Health and Long-Term Care Insurance or to experts appointed by

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67 BAR (2018), Joint recommendation on quality assurance, Qualitätssicherung I Bundesarbeitsgemeinschaft für Rehabilitation.
68 § 128 (1) s. 1 SGB IX.
69 § 128 (1), s. 7 SGB IX (e.g. Bavaria, § 1 Art. 66b (3) BayTHG I – Bavarian Participation Act I).
70 Report on the status and results of the measures under Article 25 paragraphs 2 to 4 of the Federal Participation Act (2022), p. 177.
71 §§ 114-114 c SGB XI.
72 In § 114 a (7) SGB XI and in the guidelines on the extension of the inspection cycle in fully in-patient facilities (§ 114 c SGB XI).
73 According to § 113 b SGB XI.
74 § 113 b (4) SGB XI.

them.[75] The different types of inspection are regular, ad hoc and repeat inspections.[76] Regular inspections must take place once a year.[77] An examination in an approved in-patient care facility can take place regularly at intervals of no more than two years, from 1 January 2023, if the facility concerned has achieved a high level of quality.[78] The Federal Medical Service, in consultation with the Federation of Long-Term Care Insurance Funds and with the participation of the Audit Service of the Association of Private Health Insurance, determines the criteria for a high level of quality in guidelines.

3.4 Stakeholders, experts by experience and organisations of persons with disabilities

For rehabilitation and participation, rehabilitation providers agree under § 37 SGB IX on joint recommendations to ensure and further develop the quality of (accessible) services as well as the implementation of quality analyses as a basis for the quality management of service providers. The members of the Federal Association for Rehabilitation (BAR) summarised in 2018, in their joint recommendation on quality assurance under § 37 (1) SGB IX, that rehabilitation facilities with representatives of persons with disabilities should provide them with evidence of the implementation of quality management (§ 37 (5) of Book IX of the Social Code). Whether or not there are user representatives depends on the regulatory law at *Länder* level. This obliges in-patient long term care institutions and other in-patient institutions to have elected residents committees. Whether or not services are seen as institutions differs between regulatory law and social law. In addition, the assessment of the quality of services for participation from the perspective of the persons entitled to benefits represents an essential indicator for quality assurance, such that the systematic survey of persons entitled to benefits forms an important instrument. In addition, persons with disabilities should be integrated into the processes at an early stage in all measures to create accessibility. The Federal Association undertakes measures to regularly review the topicality of its recommendations with the involvement of associations of persons with disabilities, voluntary welfare organisations, self-help groups and interest groups of women with disabilities, as well as umbrella organisations representing the interests of out-patient and in-patient rehabilitation facilities.[79]

For long-term care, according to § 113 SGB XI, the National Association of Long-Term Care Insurance Funds, the Federal Association of Local Social Welfare Institutions, the National Associations of Local Authorities and the National Associations of Long-Term Care Institutions shall agree on standards and principles for quality in long-term care and for the development of internal quality management in long-term care facilities – with the participation of the Federal Medical Service, the Association of Private Health Insurers, the associations of the nursing professions at federal level, the relevant organisations for the representation of the interests and self-help of

[75] § 114 (1) s.1 SGB XI.
[76] § 114 (1) s. 3 SGB XI.
[77] § 114 (2) s. 1 SGB XI.
[78] Deviating from § 114 (2) SGB XI.
[79] BAR (2018), Joint recommendation on quality assurance, Qualitätssicherung I Bundesarbeitsgemeinschaft für Rehabilitation, pp. 10, 16 and 18.

people in need of care and people with disabilities as well as independent experts.[80] For example, in January 2017, the Nursing Quality Committee commissioned the Institute for Nursing Science at the University of Bielefeld and aQua (the Institute for Applied Quality Promotion and Research in the Health Care Sector) to scientifically develop the quality indicators in in-patient nursing care (see Section 3.5).[81] According to § 113a SGB XI, the development and updating of scientifically based and professionally coordinated expert standards for the assurance and further development of quality in nursing care must be ensured. The aim is to bring the generally recognised state of medical and nursing knowledge into effect.[82]

3.5 Methods and methodologies

Regarding rehabilitation and participation the basis for continuous quality assurance is formed by professionally recognised procedures for the regular recording of the quality of service provision. Standardised documentation on the quality of structures, processes and results is a proven method. This documentation compiles all the necessary information for reviewing the individual service steps and the results – such as peer review procedures or structured quality dialogues. The rehabilitation providers or those commissioned by them routinely evaluate and summarise the quality data. The quality analyses not only allow for a comparison with other facilities; they also bring a focus on internal quality management. The methodological prerequisite is that the facilities included must be comparable. Characteristics (predictors) are taken into account that have a decisive influence on the success of a measure but are not subject to the influence of the facilities and services.[83]

For long-term care, the new quality system for full in-patient care contains three components (see also Section 3.1). The facilities collect care results from all residents every six months with the help of 10 quality indicators, i.e. instruments for the comparative measurement and presentation of the quality of results, which are sent to an independent evaluation agency.[84] This is the basis for the person sample of the external quality audits of the Medical Service (MD) and the Audit Service of the Private Health Insurance (PKV). The focus here is on the fulfilment of the medical care requirements under the Social Code (SGB) XI as well as on the adequacy of personal care and nutrition. In addition, the inspectors examine the files and conduct expert discussions with the nursing staff on the quality inspection. The basis for this is a consultation-orientated approach implemented through a partnership dialogue between the auditor and the specialist staff. In addition, there is a summary of general information on the facility, e.g. on equipment and accessibility.[85] According to § 113

[80] See Sozialgesetzbuch Elftes Buch (SGB XI) – Social Code Book 11, Social Long-Term Care insurance.

[81] See Qualitätsprüfungen I GKV-Spitzenverband – Quality Audits – Association of Health Care Insurance Bodies.

[82] See Sozialgesetzbuch Elftes Buch (SGB XI) – Social Code Book 11, Social Long-Term Care insurance.

[83] BAR (2018), Joint recommendation on quality assurance, Qualitätssicherung I Bundesarbeitsgemeinschaft für Rehabilitation, pp. 13 and 15.

[84] The 10 indicators are: 1. Preserved mobility; 2. Preserved independence in everyday life; 3. Preserved independence in organising everyday life; 4. Emergence of pressure points; 5. Serious consequences of falls; 6. Unintentional weight loss; 7. Implementation of an integration interview; 8. Use of belts; 9. Use of bed side rails; 10. Timeliness of pain assessment.

[85] See Pflege I Bundesministerium für Gesundheit; Pflege I Medizinischer Dienst.

SGB XI, the facility's internal quality management should be orientated towards the constant assurance and further development of the quality of care (including in crisis situations) by means of appropriate care documentation (in relation to the tasks of care and provision). The legislator also refers to (digital) further and advanced training in the context of ensuring and developing further the quality of care.[86]

3.6 The indicators and the principles

The federal working groups of the rehabilitation providers and of integration assistance providers have produced recommendations on characteristics of quality and how to determine them.

1. Quality Assurance according to the Joint Recommendation on Quality Assurance of the members of the Federal Association for Rehabilitation (BAR) – Gemeinsame Empfehlung Qualitätssicherung (GE QS)[87]

The concept of quality is defined in § 2 of the GE QS: 'The quality of services for participation is characterised by an effective and needs-based provision of services that is orientated towards the bio-psycho-social model of the WHO (ICF). The provision of services is professionally qualified, oriented towards the achievement of the participation goals according to Book IX of the Social Code and economically efficient'. Both internal and external quality assurance are essential to ensure quality.[88] While external quality assurance is primarily aimed at ensuring compliance with and development of quality standards, internal quality assurance serves to guarantee permanently high quality through systematic quality management within the facilities.[89] The evaluation of the quality of services for participation from the perspective of persons entitled to benefits is an essential indicator of quality assurance. The systematic assessment of persons entitled to benefits forms an important basis for taking their concerns into account.[90]

The term 'quality' is divided into structural quality, process quality and the quality of results.[91]

- Structural quality describes the framework conditions that are necessary to provide the agreed service in order to achieve individual participation goals.[92] The structural characteristics include concepts based on the International Classification of Functioning (ICF) and participation-orientated rehabilitation, indication-specific and target group-specific rehabilitation concepts, spatial and material equipment, staffing (e.g. number of staff employed, number of residents per staff member, level of qualifications and professional experience), the services offered, qualifications, training and further training of staff, integration into care structures (including self-help), and accessibility.

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86 See Sozialgesetzbuch Elftes Buch (SGB XI).
87 BAR (2018), Joint recommendation on quality assurance, Qualitätssicherung I Bundesarbeitsgemeinschaft für Rehabilitation.
88 According to BAR (2018), Joint recommendation on quality assurance (§ 4).
89 See BAR (2018), Joint recommendation on quality assurance (§§ 3 and 4, 6).
90 BAR (2018), Joint recommendation on quality assurance (§ 6).
91 BAR (2018), Joint recommendation on quality assurance (§ 8).
92 BAR (2018), Joint recommendation on quality assurance (§ 9).

- Process quality refers to the planning, structuring and sequence of service provision, as well as the assessment of appropriate implementation.[93] In particular, this includes interdisciplinary determination of the individual's rehabilitation, support and assistance needs, agreement on individual rehabilitation goals with the person entitled to benefits, preparation and updating of a rehabilitation or participation plan, documentation and evaluation of progress (the concrete, operable planning of services and measures at the start of the service, including the rehabilitation goals agreed with the person entitled to benefits) and interdisciplinary collaboration within and across facilities. The persons entitled to benefits are interviewed about the conditions under which the service is provided, about how the service is provided and about their participation.

- The quality of results is at the centre of quality assurance. This refers to the extent to which the individual and the general goals are achieved through the service.[94] The aims are derived from the relevant priorities of the competent rehabilitation providers for statutory tasks in conjunction with § 4 SGB IX, and they include the vocational integration or reintegration of the person entitled to benefits; averting, eliminating, overcoming, reducing and preventing adverse circumstances in relation with disability and the restriction of earning capacity; the need for long-term care; the avoidance of early receipt of other social benefits or the reduction of current social benefits; the holistic promotion of personal development and the enabling and facilitating of participation in life in society; and a lifestyle that is as independent and self-determined as possible. The current scientific state is also considered. Above all, procedures are required for the assessment of those involved, including doctors, therapists, specialist staff, beneficiaries (when and/or after a measure is delivered), as well as for the assessment of the achievement of objectives based on the reports. In the field of medical rehabilitation, procedures that show changes in functional capacity according to the ICF and in the quality of life of the beneficiaries at different points in time are important. Of relevance for this evaluation are target and actual comparisons, the duration of services or measures, complications, discontinuation of measures, ICF-based evaluations and assessments of the quality of life of the beneficiary at different points of measurement, evaluations by a doctor, therapist, counsellor or specialist staff, evaluations by the persons entitled to benefits or their confidants of the change in quality of life and the sustainability of effects.

The rehabilitation providers shall work towards ensuring that the service providers are using standardised documentation for all quality dimensions. The documentation must contain all the necessary information to enable a review of the individual service steps and the results using uniform procedures (e.g. the so-called 'peer review procedure' in the field of medical rehabilitation) (§ 12 GE QS).

In its preamble, the recommendation refers to Article 26 CRPD and its comprehensive and interdisciplinary approach to rehabilitation, the somatic, psychological and social dimensions and their consequences. The recommendation is based on the provision

[93] BAR (2018), Joint recommendation on quality assurance (§§ 10, 14).
[94] BAR (2018), Joint recommendation on quality assurance (§§ 11, 15).

of needs-based, targeted and person-orientated benefits to ensure the participation of people with disability. The recommendations therefore contribute to providing benefits and services in line with the CRPD.

The European Quality Framework is not referred to but its standards are largely included.

2. Guidance on the performance of audits of efficiency and quality including effectiveness according to § 128 SGB IX by the Federal Working Group of the Supra-Local Social Welfare and Integration Assistance Providers (BAGüS)[95]

In this guidance, the term 'quality' is divided into structural quality, process quality and quality of results, building on essentially the same characteristics and indicators. However, other important aspects are also emphasised, including the concept of social space orientation. Process quality can also be determined, for example, by the extent to which social space orientation is provided and implemented (e.g. through networking and collaboration with other service providers and institutions in the social space such as churches, clubs and adult education centres; non-professional help; help and support from the social space; and encouraging encounters with non-disabled people). The guiding function of the overall plan procedure *(Gesamtplanverfahren)* is also emphasised. It structures the individual service provision process between the integration assistance provider and the person entitled to benefits in individual cases.

The importance of good documentation is also emphasised. The service providers are required to document and justify procedures and to reflect on the quality of the results.

The guidance refers to the *Länder* framework agreements pursuant to § 131 (1) SGB IX. In the context of integration assistance, the *Länder* framework agreements determine the principles and standards for economic efficiency and quality, including the effectiveness of the services. Therefore, they play an important role as regards quality assurance. The UN CRPD is referred to in almost all the *Länder* agreements, and it is mentioned that one aim of the agreements is the implementation of the CRPD. For example, in the Berlin framework agreement it is stated that, in accordance with the CRPD, services have to be accessible, self-determined, independently usable and understandable (Berlin framework contract for integration assistance (BRV EGH) in accordance with § 131 SGB IX for service offers in the area of integration assistance, preamble).[96] The European Quality Framework is not referred to, but the standards laid down there are largely included.

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[95] See *Bundesarbeitsgemeinschaft der überörtlichen Träger der Sozialhilfe und der Eingliederungshilfe* (BAGüs) (2021), *Orientierungshilfe zur Durchführung von Prüfungen der Wirtschaftlichkeit und Qualität einschließlich der Wirksamkeit nach § 128 SGB IX* (Guidance on the implementation of efficiency and quality), Prüfungen I Bundesarbeitsgemeinschaft der Sozialhilfe und Eingliederungshilfe.

[96] See Berlin | Eingliederungshilfe.

However, the new report on monitoring the implementation of the BTHG shows that there is still a need for improvement.[97] Within the framework of the efficiency and effectiveness assessment, the service provider should examine the effectiveness of the services offered. The regulations on the criteria for effectiveness are still vague in most of the *Länder* framework agreements, or effectiveness is equated with the quality of results. So far, only a few service providers have made provisions to define criteria for effectiveness within the framework of service and remuneration agreements or to check them within the framework of audits under § 128 SGB IX. For social service providers, the definition and examination of the effectiveness of the benefit is of great importance because it can justify the reduction in remuneration.[98] The experience of the project is that the discussions between the different actors involved are seldom about the usefulness of the focus on effectiveness, and more about the authority to interpret whether the benefit is effective or not. The *Länder* that are already testing approaches include Mecklenburg-Western Pomerania, which is the only *Land* in Germany that has a fixed qualitative procedure for determining effectiveness in its *Land* framework agreement.

97 Report on the status and results of the measures under Article 25 paragraphs 2 to 4 of the Federal Participation Act (2022), p. 38; see also *Landesrahmenvertrag für Mecklenburg-Vorpommern nach § 131 Absatz 1 SGB für Leistungen der Eingliederungshilfe v.* 17 November 2019 (*Land* framework agreement for Mecklenburg-Western Pomerania), Mecklenburg-Vorpommern | Eingliederungshilfe.

98 According to § 129 SGB IX.

4 The impact of quality assurance mechanisms and systems and promising practices: strengths and weaknesses

4.1 The impact of quality assurance mechanisms

Regarding rehabilitation and participation, the agency responsible for integration assistance has a statutory right to audit for special reasons.[99] The objectives are to determine and evaluate efficiency and quality, including effectiveness, along with further quality development. Service providers must not only maintain quality-promoting practices, but also develop them further if deficiencies are found during an audit. The core task is a targeted analysis of the causes, i.e. of problems in the processes and structures. Audits take place either on an *occasion-related* basis or on an *occasion-independent* basis. First, it must be considered which alternative, low-threshold measures could be implemented before an audit. Not every fact or piece of information should be defined as an actual indication. Evidence should indicate that a service provider is unable to provide a service in accordance with the contract due to serious breaches of contractual or legal obligations. In addition, there may be information that raises concerns about the suitability of the service provider, e.g. relating to breaches of specifications, failure to provide services or poor service provision, under-staffing, structural deficiencies, a doubtful attitude of the service provider regarding person-centredness, participation and professionalism or incidents of violence. If use has been made of the opening clause in the respective *Länder* laws, the providers of integration assistance are required to carry out independent audits, not focused on any particular occasion and not initially based on any particular facts (in-depth audits of a selected quality dimension or broad audits of all areas).[100]

The agency responsible for integration assistance prepares a written report on the audit.[101] This report contains information on the audit assignment, such as results or partial results on the subjects of the audit with a description of potential deficiencies or breaches of duty, if applicable, a separate presentation of differing opinions on the audit that were not resolved by mutual agreement in the final discussion, and a summary of the outcomes of the audit with a recommendation of measures to be taken. One consequence of a violation of legal or contractual obligations can be a reduction in the agreed remuneration for the duration of the violation.[102] In addition, future activities can be discussed in such a way as to make them binding between the contracting parties. This can include quality or development agreements as well as the agreement of changed goals in the provision of services or individual components of the contract. The agreements can be made for a short or longer period of time, but in any case they are set for a specific period determined by the contracting parties.[103]

[99] According to § 128 SGB IX.
[100] § 128 (1) s. 7 SGB IX.
[101] § 128 (3) SGB IX.
[102] § 129 SGB IX.
[103] See BAGüs (2021), Guidance on the implementation of efficiency and quality, Prüfungen I Bundesarbeitsgemeinschaft der Sozialhilfe und Eingliederungshilfe, pp. 13-16, 23-24, 27-28.

Regarding Long-term Care*,* The Medical Service of the Statutory Health and Long-Term Care Insurance (MD) and the Inspection Service of the Private Health Insurance (PKV) are responsible for regular annual quality inspections under SGB XI in out-patient care services and nursing homes (see Section 3.1). If deficiencies are identified in the quality report, sanctions can be imposed on the facility and a graduated set of instruments is applied. The *Land* associations of the long-term care insurance funds are responsible for deciding, on the basis of the audit report and after hearing from the long-term care facility, whether measures must be taken – and, if so, which measures – to eliminate the deficiencies identified. The long-term care insurance fund issues a notice of deficiency and at the same time sets a deadline for remedying the deficiencies found. If the services provided by a facility do not meet the required quality, such that it is violating its legal or contractual obligations, the agreed care remuneration is reduced for the duration of the violation. If a facility no longer meets the requirements for the conclusion of a care contract, the *Land* associations of long-term care insurance funds may terminate the contract in whole or in part, in agreement with the competent social welfare agency. In particularly serious cases, the care contract may be terminated with immediate effect without notice. In the event of serious deficiencies, the long-term care insurance fund can temporarily prohibit a long-term care service from continuing to provide care. In this case, seamless care by another care service must be guaranteed. Even in the case of corresponding deficiencies in a nursing home, the long-term care insurance funds must place the persons in need of long-term care in a new facility.[104]

4.2 The role of human rights NGOs, Ombudsman, and other related offices

The German Institute for Human Rights (DIMR), Germany's independent national human rights institution, provides studies, recommendations for action, statements and publications on quality assurance of social services and is thus to be understood as a central source complementary to the legislator. The Institute is responsible for monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities and has established a corresponding monitoring unit. Its mandate is to promote and protect the rights of persons with disabilities and to monitor the implementation of the CRPD in Germany. Three selected examples of quality assurance are presented below.

In December 2022, the German Institute for Human Rights published its seventh report to the German Parliament on the development of the human rights situation in Germany.[105] In accordance with the Act on the Legal Status and Tasks of the German Institute for Human Rights, the Institute has submitted an annual report to the German Parliament since 2016. The law provides for a statement to be made on these reports. The current report focuses on the right to education of children and young people with disabilities; the situation of older people and healthcare for people with disabilities are also of high human rights relevance. Publicly available statistics, documents and studies serve as data sources, as do publications of the German Parliament and media reports. The report points out that the concerns of persons with disabilities have not

[104] See Qualität und Transparenz in der Pflege I Bundesministerium für Gesundheit.

[105] See Deutsches Institut für Menschenrechte (2022), *Entwicklung der Menschenrechtssituation in Deutschland. Juli 2021 – Juni 2022. Bericht an den Deutschen Bundestag gemäß § 2 Absatz 5 DIMRG* (Seventh Human Rights Report), Siebter Menschenrechtsbericht I Deutsches Institut für Menschenrechte.

yet been sufficiently considered in the healthcare system and in health policy in Germany. Their healthcare should be ensured in the same scope as for people without disabilities as a cross-task and quality dimension for disability mainstreaming. During out-of-hospital intensive care, the restriction of the right of self-determination in the choice of place of service is not compatible with the CRPD. Also, no nationwide care structures can be guaranteed, so persons with disabilities who need intensive care must live outside their families and their social environment. Furthermore, the medical model of disability continues to dominate in Germany. The report advocates for the special needs and rights of persons with disabilities and their participation, for the removal of barriers, for access to self-determined support and assistance, and for the equal inclusion of persons with disabilities. Disability mainstreaming in healthcare and health policy as a crucial quality dimension means the equal participation of persons with disabilities in legislative procedures for health policy, awareness raising for medical and nursing staff on the human rights-based model of disability, accessibility of medical practices and clinics, the right of self-determination for the place of stay in out-of-hospital intensive care and ensuring comprehensive care, as well as non-discriminatory regulations for pandemic-related triage.[106]

The 2021 publication *Improving Complaints Procedures: Protecting Human Rights. Twelve recommendations for in-patient care* by the German Institute for Human Rights highlights the comprehensive expansion of low-threshold complaints procedures in in-patient care as a central instrument of quality assurance.[107] People in care facilities are a particularly vulnerable group. Easily accessible, well-known and transparent complaint procedures can protect against the violation of people's human rights and can have a decisive influence on their self-determination – without the threat of a deterioration in care or other reprisals. The central task is to establish a positive culture of complaints that encourages residents to voice criticism and shortcomings. The recommendations of the German Institute for Human Rights are based on a first nationwide survey on out-of-court complaint options at nursing homes. Respondents included people in need of care and their family members, care workers, experts on care institutions, inspection authorities and complaints bodies.[108] In Germany, there are different institutions and organisations that receive and process complaints in in-patient care, including home supervisory authorities, long-term care insurance funds and crisis telephone helplines and counselling or complaint offices run by the state or through private sponsorship. In many facilities, complaint management is a set internal procedure during quality management. However, the legislator did not explicitly prescribe the introduction of complaint management, so it is a voluntary measure for quality assurance.[109]

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[106] See Deutsches Institut für Menschenrechte (2022), Seventh Human Rights Report, Siebter Menschenrechtsbericht I Deutsches Institut für Menschenrechte, pp. 18-19.

[107] See Meyer, R., and Jordan, L.-M. (2021), *Beschwerdeverfahren verbessern – Menschenrechte schützen. Zwölf Empfehlungen für die stationäre Pflege* (Improving complaints procedures, protecting human rights. Twelve recommendations for in-patient care), Berlin, Deutsches Institut für Menschenrechte, Beschwerdeverfahren verbessern – Menschenrechte schützen I Deutsches Institut für Menschenrechte.

[108] See Deutsches Institut für Menschenrechte (2021), *'Ausbau von Beschwerdeverfahren in Pflegeheimen zum Schutz älterer Menschen dringend nötig'* (Complaint procedures in in-patient care – press release), Beschwerdeverfahren in Pflegeheimen I Pressemitteilung I Deutsches Institut für Menschenrechte.

[109] See Meyer and Jordan (2021), Beschwerdeverfahren verbessern – Menschenrechte schützen I Deutsches Institut für Menschenrechte, pp. 11-12.

The 2019 study *People with Disabilities in North Rhine-Westphalia* by the German Institute for Human Rights deals with the implementation of the CRPD in the areas of housing, mobility, education and work.[110] The analysis uses selected human rights indicators to determine the state of implementation of the CRPD in North Rhine-Westphalia, providing an overview of the legal framework and circumstances as well as of developments in recent years. This is followed by recommendations for action for the state government and central actors in the various areas concerned. In the implementation of the right to inclusive education, the study states that the state Government's efforts to date do not guarantee comprehensive quality assurance of inclusive education. In its key points on the realignment of school inclusion and in its circular on the realignment of inclusion in public general secondary schools (both in 2018), the analysis states that the concept of inclusion on which those realignments were based is not compatible with the CRPD. The state government maintains the special school system alongside an obligation to establish an inclusive school system. As a result, according to the monitoring body, a strengthening of parallel structures is taking place. The key points and the circular do not replace the overall concept for the development of an inclusive school system. Possible measures include the reallocation of human and financial resources and the gradual closure of special schools. This implies, above all, the systematic further training of professionals.[111]

4.3 Promising practice

Three case studies	Public service	Private	NGO
Describe the type, scope and aim of the service used by persons with disabilities.	Field of action: Specialist integration services Mission: Counselling, support and placement of suitable jobs for the participation of people with severe disabilities in working life (taking up and securing employment that is as permanent as possible) as well as information and counselling of employers Target groups: In particular, people with severe disabilities with special need for work	Field of action: All organisations, e.g. in workshops for people with disabilities (WfbM)	Field of action: Social organisations ('From day care centres to care for the elderly')

[110] Kroworsch, S. (2019), *Menschen mit Behinderungen in Nordrhein-Westfalen. Zur Umsetzung der UN-Behindertenrechtskonvention in den Bereichen Wohnen, Mobilität, Bildung und Arbeit* (People with disabilities in North Rhine-Westphalia), Berlin, Deutsches Institut für Menschenrechte, Menschen mit Behinderungen in Nordrhein-Westfalen I Deutsches Institut für Menschenrechte.

[111] See Kroworsch (2019), Menschen mit Behinderungen in Nordrhein-Westfalen I Deutsches Institut für Menschenrechte, pp. 9 and 35.

	support, people with severe disabilities who, after targeted preparation by the WfbM, are to participate in working life on the general labour market, dependent on costly, personnel-intensive, individual support, and school leavers with severe disabilities who are dependent on the support of an specialist integration service to take up employment on the general labour market		
What quality assurance systems exist? Is there a timeframe? What is the relevant authority? (questions under Section 3.1, 3.2, 3.3) Does the quality assurance system explicitly address disability issues?	**Example: KASSYS**[112] Mission: To increase the effectiveness and efficiency of the intended process goals in specialist integration services in accordance with § 37 SGB IX Prerequisite and obligation for the commissioning and participation of the specialist integration service in the context of participation in working life or accompanying assistance Integration office with a steering function and legal obligation as the client responsible for the structure, in particular with regard to the obligation of all participants towards quality assurance and its further development	**Example: DIN EN ISO 9001:2015**[113] Mission: Definition of minimum requirements for a quality management system Characteristic: External certification	**Example: Paritätische Qualitätsgemeinschaft® (PQ-Sys®)**[114] Mission: Support of member organisations in the introduction and further development of their own quality systems, representation of interests to politicians, funders and service providers with regard to the design of the quality system Characteristic: Combination of internal evaluations and external assessments (DIN EN ISO 9001 and EFQM model) with recognition by funders and service providers

112 See Bundesarbeitsgemeinschaft der Integrationsämter und Hauptfürsorgestellen (BIH) (2021), *KASSYS Rahmenhandbuch für Integrationsfachdienste (IFD) nach den §§ 192 ff. SGB IX* (KASSYS Framework Manual for Integration Services), KASSYS I Bundesarbeitsgemeinschaft.

113 See TÜV SÜD Management Service (2021), *Qualität auf einen Blick, Leitfaden zur ISO 9001:2015, Aktualisierte Version 2021* (Guide to ISO 9001:2015), ISO 9001:2015 I TÜV SÜD.

114 See Der Paritätische Gesamtverband (2021), *PQ-Sys®, Das Paritätische Qualitätssystem* (Parity Quality System), PQ-Sys® I Der Paritätische Gesamtverband.

Which methods and methodologies were used in the quality assurance system? (questions in Section 3.4)	Interviews (exploration: conversation to determine personal, disability-related and workplace-related data) Observation procedures Evaluation of documents and findings	Documentation of processes (management, strategy and core processes as well as supporting processes), e.g. in the form of checklists or electronic workflow	Customer and staff surveys, job aids, quality checks and quality management documentation Quality Check PQ-Sys® (structured presentation of quality criteria in the form of a questionnaire for self-assessment of the organisation, agreement on improvements, their follow-up and documentation)
How are people with disabilities / disability organisations involved in the assessment process? Are they consulted? (questions under Section 3.5)	Involvement of associations of persons with disabilities, including associations of non-statutory welfare organisations, self-help groups and interest groups representing women with disabilities	No information on the involvement of people with disabilities.	No information on the involvement of people with disabilities.
Which indicators are used in this particular quality assurance system?	Structural quality (e.g. staff, equipment, public relations and networking) Process quality (e.g. information, support, mediation) Outcome quality (e.g. measurement of client satisfaction, assessment of achievement of agreed goals)	Customer orientation Leadership Involvement of people Process orientation Relationship management Fact-based decision-making Improvement	Quality planning Quality control Quality assurance Quality development
Which CRPD principles are included in the quality assurance framework?	Focus of work: Promotion of participation in working life	No reference to CRPD.	No reference to CRPD.
What evidence is there that the relevant quality assurance system has an impact on the quality of the social service delivered to persons with disabilities, on the attractiveness of the sector and on	Development of a training concept with suitable training measures, taking into account the wishes of the professionals Universal understanding of quality: Besides goal and process orientation or resource	Worldwide comparability as well as compatibility with other management systems (integrated management system)	QM training in PQ-Sys® (personnel development): Each training course with examination and certificate (quality management basics, application, control and further development, auditing)

the skills of the workforce?	orientation, staff satisfaction above all		

4.4 Analytic reflection

There is a good legal basis for quality assurance in Germany. Under the Federal Participation Law (*Bundesteilhabegesetz* – BTHG), the criteria of the CRPD, relating to the equal, full and effective participation of persons with disabilities in political, social, economic and cultural life and their ability to enjoy an independent and self-determined lifestyle, have been strengthened and are taken into account in assessing the quality of services and facilities.[115] Furthermore, in this context, the special needs of women and children with disabilities and those at risk of disability, as well as of people with mental disabilities and those at risk of such disabilities, are taken into account.[116]

Besides, the law provides for different assurance mechanisms, such as audits of integration assistance providers under SGB IX and in the framework of long-term care insurance (SGB XI). However, the opening clause of the respective laws, whereby audits can also be carried out without a specific cause, is only used in some *Länder*, which means that an important instrument for determining actual compliance with quality standards is not used.[117] The new report on monitoring the implementation of the BTHG shows that there is a need for improvement.[118] The regulations on the criteria for effectiveness are still vague in most of the *Länder* framework agreements. Only a few service providers have made provisions to define criteria for effectiveness. The practical implementation of the optimised control options varies greatly from region to region, and local providers in particular say that they lack both the capacity and the professional competences for more intensive performance and quality audits.[119]

In Germany, there is some legal basis for the quality assurance of social services.[120] However, this is not a holistic model of quality assurance. While it is often defined as a cross-cutting issue in organisations and as being relevant in all areas, quality assurance is not comprehensively integrated into the education and training of staff. The increasing academisation of professions in the social sector does not automatically mean that professionalisation in quality assurance is taking place.

The COVID-19 pandemic had a particular impact on many dimensions of quality. The partial report from the consultation process of the German Association for Rehabilitation (DVfR), issued in 2021, states that the pandemic had a central impact on the social participation of people with disabilities, chronic diseases and/or care

[115] Law on strengthening the participation and self-determination of people with disabilities (Federal Participation Act – *Bundesteilhabegesetz*) v. 23 December 2016.
[116] See § 37 a SGB IX.
[117] § 128 (1) s. 7 SGB IX.
[118] Report on the status and results of the measures under Article 25 paragraphs 2 to 4 of the Federal Participation Act (2022).
[119] Report on the status and results of the measures under Article 25 paragraphs 2 to 4 of the Federal Participation Act (2022), p. 177.
[120] See, e.g., § 37 SGB IX or § 113 SGB XI.

needs. Those affected feel increasingly marginalised due to restrictions in leisure activities and social contacts.[121]

[121] See Deutsche Vereinigung für Rehabilitation (DVfR) (2021), *Corona-Konsultationsprozess der Deutschen Vereinigung für Rehabilitation, Ergebnisse, Themenfeld 4 Soziale Teilhabe – Spezielle Aspekte* (Coronavirus consultation process of the German Association for Rehabilitation), Soziale Teilhabe I Deutsche Vereinigung für Rehabilitation, p. 73.

5 Recommendations

5.1 Recommendations for Germany

For the sake of legal certainty, the *Länder* should establish common definitions of the criteria for effectiveness at *Länder* level, in accordance with § 128 SGB IX.
Rationale: The regulations on the criteria for effectiveness are still vague in most of the *Länder* framework agreements regarding integration assistance, and the views on determining the criteria differ.

Germany should implement the right of integration assistance providers to carry out random audits in addition to occasion-based audits under SGB IX.
Rationale: So far, there is only an opening clause for the *Länder* to carry out audits without concrete cause.[122] Hence, this right is not binding and is not used nationwide.

Germany should establish a requirement for a certification procedure for out-patient rehabilitation services and facilities to prove the successful implementation of quality management at regular intervals.
Rationale: The requirement for a certification procedure is only binding in in-patient rehabilitation facilities.[123]

5.2 Recommendations for the European Commission

It could be envisaged to transfer quality assurance systems that exist in the European countries to internationally recognised test procedures by means of higher-level quality criteria. As a result, comparability could be established throughout the EU, while at the same time (legal) quality assurance is maintained in each country.

A European certification for quality schemes could be considered.

The European Commission could set qualitative as well as quantitative targets for high-level quality assurance schemes.

If a European quality certification is introduced, funding could be linked to the successful implementation. In any case, beyond compliance with the quality criteria, it is important to ensure that funding is made dependent on compliance with the implementation of the requirements of the CRPD.

[122] § 128 (1) s. 7 SGB IX.
[123] According to § 37(2) s. 2, (3) SGB IX.

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