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Achieving Quality Long-Term Care in Residential Facilities

Murnau/Bavaria , 18–19 October 2010

Synthesis Report

On behalf of the
European Commission
Employment, Social Affairs
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Kai Leichsenring
European Centre for Social Welfare Policy and Research

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Summary

Reforms to the long-term care insurance system in Germany which have led to improvements in quality assurance at the federal and the regional level were at the heart of this Peer Review, held in Murnau from 18–19 October, 2010.

The Peer Review was timely. Quality in residential care facilities is a concern in all EU Member States and at the EU level. The Bavarian State Ministry of Labour and Social Welfare, Family Affairs, Women and Health, and the German Federal Ministry of Health hosted the review. They were joined by nine peer countries (Austria, Cyprus, the Czech Republic, Estonia, Finland, France, Luxembourg, Spain and Sweden). The stakeholder organisations AGE Platform Europe and European Social Network (ESN) took part in the Peer Review, as did representatives of DG Employment, Social Affairs and Inclusion of the European Commission.

The German approach to improving quality assurance in residential care facilities is driven by the specific requirements of long-term care. The Federal Long-Term Care Insurance (LTCI) was introduced in 1994 as a specific branch of health insurance, and included the delegation of needs assessments (access) and quality assurance (inspection) to the medical advisory services of the care insurance funds (MDK). It left unchanged the system whereby the Länder (states/regions) had responsibility for the social infrastructure, social assistance and the general surveillance of services and facilities.

A reform of the LTCI in 2008 outlined (together with a rise in contributions and benefits) a strengthening of quality assurance through annual checks and transparency agreements with providers — the rationale being that it would improve the quality of information available for consumers to choose between facilities, using a points system. The MDK is now responsible for inspecting care quality following traditional guidelines and 'transparency guidelines' which deal with quality of structures, processes and results. The MDK's inspection process in care homes and home care organisations is highly structured, and includes the provision of advice based on the result of the inspection.

The transparency requirement has been implemented for over a year now, and more than 10,000 reports are already available online. Apart from a general mark covering all areas, those interested can also distinguish the points awarded for 12 more specific areas including nutrition, treatment of pressure sores and medication; but this has proved controversial, with some arguing that key care issues should have greater weight in the overall marking. Some care home owners have questioned the marking system itself, and have taken court action over their ratings. From 2011, each facility will be inspected annually where previously only about 20% of care homes were inspected each year. The staffing of the MDK has been increased to meet the new inspection schedule.

Parallel to these regulations, at the federal level each of the German Länder developed its own policies for the general surveillance of services and facilities — with their own corresponding regulations, structures and proceedings for monitoring compliance. In Bavaria, this is the role of the specialised bodies for quality development and monitoring in long-term care facilities and facilities for disabled persons — the FQA. The FQA, which are affiliated with local government administrations, check compliance with the quality requirements of the Bavarian Act on Long-Term Care and Quality of Life. The focus is on the services provided and the approaches taken to quality assurance. MDK and FQA inspections are conducted unannounced. German law requires coordination between federal quality assurance and the supervisory bodies in each state. Debates about different co-ordination mechanisms are ongoing.

The German experience stimulated a lively debate and prompted participants to present their experiences, which ranged from less intensive inspection (e.g. France, Luxembourg) or inspection on demand (Finland, Sweden) to quality assurance by very focused and sophisticated instruments (e.g. the Inter-RAI programme in Finland) and voluntary approaches based on incentives (e.g. Austria). International stakeholders pointed out the general trend in self-reporting and self-assessment (which still needs to be monitored), and to the importance of stakeholder involvement in the organisation of long-term care at all levels.

Following presentations of general trends in quality assurance and quality management in Europe, and of results from a research project[1] on the 'Development and implementation of outcome measures for nursing homes' the following issues were discussed and met with general agreement during the Peer Review:

- **Policy debates involving all stakeholders** are needed in each country to decide on an optimum, and sustainable, quality of long-term care. There is a **need for a dialogue on quality** between purchasers, providers and other stakeholders, as well as residents and their families.
- It was generally agreed that **minimum standards** are needed for long-term residential care, and that **compliance should be monitored**, but incentives should be offered to further develop general quality thinking in care homes.
- An essential aspect of quality deals with ensuring **dignity** and **rights** in daily care: it is about creating living and working conditions that foster **respect** for individuals and protect them from abuse.
- **Quality management systems** are being developed in the various peer countries. The more sophisticated the external inspection system is, the more it calls for effective internal quality management; otherwise a large gap between results of inspections and actual quality in daily work is possible.
- Care staff are not used to working with **quality management methods or quality indicators**. The introduction of such systems thus requires **participative leadership and human resource management**. Both management and staff need training on quality management and related issues. Here, a **lifelong learning** approach which will often go beyond legally prescribed training is required.
- **Benchmarking of care quality** is more than just comparing aggregated data. Some benchmarking initiatives within groups of

1 For final results of the project see: http://www.uni-bielefeld.de/gesundhw/ag6/projekte/ergebnisqualitaet.html.

care homes or on a regional level have started to emerge in some Member States. However, since benchmarking requires major investment, notably in training, it may not be feasible in all countries.

- Concerns were expressed regarding the **sustainability of parallel national and regional inspection systems** (sometimes in conjunction with a third system — the providers' own internal quality management). The general trend is that countries are **moving away from an inspection-only approach** and adopting a quality management approach that combines inspection with advice and self-assessment reports with an effective internal quality management system.

- At the European level, a discussion is in progress regarding **social services of general interest**. In some countries, the voluntary **European Quality Framework for Social Services**[2] could be a basis for national debate without replacing — or being superimposed upon — existing quality assurance and quality management systems[3].

- **Care services** are increasingly provided **across Europe** as more and more care service providers, as well as beneficiaries, operate and live outside their home country, which presents an additional challenge for **quality assurance**.

- The use of the **European Social Fund** (**ESF**) to support quality thinking, training and mutual exchange in the area of health care and social services was discussed.

- **Modernisation** of care homes entails **openness to other parts of the care chain**. In the future, the quality of long-term care facilities will also depend on their openness to the community, networks, volunteers and other social services. The **relationship between**

2 For more information see: http://ec.europa.eu/social/main.jsp?catId=758&langId=en.

3 In this context, mutual learning has also been facilitated by the PROGRESS Programme of DG Employment, Social Affairs and Inclusion. See, for instance, the project 'Quality management by result-oriented indicators. Towards benchmarking in residential care for older people' (http://www.euro.centre.org/detail.php?xml_id=1396); or 'Benchmarking European standards in social services' (http://www.josefsheim.net/josefsheim/progress.shtml).

health services and social services needs further discussion. Some countries' perspectives on long-term care are more health-oriented while others are more focused on social services.

- In the long run, **transparency of quality** could facilitate the regulation of pricing according to the quality of the care home. However, any moves towards performance-based financing of care homes should be undertaken carefully and with incentives for those who are able to prove good performance.

Introduction

The importance of long-term care services and citizens' expectations of them are rising, and at the same time governance structures are moving towards market-oriented mechanisms. As such, it has become crucial to have effective instruments to define, assess and improve quality in a sector which, notwithstanding important co-payments of users, is still mainly funded by public resources.

Across Europe new approaches to long-term care have responded to the different needs and expectations of citizens, for example: community care services have been extended, the first steps towards more coordination between health and social care have been taken, more differentiated care services have been installed, and residential care facilities' missions have been adapted (Billings & Leichsenring, 2005; Pavolini & Ranci, 2008).

Residents increasingly prolong entry into a care homes, preferring the help of informal family carers or formal services or both in their own home; this means they are likely to be frailer when they seek residence in a long-term care home. Traditional old-age homes have had to meet this changed demand; they have morphed into nursing homes or facilities with service housing. They have also had to contend with rising expectations from "customers" who have experienced high standards of living vis-à-vis the past.

With the introduction of systems which give people in need of care the power to purchase services themselves, people want to know what they can get for their money (Glendinning, 2009). Policy makers and the care home industry have taken on the job of defining new structural and procedural standards, though efforts remain unevenly distributed within and between Member States both in quantitative and in qualitative terms. For instance, the percentage of older people with long-term care needs (according to national definitions) who are living in care homes, ranges from about 5% in Estonia to almost 36% in Sweden (European Commission/DG ECFIN, 2009).

Improving quality in residential care facilities involves the development of quality guidelines, minimum standards and accreditation mechanisms

to complement traditional approaches such as professional ethics and relationships of trust between public purchasers and public or non-profit service providers. Criteria to choose between different providers, for example in cases of public tendering, and for guaranteeing accountability, have been developed to help maintain standards and a system in the context of a new quasi-market with less planning restrictions, new actors etc.

The exchange of experiences from policies and initiatives in participating countries was the purpose of this Peer Review. These will be covered in this report in the following four sections: first, a description of EU initiatives in the context of quality development of Social Services of General Interest; secondly, ongoing reforms and debates in Germany — the host country — will be described; thirdly, a synthesis of other peer countries' policies will provide an overview of trends and approaches in Europe; finally, trends and potential learning points will be discussed.

A. The policy context at the European level

Though long-term care facilities, as a part of health and social services, were not originally dealt with at the EU level, they are increasingly on the European policy agenda in debates about Social Services of General Interest (SSGI), and in the context of the Open Method of Coordination (OMC). The former have focused on imminent issues with respect to basic principles and EU legislation concerning the internal market, competition and freedom of movement which indirectly call for increased coordination between Member States and EU institutions in the area of health and social services. This growing interaction is organised partly through the OMC which is backed up by the Social Protection Committee. In this context, two Communications from the Commission are relevant for EU policies on quality in long-term care:

- Following the Communication 'Working together, working better: A new framework for the open coordination of social protection and inclusion policies in the European Union'[4] (European Commission, 2005) the existing OMCs in the fields of social inclusion and pensions were merged with cooperation in health and long-term care. Apart from some overarching objectives for the OMC for social protection and social inclusion, two specific objectives were defined for health long-term care, namely to provide access, high-quality and sustainability.

- As a result of the debates about SSGI, the Communication 'Services of general interest, including social services of general interest: a new European commitment'[5] (European Commission, 2007) proposed 'a strategy for supporting the quality of social services across the EU' in the framework of the OMC, 'the development, within the Social Protection Committee, of a voluntary EU quality framework providing guidelines on the methodology to set, monitor

4 Available from: http://europa.eu/legislation_summaries/employment_and_social_policy/social_protection/c10140_en.htm

5 Available from: http://ec.europa.eu/services_general_interest/interest_en.htm

and evaluate quality standards' as well support bottom-up initiatives under the programme PROGRESS.[6]

Over the past few years several Peer Reviews have addressed issues concerning quality in social services. In Belgium, the assessment and improvement of quality had been identified as a key issue for 'The future of social services of general interest' (2007)[7] — the growing emphasis on 'value for money' calls for active quality assurance and a move towards quality management strategies, even if this approach will make regulation more complex.

In the Netherlands (2009) the debate on 'Long-term care: How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities'[8] also came to the conclusion that to further develop long-term care systems, it is crucial to develop strategies 'to erode boundaries that obstruct integrated care' and to confront the challenge of labour shortages (Rothgang, 2007: 31). In Romania (2010) the use of specific quality management tools was discussed during the Peer Review 'Achieving excellence in social service provision'.[9]

Some important issues of quality assurance were also raised in Denmark (2009) in a Peer Review on 'Combining Choice, Quality and Equity in Social Services'[10]. There was an argument by countries where the supply and overall coverage of services remains insufficient being concerned that 'the rigorous enforcement of quality standards could result in some providers being forced to close with existing users losing their services'. This risk was in tension with other priorities of improving the overall supply of services

6 See, for instance, the projects 'Quality management by result-oriented indicators. Towards benchmarking in residential care for older people' (http://www.euro.centre.org/detail.php?xml_id=1396); or 'Benchmarking European standards in social services transnationally' (http://www.josefsheim.net/josefsheim/progress.shtml).

7 See http://www.peer-review-social-inclusion.eu/peer-reviews/2007/the-future-of-social-services-of-general-interest

8 See http://www.peer-review-social-inclusion.eu/peer-reviews/2008/how-to-organise-affordable-sustainable-long-term-care-given-the-constraints-of-collective-versus-individual-arrangements-and-responsibilities

9 See http://www.peer-review-social-inclusion.eu/peer-reviews/2010/achieving-excellence-in-social-service-provision

10 See http://www.peer-review-social-inclusion.eu/peer-reviews/2009/combining-choice-quality-and-equity-in-social-services

and 'the costs of compliance with new quality standards' (Glendinning, 2009: 47). Furthermore, the lack of user involvement in quality assurance was addressed.

As the voluntary 'European quality framework for Social Services' compiled by the Social Protection Committee had been published just a few weeks before the Peer Review, the quality principles and quality criteria of the framework were considered as a useful background for the debate on quality assurance and quality management in care homes. Participants underlined that the framework will be more important for countries where social services, in particular long-term care facilities, have not yet met standards.

B. The German and Bavarian policies for quality assurance

In Germany, the need for reinforcing external quality assurance came with the opening of the 'care market' for providers when the long-term care insurance (LTCI) was introduced in 1994. Relationships between the LTCI — which became the main purchaser/regulator of care, regional and local authorities that are now mainly co-funders (local authorities) and providers were radically changed. In the first instance, the following new forms of contracts were stipulated:

- 'Provisional contracts' between the provider and the regulator which indicate an authorisation of the provider on the basis of a number of basic structural prerequisites.

- 'Framework contracts' on the regional level between the Federation of Providers and the regulator (regional branch of the LTCI) concerning the content of services, financial stipulations (reporting and accounting), personnel levels, and control mechanisms.

- Agreements concerning the funding of services by the LTCI are made between each provider and the regulatory authority on regionally defined 'care packages', i.e. a set of services in which each individual service included is rated by means of points, and individual arrangements.

Furthermore, these agreements, based on the LTCI legislation (SGB XI, § 80), stipulate authorised providers should use quality management systems but no specific system or method has been defined. Consequently, many different approaches have been developed. Adaptations of the classical ISO (International Organization for Standardization) and EFQM (European Foundation for Quality Management) models have been introduced by large organisations. In practice, providers tend to comply with the necessary minimum standards, rather than actively searching for quality improvements or competitive advantages (Blonski, 1999).

The role of the MDK

A crucial development in quality assurance was the establishment of the 'Medical Service of the Federation of Sickness Funds' (Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen — MDS), and its operative units on the regional level (Medizinische Dienste der Krankenversicherung — MDK). The MDK is responsible for training and organising medical doctors and specialist nurses who assess the individual needs of applicants for LTCI benefits; it also carries out quality inspections with a view to advising providers on potential improvements. The MDK can cut payments or exclude care home providers entirely if quality problems are detected, and not rectified within a set period — although this is seldom deemed necessary.

Reports of the MDS (the latest report is from 2007) and related research (Garms-Homolova & Roth, 2004) note problems in various areas, namely structure, process, and outcome.

The reports of the MDS on the quality of care providers, which do not refer by name to any providers, have spurred changes in care provision. Between 2003 and 2006 aggregated data have shown a general tendency towards improvement with respect to the criteria, which indicates care home managers have started to adapt to the requirements, without the use of enforcement measures. Although it remains to be seen whether providers have just learned how to prove compliance with prescribed standards, or whether systematic quality management has actually been established.

A reform of the LTCI legislation changed the inspection guidelines so that transparency was required and external assessment was introduced in five quality domains: care and medical provision; attendance of residents suffering from dementia; social care and day-time activities; accommodation, meals, domestic economy and hygiene; residents' satisfaction (based on a survey). These guidelines are supposed to ensure accessible data for users or potential users to judge the quality of each care home. The results for each domain as well as the end result are made publically available in the form of school marks (MDS, 2009).

The quality reports of the MDS have sparked a fierce debate about quality in long-term care, mainly between provider organisations and the MDS — including a number of trials at the social court — concerning the validity of inspection results and the rating system. As a result, the transparency reports were evaluated (Hasseler et al, 2010) and are currently being revised to prepare for compulsory yearly inspections for each care home from 2011 onwards (MDS, 2010). User organisations are less involved — with the exception of a small initiative supported by the Ministry for Consumer Protection (www.heimverzeichnis.de) that has started to check care homes (which applied voluntarily) against 120 criteria in three quality of life domains: autonomy, participation and dignity. The check is carried out by trained volunteers who evaluate care homes based on a single day visit. Only results of those care homes that comply with at least 80% of the criteria are published on the website.

A new approach to measure and assess quality in care homes

The German federal ministries of Health, and of Family Affairs, Senior Citizens, Women and Youth commissioned a research project to develop a set of indicators to assess the outcomes of long-term care facilities. The initial results of this study were presented by Klaus Wingenfeld from the University of Bielefeld.

The indicators should be evidence-based, applicable to daily practice, suitable for internal quality management, and verifiable on inspection. They should also avoid, as far as possible, making bold claims which are not comparable between care homes. Given the empirical, methodological and practical difficulties, six important domains were selected from a pool of possible areas, and put to the test in 46 facilities between January and October 2010:

- Functional outcomes: the maintenance and promotion of autonomy in day-to-day living;
- Individual safety: protection of residents against risks, injuries and burdens;

- Accommodation and household assistance;
- Activities and communication (notably, the residents' own perception of their opportunities to communicate within the facility);
- Responses to difficult situations (for instance, in the case of residents who have psychological problems);
- Information gathered through contact with the residents' relatives, using surveys or other methods.

To check the quality of the results, data were collected at three different points over the period. An example of how quality was monitored in a domain: three indicators for autonomy were developed; they were steadiness of: mobility, self-care ability, and the ability to organise everyday life.

The results obtained under these criteria can then be compared over an interval of six months. Take the changes in residents' mobility for example: of the patients with no or mild cognitive impairments, 66.3% had no decrease in their mobility over the six months, and 39.7% showed substantial cognitive impairments. This illustrates the importance of distinguishing between groups of residents in the indicators, notably between those with and without dementia. Having differentiated between relative starting points, valid comparisons between care homes are insightful — for instance, comparing 10 facilities, the percentage of residents with no or mild cognitive impairments whose mobility did not decrease during the last six months was over 80% in the best-performing home and less than 50% in the worst. Such results allow for a benchmarking approach on a domain-by-domain basis.

Other indicator domains keep track of the following sub-indicators: safety outcomes include pressure sores, malnutrition, falls with severe physical consequences, contractures, pain management and medication management; activities and communication include choice and autonomy regarding essential elements of care and social life, the level of everyday activities and support, complaints handling, staff attitudes, respectful treatment by staff, and privacy. For all indicators, efforts are made to bring

residents and their families into the evaluation, although this is often difficult to achieve.

An initial conclusion from the trials is that the approach works but certain challenges remain. These are listed below:

- For some indicators (e.g. pressure sores in low-risk residents) comparisons between facilities may have little statistical value, whilst for other phenomena (e.g. contractures), scientifically precise methods of measurement are lacking. This should be considered when decisions are made about which indicators to carry forward.

- Quality assessment requires a combination of internal quality management and external inspections. Measuring outcomes requires a 100% sampling rate which can only be achieved by internal quality management; spot checks would not be sufficient. However, internal monitoring alone would not be reliable and needs to be validated by external quality checks, for which the sampling rate can then be much lower. There is a need to improve quality management methods within the facilities as many of them would not be capable of implementing the proposed system at the moment. The relationship between internal quality assurance and inspections will need to be redefined.

- Remaining challenges include care components that cannot be assessed in conventional outcome terms, such as end-of-life care or measuring quality of life. Furthermore, the emphasis on outcomes might endanger the assessment of structure and process indicators which are important.

Once established, this approach is expected to act as a stimulus to improve internal quality management, encourage more effective use of the resources devoted to quality assurance, generate more objective public discussions of care quality, and valid information on quality for (potential) users of long-term care.

Participants found aspects of this approach appealing, particularly the weightings of individual care needs, but also highlighted some major issues with feasibility and costs.

The role of regional governments in Germany: the Bavarian Care and Housing Quality Act

Though regional governments and local authorities have lost most of their steering competencies in long-term care, the latter participate in the shared public responsibility of guaranteeing care, within the framework of municipal services of general interest for example ('Kommunale Daseinsvorsorge'); while the former carry out inspections in care homes. In relation to the responsibility to inspect, the Bavarian government has transformed the inspection unit ('Heimaufsicht') into a Department for Quality and Inspection ('Fachbereich Qualität und Aufsicht & FQA') that developed guidelines for the assessment of quality in care homes, based on the 'Bavarian Care and Housing Quality Act' (2009). The guidelines focus on the quality of life of residents in care homes that is assessed in the context of so-called 'key situations' with respective criteria and indicators. Observation, interviews and a consensus-building dialogue between the external auditors, and the management of the care home, are used as methods to support self-assessment and to draft a report to help (potential) users to judge the quality of the care home (Bayerisches Staatsministerium, 2009).

The Bavarian Nursing and Residential Homes Quality Act defined quality requirements, such as respect for the residents' dignity, interests and needs, the promotion of independence and self-determination and the provision of services based on the current state of recognised specialist knowledge, so that the central focus of the guidelines is on the dignity and quality of life of residents, relationships and the principle to support the facilities in developing quality.

The assessment method takes full account of these values and tries to be as transparent as possible in examining both hard and soft factors to arrive at a final judgement and proposals for improvement. Each of the 480 auditors was therefore trained for 12 days before they could apply the

audit guidelines issued by the FQA and to carry out the inspections in care homes for older people and in facilities for people with disabilities. The audit is planned to correspond with the facility's day-to-day activities, and takes place without prior notice. Auditors prepare for the visit by reading reports of previous inspections, including by the MDK, and by looking at the facility's documentation.

The audit methodology is characterised by the following aspects:

- a cultural studies approach (oriented towards understanding and exploring),
- perception and a dynamic opinion-forming,
- accountability of auditors, auditor team and representatives of the organisation,
- respect for self-determination and individuality of residents,
- a multi-professional team and continuity of the auditing team,
- focus on quality development, rather than a judgement on the organisation,
- audit as a 'moment of truth' to reveal values and related practices,
- a qualitative approach to reveal soft facts and to document them in a transparent way.

The audit is based on dialogue, mutual understanding, and a long-term relationship that exists beyond inspection day. The first step is to try to understand how the facility aims to meet the statutory requirements. Then, observing 'key situations' over a period of time, it is possible to judge whether the management system is effective on a day-to-day basis. Under the 50/30/20 rule, only 20% of the auditing time is devoted to the examination of records, 30% to discussions with staff, and 50% to participation in situations involving the residents. Each audit team consists of 3 to 4 members from different disciplines; in practice it is usually a medical doctor, an administrative

expert, a socio-pedagogical specialist and a care specialist. Throughout the morning, the auditors assess quality criteria, being guided by questions they have prepared. The auditors then provide feedback to the facility managers and, if possible, other stakeholders, taking care to emphasise positives as well as covering negatives. After further investigations in the afternoon, the audit team hold an internal meeting, and then a concluding discussion is held with representatives of management and staff, and sometimes representatives of the residents' council as well.[11]

Participants welcomed the benefits of this approach compared to external quality assurance, but wondered about the sustainability of two different types of inspection, both of which are staff intensive and time consuming. It was acknowledged that the FQA approach might be more oriented towards quality improvement, while the MDK transparency criteria might be more focused on providing information to the public.

Other initiatives

Quality assurance and quality development have been key issues on the political agenda in Germany for the past few years. Both the Ministry for Family, Senior Citizens, Women and Youth and the Ministry for Health, as well as the Regional Governments, initiated numerous measures to improve the framework for quality assurance in residential care. One of them was the 'Round Table for Care', which involved all relevant stakeholders, and elaborated on the 'Charter of Rights for People in Need of Long-Term Care and Assistance' and recommendations for improving framework conditions in long-term care to face challenges of demographic ageing, concerning quality assurance and improvement, to name some (DZA et al, 2005). Other institutions driving quality debates are the 'Federal Conference for Quality Assurance in Health and Long-Term Care' (Bundeskonferenz zur Qualitätssicherung im Gesundheits- und Pflegewesen e.V./BUKO-QS) and the German Network for Quality Assurance in Long-Term Care (Deutsches Netzwerk für Qualitätssicherung in der Pflege/DNQP), which has been responsible for developing expert standards for care.

11 Guideline (in German) available from www.stmas.bayern.de/pflege/pruefung. Version 6.0 will be published in 2011

C. Policies and experiences in the peer countries

Austria

Austria is a federal republic made up of nine regions which each have the responsibility for long-term care, and for the definition of quality criteria and quality assurance. The nine different regulatory frameworks are mainly focused on structural and process criteria, such as staffing ratios and structural preconditions. Some regions have started to include the implementation of a quality management system as a compulsory requirement for authorisation. With the spreading of a new European quality management system for care homes (E-Qalin) — developed with partners from Germany, Italy, Luxembourg and Slovenia — the number of care homes with an internal quality management system has increased from about 20 to 200 plus in six years, which equates to roughly a quarter of all care homes in Austria. This system combines classical quality management instruments with organisational development and appropriate learning and training methods. It is a potential starting point for the empowerment and involvement of staff and other stakeholders to participate in the enhancement of processes and results of services.

A National Quality Certificate (NQZ), which was developed alongside the inspections and carried out by the regional governments, constitutes a voluntary certification (external audit) of accredited quality management systems (ISO, QAP[12] and E-Qalin). The certificate was developed by the Ministry of Labour, Social Affairs, and Consumer Protection; the federation of care homes; and all regional governments. The NQZ audit focuses on quality as experienced by residents, staff competence levels, finance and personnel management, as well as on the involvement of relatives, the authorities, the public and the media. Sustainability and intergenerational learning are also covered.

12 "Quality as a process" — evaluation of management systems based on the EFQM model.

The NQZ is broadly supported by political decision-makers at federal and regional levels, based on a consensus that it should remain voluntary. It is felt that a compulsory system would result in a reduction of standards or organisations that implement quality management just to tick boxes and not for their own sake.

Cyprus

The Social Welfare Services' (SWS) department of the Ministry of Labour and Social Insurance is the only body responsible for quality assurance in the 120 or so care homes in Cyprus. In order to be registered, residential care homes have to pass an inspection by the SWS (District Offices) which is repeated at six-month intervals. Care homes are not required to dispose of an internal quality management system, and neither public nor private providers have introduced particular methods for internal quality assurance.

The inspection covers legal requirements, staff qualifications, levels of health and social care, structural facilities (comfort, security, and hygiene), quality of food, level of nutrition, treatment of residents and their families, infrastructure, leisure activities and occupational therapy, contacts with relatives and the community, and the general atmosphere in the premises.

If a facility does not comply with one or several requirements, the management is given notice and a period of time to improve critical aspects. Following a further inspection premises are subject to closure if they still fail to comply.

Czech Republic

In the Czech Republic, where reforms have created a mixed bag of responsibilities, registration conditions and obligations of social service providers were defined by the Social Services Act 2006, which also strengthened client and resident rights. In particular, fifteen social quality standards, for the most part defining structural and technical aspects, like staffing standards, are controlled by inspections carried out by the Federal Ministry of Labour and Social Affairs on services managed by the regions

and by the regions on services provided by NGOs or municipalities. All social services will be inspected within the next seven years.

Regarding provider organisations, several projects to improve quality have been carried out (supported by the European Social Fund), for example the transfer of E-Qalin to the Czech Republic is underway, ISO and EFQM quality systems are already applied by between twenty and thirty care homes, and by 2011, a project will make Common Assessment Framework (CAF), which is usually applied in public administration and schools, available to care homes within two years. Another project, the Quality Mark, is run by the Czech association of care providers, together with other stakeholders including the users.

Estonia

The Estonian Social Welfare Act stipulates that responsibilities for monitoring the quality of services fall on social county governors. Quality is assessed according to the legal requirements for service providers, staff and premises. However, while the Social Welfare Act prescribes detailed requirements for public social welfare services — such as childcare services or services for persons with mental health problems — requirements for other social services are not defined on a national level. According to the principle of local autonomy, it is up to the local authorities to establish the requirements for services under their responsibility, including care services for older people, but only a few municipalities have done so. Regulations for supervision and inspection are also lacking, though county governors are meant to submit a yearly supervision report to the Government and if the county governor detects deficiencies in the course of supervision he or she has the right to propose enforcement measures (suspension or revocation of accreditation, termination of contract, penalty payments).

More detailed regulations have thus been developed concerning the provision of long-term care services for people with mental health problems specifically. Any legal person, local government agency, or agency administered by governmental authorities wishing to provide the service must hold a valid activity licence granted by the Social Insurance Board for

five years. The Social Insurance Board is also responsible for monitoring and supervision, and enforcement measures which similar to those of the county governor. In particular, the director general of the Social Insurance Board, who also concludes contracts with service providers, may refuse to enter into a contract with the service provider if they do not comply with the established requirements.

An ongoing reform of the Social Welfare Act seeks to improve the definition quality requirements for individual services in order to enable a more efficient supervision process.

Finland

In Finland, where the percentage of non-public providers is still rather low, the National Framework for High-Quality Services for Older People from 2001 was updated in 2008 to take account of government strategies, national targets for old-age policy, the findings of framework assessments, new research data and changes in the operating environment. This national framework aims at increasing the number of services that are supporting older people living at home, and reducing the necessity for residential care. It also seeks to improve the accessibility, safety and comfort of residential care environments for older people.

Finnish municipalities and care organisations are free to choose their quality assurance mechanism; one popular way is to adopt Total Quality Management (TQM) systems or the Balanced Score Card model which involve the entire organisation, working from the top down. Almost one third of all municipalities, which are still the main providers of services, use indicators derived from Inter-RAI (Resident Assessment Instrument) to develop their services, and to create benchmarks. Organisations use indicators for benchmarking purposes to work directly on improving care and the wellbeing of clients. Furthermore, RAI data sets also allow for a calculation of the price of services, based on so-called 'resource utilisation groups' (RUG).

Data collection and analysis as well as regular training on these issues are supported by the National Institute for Health and Welfare (THL). Staff training on how to use the instruments and their results is offered twice a year; training is also provided for managers on how to use the outcome reports, and an expert panel analyses and revises the criteria regularly.

This approach to quality assurance and development has triggered remarkable improvement processes and permits the supervising regional authorities to conduct onsite inspections only if somebody lodges a complaint about a particular facility. Still, inspectorates claim that they lack the resources to follow up every complaint thoroughly.

France

In France, several agencies are responsible for quality control in residential facilities for older people, in particular the National Inspectorate for Social Affairs (IGAS) but also local level authorities and health insurance authorities. The requirement for quality assurance measures in care homes was first introduced in 1997 by tripartite agreements between the authority responsible for health insurance, the local authority (*Département*) and the residential care facility. As a result, several measures were introduced in order to facilitate internal quality assessment, such as:

- the new function of the 'coordinating doctor' in care homes was created to guarantee the application of best gerontological practices, to facilitate care planning and the regular assessment of care quality;
- the self-assessment tool 'ANGELIQUE' — which is still widely used;
- some facilities have acquired third-party certification using AFNOR or SGC-Qualicert, although these privately funded certifications do not replace the statutorily required external assessments.

External assessment occurs only every five to seven years. Since 2002, an external assessment must be carried out by an authorised structure at some point during the seven years that follow the authorisation to create a care home (the result of this assessment must be available two years before

an authorisation comes to an end, i.e. after five years, in order to help make a decision about the renewal of the authorisation).

In 2007, the National Agency for the Assessment of Nursing Home and Home Care Providers (ANESM) was founded to evaluate and adapt guidelines and recommendations for quality health and social care, based on good practice, to support providers in internal and external quality assessment processes. It also authorises third parties (consultancy, certification or training agencies) to carry out the external audits discussed above.

Although inspections on structural, security and hygiene requirements are also carried out regularly by regional or local authorities (*Département*, *Conseil Général*), the French approach to quality development is currently based primarily on incentivising providers and providing opportunities for improvement by examples of good practice.

Luxembourg

In Luxembourg, responsibilities for long-term care are divided between the Ministry of Health and Social Security (mainly through the Long-Term Care Insurance) and the Ministry of the Family and Integration. The latter has stipulated minimum standards for the legal authorisation of residential care providers and the Ministry of Social Security has set up a 'quality commission' to regulate the provision of services in the context of the Long-term Care Insurance. This commission gathers representatives of all stakeholders and has established qualification standards. Furthermore, it promotes expert standards and guidelines for 'good practice' in a variety of areas, for example hygiene in the long-term care facilities.

Quality assurance is guaranteed by both supervising bodies. The Ministry of the Family and Integration carries out follow-up visits within the framework of legal regulations for the authorisation of providers. At least once a year compliance with the contractual agreements is checked to ensure the conformity and the respect of minimum quality requirements in structural and organisational quality. During these announced inspections experiences are exchanged and corrective measures are sometimes suggested. For its

part, the 'Department of Evaluation and Orientation' visits facilities to inspect their compliance with the procedures for the long-term care insurance.

There are no statutory obligations for internal quality management but the main providers of care homes have decided, on a voluntary base, to implement certified quality management methods such as E-Qalin, EFQM or ISO.

For the future, a joint dialogue between regulators and providers is planned in order to adapt existing legal standards and quality criteria, to implement a 'Dementia Plan' and to develop a new normative framework to come up with new types of care structures to guarantee services for different care needs.

Spain

Spain is currently engaged in a complete overhaul of its long-term care system by implementing the 'Act on the promotion of personal autonomy and care for dependent persons'. Standards and other quality issues are currently being elaborated and will be compulsory for all accredited providers. Requirements will be further defined concerning, amongst other domains, the following: a) material resources and equipment, b) human resources — staff ratio and staff training, c) all sorts of administrative documentation, d) accessibility of premises and environments, e) job quality, f) continuous quality improvement.

The law and respective regulations stipulate for the first time that each provider has to dispose of a quality management system. Detailed regulation for accreditation and contracting is being decided on the level of the Autonomous Regions, as the main purchasers of care services. This has led to ample regional variations of requirements in opening and running a care home. The competences of Autonomous Regions also include the creation and maintenance of Centres and Services facilitating the necessary accreditation in order to guarantee compliance with the quality requirements and standards, inspection and, where applicable, enforcement of sanctions for non-compliance. Inspections are based on the accreditation criteria that

focus on staff ratios and other structural criteria, as well as hygiene and care specific programmes.

Though certification is not compulsory, most providers participating in competitive tendering processes maintain a certified quality management system, usually based on UNE ISO 9001 or EFQM. Providers would thus be keen on linking certification experiences to the complex negotiations that are currently taking place at the Territorial Council — where the different Autonomous Communities and the Central State Administration try to reach consensus on the implementation of the law, its detailed requirements, and quality standards.

Sweden

In Sweden, the responsibility of care for older people rests with three authorities acting at different levels. At the national level, policy goals and general guidelines are provided by the Swedish Parliament and the Government with its subsidiary agencies. For instance, the National Board of Health and Welfare is responsible for supervision, follow-up and evaluation of municipal and county council services; at the regional level, twenty county councils are responsible for the provision of health and medical care; and at the local level, Sweden's 290 municipalities have a statutory duty to meet the social service and housing needs of older citizens. The local authorities are independent bodies with the liberty to interpret national legislation — the Social Services Act and the Health and Medical Services Act.

External quality assurance in care homes, about 85% of which are run by local authorities, is usually carried out only in cases of complaints or reporting of abuse through external follow-ups by the National Board of Health and Welfare.

Another tool to make quality of care homes and services transparent is the 'Elderly Guide', a website addressing older people and their families who are looking for information about the quality of care in all municipalities. The guide contains information, provided by the municipalities and usually gathered once a year through special surveys, in relation to 36 indicators on

individual units of special housing, home-help services and day care services. The quality dimensions used in this guide are numerous: accessibility, user involvement, staffing, training and continuity of care personnel, user independence, food, support for families giving care, physician's involvement, preventative nursing care and services, management, follow-up and information provision. The results are searchable in various ways; they can be presented in summary tables, diagrams or as a general report, and the visitors can choose which municipalities or units to compare (Swedish Ministry of Health and Social Affairs, 2007).

Further efforts are underway to improve the coordination of the health and social care legislation, including a more systematic approach to quality management, including self-assessment routines, follow-up and feedback on experiences. However, the general trend is to focus monitoring on outcome indicators that reflect the quality perceived by older people themselves, rather than on structural and organisational issues. This approach is based on user surveys that have been carried out since 2008 and culminated in recent national legislation stipulating that, as of 1 January 2011, ethical values and dignity in care for older people have to be guaranteed. The future challenge for municipalities — and the National Board of Health and Welfare — will be to develop indicators which measure 'dignity' and other ethical values as well as 'changed attitudes'.

D. Discussions at the Peer Review meeting

Following the presentations during the Peer Review, three major issues were identified; namely the transferability and sustainability of the presented external quality assurance tools, the appropriateness of methods and instruments for quality assurance, and general issues concerning the development of long-term care systems.

Sustainability and transferability

Given the wide range of activities concerning quality assurance in Germany, participants were concerned about how these different initiatives on the national and regional levels, and on the level of scientific research, could be coordinated with daily practice in care homes. The high costs of inspections (MDK) and external audits (FQA) were considered to be a barrier for their transfer to other countries — most of which have actually implemented different methods and approaches already.

Indeed, the costs (on average about €4,500 per care home) and the number of skilled inspectors necessary to carry out yearly inspections by the MDK — in about 11,000 care homes and 12,000 plus home care providers — are considerable. Currently, finance is organised in the framework of the LTC Insurance, but for the long-term sustainability of the approach, inspections will have to be reduced — for instance in well-performing care homes. The FQA audits require up to four auditors per care home and individual training of 12 days for each of the 450 or so auditors. It might become necessary to make the approaches more compatible, although their objectives are distinct — while the MDK transparency inspection chiefly aims at informing the public, the FQA audit is geared at supporting the quality development within the care home and to assess whether it is effective.

To supplement the discussions among the MDK and the FQA, the Bavarian authorities and the federal Ministry of Health, a cost-benefit analysis of quality assurance in German long-term care could be commissioned to investigative the mid-term perspective.

Methods and instruments of quality assurance

As long-term care systems in Europe are only just emerging, it is quite natural that methods to define, assess, and develop them still need fine-tuning, and the fact that a range of approaches are being taken will prove useful in the long-run, when a comprehensive set of approaches can be evaluated. Discussions are still far from being "European"; countries have developed their own approaches responding to their needs and following their traditions. So far, the general quality management (ISO, EFQM) have been adapted to national and organisational contexts, while only a few specific quality management (E-Qalin) or quality assessment (Inter-RAI) tools have spread trans-nationally.

Comparisons and benchmarking will remain a major challenge because instruments have to respond to the differentiated care needs of LTC service users and residents.

Appropriate methods to gather feedback from residents, family and friends, as well as from staff and other stakeholders will be pivotal to developing transparency and outcome-oriented assessments further. It was emphasised that whatever instrument or method is being applied, it should be based on the involvement of different stakeholders and on trust between them — as long as quality management is perceived as a necessity just to please the inspectors, real transparency is not achievable. This is underlined by the fact that enforcement measures are relatively weak in this sector. The closure of a care home due to non-compliance with quality requirements is only the very last resort of public authorities — out of some 2,000 care facilities in Bavaria, only 4 closures were ordered in 2007–8.

Finally, differences in staffing, working conditions, and training of management and staff are problematic. Basic training and continued training have improved in most countries, but future policies should face the imminent labour shortages in long-term care and work at retaining staff through attractive labour conditions and training.

Financing further development

It goes without saying that quality development and quality assurance in LTC call for additional investment and for steady financing. Apart from national funding, to what extent the European Social Fund (ESF) could be used to fund additional training and innovative approaches was raised. In its next programming period, the ESF will support all the goals of the EU2020 strategy, including the fight against social exclusion. Projects to promote participation by older people might well qualify for funding, in particular in New Member States.

E. Conclusions and key learning points

Political debates involving all stakeholders are needed to decide upon the desirable, and sustainable, quality of long-term care

Some countries have intensified the social and political discussion on long-term care with tangible results, while others are starting to acknowledge long-term care poses problems. Germany has laid the basis for further development by introducing the LTC Insurance, which triggered further debates at the 'Round Table for Care', the 2008 reform and new ways to monitor quality of care homes and services. In Finland, debates on the National Framework for High-Quality Services were the starting point for substantial investments in quality development. Interestingly, the Nordic countries have implemented an approach based on incentives, training and transparency, rather than on inspection alone. The general trend to monitor the quality of outcomes and quality perceived by residents and clients (e.g. Sweden, England, partly Germany) will present new challenges in terms of methods and ways of assuring quality, some of which were discussed during the Peer Review.

What remains an issue in all countries is the dialogue between health and social care, and the coordination of fragmented services. While some countries have developed a medical-oriented concept of long-term care, others focus on social care. The general policy objective is to help people with LTC needs stay in their own homes for as long as possible, but services and support mechanisms are still lacking in most countries.

At the European level, the ongoing discussion in the context of social services of general interest has advanced with the agreement on the voluntary European quality framework. This could become a basis for national debate, particularly in those countries where long-term care services are scarce.

Minimum standards and inspections to monitor compliance are needed, but will not guarantee the development of quality thinking in care homes

The Peer Review underlined once again that the general development of quality assurance is based on defining minimum standards, inspecting

structural and process quality towards the designation of result and outcome indicators, and more sophisticated monitoring processes combining internal quality management methods with external audits (certification) and incentives for continuous improvement. The German and Bavarian examples have shown the success of this strategy, although it remains to be seen whether it will be possible to sustain and harmonise the two distinct approaches that co-exist in Germany.

Other strategies have been shown to be effective. For instance, the example of Spain has shown that certification and internal quality management at the level of providers can also improve the knowledge base for the local public administration and national policy debates. The Austrian example has revealed an interesting combination of top-down and bottom-up strategies, with providers developing and implementing internal quality management (E-Qalin, QAP, ISO) and an external audit by a third party that will be acknowledged by the Ministry of Labour, Social Affairs and Consumer Protection as the 'National Quality Certificate'.

The dialogue on quality criteria, indicators and methods between public purchasers, providers and other stakeholders, including residents and their families, needs stepping up to make these systems sustainable, but there was uncertainty whether parallel national and regional inspection systems, and third party certification, would be feasible in the long run. Furthermore, when preparing reforms in this context, special emphasis should be put upon the following issues, (peer countries can be turned to for support and information):

- The frequency of inspections or external audits: Under which circumstances should these take place yearly (Germany, Luxembourg, Cyprus), every five years (France) or just upon request following complaints (Finland, Sweden)?

- Training for inspectors or auditors: Which kind of training? Who and how many should they be: Twelve days like in Bavaria? Ten days like in Austria (NQZ)? Should they inspect alone (Spain), in pairs (Germany's MDK), or in multi-professional teams with up to four members (Bavaria)?

- How can the dialogue between inspectors/auditors and provider organisations be organised (Bavaria's FQA, Austria's NQZ, Germany's MDK)? Which incentives could be conceived for providers to adapt their internal quality management to inspection methods (Spain, France)?

- How can different approaches to quality management be combined with criteria defined by public administrations (Spain)?

Internal quality management is needed as a basis for external quality assessment and calls for enabling mechanisms for management and staff in care homes

Presentations and discussions during the Peer Review exposed an impressive number of initiatives and systems for quality management are being developed in the peer countries. A clear message was that the more sophisticated the external inspection system is, the more it calls for suitable internal quality management; otherwise, even the most advanced inspection systems based on a partnership and quality management approach won't stimulate continuous quality improvement.

The implementation of quality management in care home requires appropriate leadership and human resource management, as staff and management of care homes are still for the most part new to quality thinking; this means training for management and staff on quality management, but also on project management, group facilitation, communication and the organisation of relationships within care homes between staff, residents and other stakeholders. Here, a lifelong learning approach which goes beyond legally prescribed training is often needed.

Benchmarking of care quality will remain the exception unless there is internal quality management and significant investment. Different approaches to benchmarking are being trialled in Germany and Finland; both require major investment, again notably in training, and may not be feasible in all countries.

The development of quality management will depend on the extent to which relevant stakeholders are ready to invest in the professionalisation of the care sector as a whole. Investing in external quality assurance alone will not be sufficient to guarantee transparency and continuous improvement.

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Achieving quality long-term care in residential facilities

Host country: **Germany**

Peer countries: **Estonia, Finland, France, Luxembourg, Sweden, Spain, Czech Republic, Cyprus, Austria**

With Europe's population aged 65 and over projected to rise by approximately 77% between 2004 and 2050, the number of people requiring long-term care is likely to grow sharply. To meet these needs, a vast continuum of long-term care services has emerged, ranging from nursing homes to alternative non-institutional settings. However, ensuring the quality of these facilities has not always proven easy.

A multitude of initiatives have been undertaken throughout Europe to assess and regulate the quality of long-term care for older people, and the purpose of the German Peer Review is to enable Member States to exchange their various experiences.

An important focus of the Peer Review will be on ensuring a quality of life that is objectively good for all residents. One of the measures used by the Government of Bavaria is support for on-the-job and off-the-job training with governmental aid of around € 1 Mio. a year.

Key questions of the Peer Review will be how Member States actually define quality of life in residential facilities and what kind of means are used to assess this quality.