



GUIDELINES

FOR PROMOTING INNOVATIVE ASPECTS

OF THE GOOD PRACTICE OF “WORK ACCREDITATION”

FOR AT HOME CARE SERVICES

PRO-DOMO PROJECT
REF. N.: LLP-LDV/TOI/09/IT/0456

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Preface

In February of 2009 the City of Parma presented ISFOL with the project “PRO DOMO - to promote and develop at home assistance services to people”, to be inserted in the “Lifelong Learning” Program - a section of the “Leonardo da Vinci” program, which is a call for multifaceted projects dealing with transferring innovations.

The project includes the involvement of National and International partners.

The national partners of the project are:

1. PRO.GES
2. THE RESEARCH CENTER FOR DOCUMENTATION AND STUDIES of Ferrara [CENTRO RICERCHE DOCUMENTAZIONE E STUDI (Ferrara)]

The European partners are:

3. Instituto Municipal de Formacion y Empleo (ES);
4. Katholische Universitat Eichstatt-Ingolstadt (D);
5. Greenhat Interactive Ltd (UK);
6. University of Debrecen - Faculty of Health (HU);
7. Konfederacija Sindikatov 90 Slovenije (SI).

The Leonardo da Vinci program for this sector is articulated on the basis of various types of actions (called Measures), which are listed below:

- Mobility of individuals (training and exchanges);
- Multilateral projects to transfer innovations and multilateral projects to develop innovation;
- Multilateral Projects and Networks of experts and organizations on specific themes;
- Bilateral and Multilateral Partnerships centered on themes of reciprocal interest to partners;

The Leonardo da Vinci program is aimed at:

1. Supporting those who take part in training and continuing education activities helping them to acquire and apply knowledge, competencies and qualifications to favor personal growth, employment potential and participation to the European workplace market;
2. Supporting the improvement of quality and innovation of systems, institutes and practices in education and professional training;
3. Increase the attractiveness of instruction and of professional training and of mobility for employers and single individuals, and to ease the mobility of working individuals while on training;

One of the specific objective of the “Leonardo da Vinci multilateral projects for transfer of innovation”, is to increase the quality and attractiveness of the European educational and professional training systems through the adaptation and the integration of innovative contents, or of the results of previous Leonardo da Vinci projects, or of other national level innovative projects within the public and/or private professional training systems and in national, local, regional and special interest level companies. The innovation transfer process for training results and contents includes and implies the following:

- Identification and analyses of *target groups*;
- Selection and analyses of innovative contents geared to satisfy such needs, and the analyses of the possibilities to realize the transfer;
- The integration (or certification) of the innovative contents into European, National, regional, local and field interest training systems and practices;
- Adapting the innovative content to the training systems, to the culture, needs and necessities of *target groups* (adapting of product, etc.);
- The transfer of innovative contents to new social, cultural and linguistic contexts;
- Use of the innovative content in the scope of new sectors, or in new *target groups*, including a transfer within public and private training structures;

The objective of the PRO DOMO project is to make the procedures and regulations activated by the City of Parma to improve the quality of at home services through the instrument of “accreditation” available to all the partners. The purpose is to divulge and diffuse this methodology so that it can be further used in national reference environments.

The guide lines represent the necessary instrument to transfer innovation through the competent territorial structures.

1. CONTEXT

Dealing with the topic of “Accreditation” presupposes the need for an overview of the system which provides At Home Care services to users who need them, given by subjects who are external to the users’ family unit. In every context and at all times, mankind has always had the need to exchange assistance and help in the practice of that important virtue that sociologists call “solidarity”.

If in past centuries the main structure issuing those services was represented by the family of belonging, starting from the second half of the past century, the situation has considerably changed, to the point that the impact of the request for at home social assistance services has changed from being a marginal feature to becoming a characteristic of modern western society.

Various factors have produced such a radical change; these happened in such a fast way that noteworthy opportunities very soon showed themselves to be carriers of manifold problems as well. For example, consider the differences in the role that women have taken in modern society with respect to the role they had of a few years back in many areas of the planet. The role of man has had to consequently change with regard to the new requests of women in general, and of wives and mothers in particular.

If once the family was considered to be a solid structure where a harmonious development could be safely found, together with a valid support and a secure refuge in case of need, today it is the family who needs urgent support and frequent rebalancing. From this situation, the need was born to build a safe and efficient system of assistance to individuals experiencing difficulties who prefer to remain at their home to avoid going into structures which could cause a worsening of their psychological and physical health.

While in the past external assistance was born and developed mainly in view of the phenomenon of ageing or for situations of disability, today new professional figures have been appearing on the scene, for example, care givers for assistance to minors age 0 to 6 and over (c.d. Tagesmutter).

At the same time, a process of restructuring of Public Administration has taken place, since this has been gradually delegating management and operational functions of services to private subjects organized mainly as associations and cooperatives.

1.1 Ageing in Italy

The process of population reaching a senility stage which is happening in Italy has been defined by many experts as being a “secular ageing process”, where by the term “secular” it is intended a definition of irreversible and permanent. In such perspective, population ageing results absolutely unstoppable, especially in virtue of the medical and health progress aimed at reducing mortality incidence.

This trend has caused a discontinuity with the past, especially in relation to the different life stages; if these in the past were three, now essentially there are four. The first age in that in which socialization and forming through education take place; the second age is characterized by professional activity and the acquiring of responsibilities; the third age is that in which the ability

to dedicate time to one's own interests prevails and coincides with retirement; at last, the fourth age is that in which one lives in a state of senility and loss of self-sufficiency on various levels.

Because of the prolonging of life and particularly of old age, sociologists and geriatric doctors are in agreement upon dividing the elderly in *young old* up to 75 years of age, *old old* up until age 84, and *oldest old* from 84 years of age on. Demographic researchers, economists and sociologists agree in identifying some gaps between different generations of elderly people. The largest increase in elderly population has taken place in the first half of the 1990s, when "poor" categories of elderly people born in 1915-18 have been replaced by wealthier ones formed by those born in the following years (the 1920-24 class, which contributed to a general increase). Today we witness a more regular increase in the number of elderly, because the generations which pass the threshold of 65 years of age have not experienced sudden variations: this is with the exception of the class of 1944 and 45, which have a lower numeric consistency because of the war. After that period, the boom of birth rate after the war and up to the first half of the 1960s will cause an increase in the elderly population which has never been experienced before, and that will be destined to last until about half of the 21st Century. These generations all differ in level of education, growth, culture but most of all they differ in their "contributive status" which insures them a retirement fund which can insure a good quality of life. We describe two different cases in order to explain the new directions in ageing:

- The first one is formed by the so called *oldest old* generation (age 84 and over), which are characterized by a low level of socialization (with some analphabetism problems still persisting), with low pensions (because of the discontinuity of work and of contributions to retirement funds) and with little spending power. In most cases these are women, because of a longer life expectancy. Many of these have had to assist other elderly people and have a life history showing heavy work and many sacrifices. Because of their condition of solitude due to the fact they have remained alone (and in this case it is appropriate to make a distinction between those who have children who live in other places, those with children who live nearby, and those without children), they benefit from forms of "short range solidarity": next door neighbors, some relatives, a parish. When the elderly person can count on a family relationship – close family or distant relatives – the presence of a care giver is always registered for those who need it. In such a variant, for the reasons described above, often cases of people living below the threshold of poverty emerge, who survive by means of their extremely simple lifestyles;
- The second variant is that of the "young" generations. Characterized by more average scholastic and work curricula (those who attended elementary school, middle school, high school and some college degrees and doctoral degrees). Better life conditions and a better system of retirement contribution has granted them a larger spending power and a better quality of life. They frequent a group of friends or social centers, they do volunteer work, travel, read, go to the cinema or dancing. They can be couples (husband and wife) which by now are free from adult children responsibilities, or widows and widowers who generate an increasingly growing phenomenon in Italy of live-in companionship between elderly who do not remarry in order not to lose some economic advantages. Given their relatively young age, many often do some small work "under the table". People with college or doctoral degrees continue an "informal" work career as consultants or on high profile project work even after retirement, which is not aimed simply at covering living expenses and support. Time which is freed from the need to work because of a pension, is difficult to fill. For women, it is easier to return to family care and relationships full

time. For these reasons, as far as men are concerned, they prefer “soft” work engagement which allows them to do some professional activity and to cultivate their hobbies. In the future, due to consistent increase of graduate women from the 1970s to the present, a prolonging of “female informal work” could become a factor.

Therefore, the situation expected in the next 15 to 20 years delineates the presence of Italian elderly people with a good spending power, with good educational level, inserted in a good social network. When health conditions change, it is expected that as their first choice they remain at home taking advantage of home care or of the support of care givers. Resorting to a nursing home structure will tend to happen later and later in time, and these will tend to receive people with higher levels of invalidity and lack of self-sufficiency, due to multiple pathologies or strongly accentuated chronic syndromes.

If the current growing trends of atypical work will consolidate in future years, people who are age 40 today will have economic problems when they will retire. What pension will it be possible to guarantee to this mass of atypical workers? The population ageing processes, the scarce contribution to retirement funds of the atypical contracts and the increase of frequency of unemployment periods, prefigure a devastating mix for the retirement future of these workers. Unless some adjustments are made, in 20 to 30 years we can expect to return to an over 65 generation of people with the same problems of the generations between the two wars. But the most engaging challenge will concern elderly immigrants. Italy has experienced only recently the impact of immigration. Today, we are witnessing G2 or G3 , young people of second or third generation who came as children to Italy or who were born in our country, who attend high school, go to college, work in the manufacturing industry or in the service industry. In 15 to 20 years the parents (first generation) will be old and little is known of their ageing processes, of their family systems to protect and care for the elderly, of the practices of their “living worlds” of support. We know that many of them will have lower pensions than Italians because of discontinuity in contributing to funds; we know that the mentality and family management is different according to the nationality (Morocco, Senegal, Cameroon, Romania, Albania, Ukraine, China etc.). What will be the needs for care and assistance of these people? Which services could be adapted to their needs and which will have to change? There is a need of more research to learn in time from this reality which is still unknown, in order to offer appropriate answers, which can be efficient and effective, but most of all, humane and of good quality.

1.2 Welfare in Emilia-Romagna

A large presence of literature about this topic testifies that the Emilia Region model of welfare between the end of the war and the end of the 1970s has been an important reference point not only in Italy, but also in other European countries: services were widespread on the territory, had a good level of accessibility and were of good quality. Those were the years when the people of Emilia Romagna reached a better level of health and well being (a record peak recorded by the national surveys), through a system which was calibrated on an effective universal value borrowed in large part by Anglo Saxon and Scandinavian models and oriented on effectiveness, even though it was also characterized by strong standardization.

In the 1980s there were great changes in society and it seems that on one side service users became fragmented in small “areas of need”, while, on the other side reducing the cost became necessary. It was in that phase that the model of the region Emilia started to show its first

limitations: a strong rigidity emerged in inner reorganization, redistributing human resources in a different way in order to elaborate answers to need which were less and less standardized in time and more suitable to the different targets. An example of this is the phenomenon of “caregivers”, though it does not apply only to the Emilia model: in order to face a consistent increase of the phenomenon of the aging population, and in the presence of a clear need of the elderly and their families to remain at home, in the absence of a flexible range of offer, people were induced in a sort of “do it yourself” system. Gradually, the third sector opened up and the system became more complex and more difficult to manage in an integrated system. Since the 1990s, the system with its costs has become more and more difficult to manage in the social and health fields, both for public administration and the private sector. But most of all, because of the shrinking and the reduction of the solidarity networks both in the cities and in the small towns, some mixed structures have been created, as for example in Parma, where the community welfare has been integrated with the family welfare. On one hand this has made it possible to take actions tailored to the needs of the persons and of those living with them, in an attempt to recuperate and strengthen the natural solidarity networks through participation. On the other hand, prolonging the at home care as much as possible is seen as an opportunity to learn how respond in manner which is more and more humane and in line with the needs of the person. In Italy, a law was passed in 1972 which transferred health functions to the Regions. Furthermore, since 2001, following the modification of chapter V of the Constitution, a diversification of the health organization at the regional level has been implemented. Regional law 29/2004 titled “Norms about the organization and functioning of the regional health service” redesigned the organization and functioning of the system in a federalist perspective. The Regional Health Service of Emilia Romagna is governed by the Department of Health Policies, which since 2005 has also managed the programming and management of policies for lack of self-sufficiency and the coordination of social health services.

The Local Health Unit Company (ASL/AUSL which normally is a provincial entity) represents the operational arm of the Regional Health Service and is structured in three main bodies, with different modes of organization varying from one AUSL to another:

- The Districts
- The Hospitals
- The Departments

The Districts represent a branch of the Local Health Company where the complex integration of social health activities in favor of the population is implemented. The population represents its user target: the citizen/user is the center of its activity, and the unit guarantees a unified and complete program of care service and continuity in care. The District must guarantee that there is a dual coordination of service: an internal one, concerning the organization of units of the district itself, and an external one, with respect to other AUSL structures and to other local Entities, as shown in figure 1.

[figure 1: Primary Care, at home; Secondary Care, in hospital; Residential Care, Cdr RSA; District]

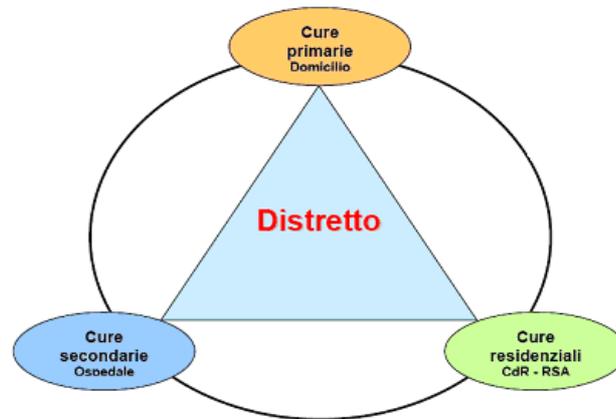


Fig.1 - District Functioning

Concerning the instruments for programming, the Emilia Romagna Region operates through the Social and Health Plan which was written for the first time during the 2008-2010 three year period. The key principles of this plan (universal value, equity and solidarity) are at the base of a rearrangement of the territorial governance system and of their programming, with the purpose of implementing an integrated system of social services, of social health, and of health services. The social and health territorial Council operates on an intermediate level, while the single District (or the single Town or association of Towns, when these coincide with the territorial competence of the District) through the triennial Act of Address and Coordination, elaborates a District Plan for social health and welfare. All of the tools for programming have an integrated aspect and include social, social health, and health programming.

The Regional Health System of Emilia Romagna includes 11 USL Local Health Units, 1 Hospital, 4 University Hospitals and 1 IRCCS, distributed in three large areas (Northern and Central Emilia and Romagna) and with a total of 16,152 public admittance beds and 3,625 accredited private admittance beds (these numbers were updated on December 31 2008). The Regional Health Service, moreover, has a number of spaces dedicated to specific population categories. In detail, there are 31 “Young Spaces” dedicated to youth age 14 to 19, and 17 Spaces for immigrant women and their children. The Regional Health Service is organized in 38 Districts which guarantee the basic levels of assistance and work in detecting population, program and issue services, and evaluate results.

On the basis of these activities the District’s Director charges the competent territorial and hospital departments of the Regional Health Service (Primary Care Units, Mental Health and Pathologic Dependence Department, Public Health Department) to issue services. The District Committee is in charge, practically and together with the Director, of managing the Fund for lack of self-sufficiency on the local level. Regional Law 2/2003 started a process through which public assistance and benevolent Institutions (IPAB) were transformed into public Companies of services to the person (ASP), with the purpose of creating a public net of assistance services, social and social health services, residential, semi-residential and at home services and in order to guarantee a wide and standardized type of assistance. The ASPs refer to the Towns of the local District, which form a council of associates. The Towns’ functions are both to be vigilant on operations and to set directives. The Regional Health System works through a logistics network which involves not only public but also private structures managed by commercial and non-profit bodies through

conventions. Great importance is given to the at home assistance sector. This type of assistance includes mainly general medical assistance (57,2%), nursing assistance (36,4%) and specialized assistance (1,5%), with a net prevalence of requests from elderly people over age 80. In order to improve the services offered in this area, it is important to underline the role of the “Regional Fund for lack of self-sufficiency”: this fund is destined to the improvement of the service network, particularly to improve service dealing with at home care. The first three year program which used this fund was completed in the year 2009. This tool, which provides for an important synergy between health services, social health services, and social services granted by Towns, has been designed to offer people a tangible help in sustaining the expense for residencies, for at home care and for promotion of new types of assistance.

The Regional Fund for lack of self-sufficiency, aside from strengthening the at home service network, has made it possible to improve and qualify all of the services designed for assistance and care of people who have lost their autonomy. Therefore, structures such as residencies and assisted living structures which have public convention to give assistance to the elderly, to disabled people, to people with psychological problems and people with pathological substance dependencies are all included in this program of care service. The Regional Health Service is financed with resources coming from the IRAP income (a regional tax on productive activities), from the additional regional IRPEF income (a tax on physical persons’ income), from a share of the tax duty fund and a regional share of the IVA tax (tax on added value or VAT). To these sources of financing are added the revenues of Local Health units and the active surplus of patient mobility (reimbursement to the Health Services of Emilia Romagna related to health services given to citizens coming from other regions). Every year, the resources are distributed between Regions by CIPE (Inter-ministerial Committee for Economic Programming), based on the Ministry of Health’s proposal agreed upon with the Regions themselves. The allotment is determined on the basis of the density of population, and it is also decided on the basis of specific health consumption by age groups. The resources allotted to Emilia Romagna are divided among the USL Local Health Units on the basis of similar criteria to those of the national allotment and are destined to the financing of the essential levels of assistance (LEA), to the financing of special projects and to achievement of specific preset health objectives.

1.3 The elderly in Parma: new needs and the “Accreditation” system

When comparing the data about ageing coming from the province of Parma to the regional, national and European context, it emerges that this phenomenon has reached important dimensions. The old age index in the province of Parma exceeds the regional one of 6 points, the national one of over 36 points, and the European one of over 71 points; in Emilia Romagna, the province of Parma is in the fifth place for high level of old age population (the first one is Ferrara). The value of the old age index is not homogeneous throughout the province. To understand how much the elderly population data affects the province of Parma, we note that the index of dependence from elderly people in Parma is 1,3 points higher than the regional value, 5 points higher than the national value, and almost 11 points higher than the European value. In spite of this data about ageing and in spite of a low rate of natural population growth, the province of Parma, being an economically strong province both at regional and national levels, is able to attract migrants for work, making the active population turnover index lower with respect of the regional one, even though it differs from the national index by about 27 points. In this perspective

of services to the persons in the Emilia Romagna region, the City of Parma, differently for what happens in the case of residential and assisted living services for elderly people, has chosen to manage the at home care services in a way altogether different from the regional model of *community welfare* (the direct management or service contract through ASP, the Public Companies of Services to the Persons), and has adopted a model of *family welfare*, giving the elderly or their families a voucher to spend at accredited providers who are in competition among themselves.

The elderly services accreditation program, which will be presented in Chapter 2, has the objective of promoting the quality of life and citizenship rights through an integrated system of services and care services.

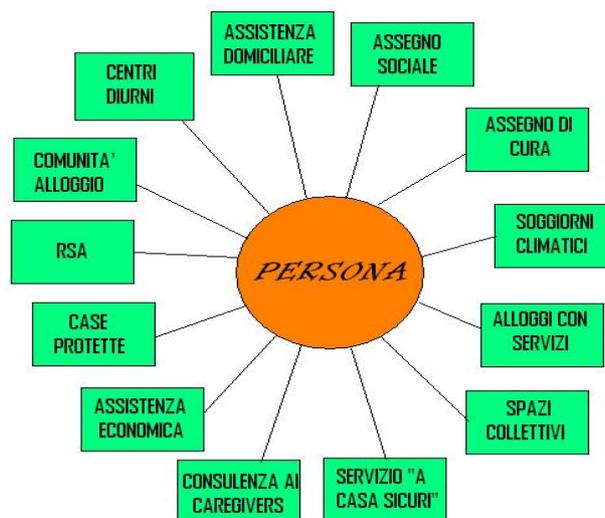
The integrated system gives incentive to operative synergies among all of the formal and informal community resources (social health services, health services and hospitals, volunteer work, associations, non-profit or cooperative enterprises, etc.). This model places the elderly person or the non-autonomous adult and their families at the center of a care service, guaranteeing them the right to take an active role in it by letting them participate in the formulation of the assistance project and recognizing their right to assist in the choice of an accredited supplier. In this respect, the role of the City towards the citizens will be to guarantee:

- A care plan;
- The type of care service, its quantity, quality, price;
- The economic support through a voucher (a service coupon) with which the City Administration grants the citizen a contribution for the project which is financial and personalized, and which is issued in the form of a voucher;
- Freedom of choice in selecting a service provider;
- The service provider's characteristics and quality standards (the provider gets accredited);
- The efficiency and effectiveness of service through monitoring the progress of service issued;
- Support to the persons and the families who are not able to choose.

The final objective of the project is to activate a form of competition between the various accredited providers in order to maintain low costs and to elevate the standards of performance. The territory of the City of Parma, as of January 1st 2010, estimates population of 184,467 inhabitants, of which 21.23% are over age 65 and 10.43% are over age 75. Population ageing presents a series of important challenges for the community, but first of all for the local public structures which have to face this issue in order to guarantee opportunities to the autonomous elderly people, and assistance to non-autonomous people and their families. The Welfare and Inclusion Department of the City of Parma has analyzed elderly population needs on its territory and has decided upon a series of priorities, according to a new definition of Welfare which guarantees a personalized care service and an active and involved community. The specifically identified priorities are:

- To reach a consolidation and widening of the range of assistance services from which people benefit by keeping their autonomy;
- To qualify and innovate the social assistance and social health services;
- To guarantee economic sustainability of services.

The purpose of all this is to improve social and everyday life, helping the well being of assisted people and of care givers, guaranteeing a continuity of assistance services and promoting an active community. To reach these objectives the City of Parma has planned a local system of Welfare which includes diversified and articulated services, which is extremely accessible and supported by a resource management system which is flexible and varied, and by a series of organizations which are able to adapt to changes made indispensable by the rise of a need for newer and newer services. Such a system makes it possible to respond in an innovative way, targeting various requests from people who often have manifold and highly variable needs. The elderly who are not self-sufficient and living within the City boundaries can count on a network of integrated services, as shown in Figure 2:



Source: Welfare and Inclusion Department of the City of Parma

Fig.2 – The network of services for non-autonomous elderly people present in the City of Parma.

The City acts in synergy with private institutions and other subjects operating in the field of personal care through accreditation. This model of management, in vigor from April 1st 2001 to March 31st 2011, is based on a philosophy which places the person in center of action. The assisted person therefore becomes someone who participates in and is aware of their own social life and of their own care plan and chooses the services from which they can benefit. On the other hand, the methodology of accreditation is a positive input to improve the quality of services through a path of participation and sharing of responsibilities in all the phases of service. The cost of service is established by the City Administration and is the same for everyone.

The at home assistance service

Among the various categories of people in situations of special need, the City's at home assistance service is designed mainly for citizen over age 65 and for all those citizens who are not self-sufficient due to pathologies of the geriatric type. The service makes it possible to give targeted assistance which tends to prevent social isolation and exclusion, and to promote autonomy of the individual. At home assistance care, moreover, makes it possible to tutor the physical, psychological and relational conditions of the elderly through a series of care services which differ in type and complexity of assistance (this aspect is determined by the minimum amount of time needed to complete the service, by the number of operators necessary and by the modalities of service). The services from which citizen can benefit are:

- Personal Care (for example help in getting in and out of bed);
- House cleaning;
- Meal service and eating assistance;
- Accompaniment and running of errands;
- Socialization activities;
- Seaside vacationing.

The cost of each service is determined by the hourly rate of the company employing the operators; the average annual cost of the vehicle used; the operator travel expense; the cost of a team. The citizens contributes to the total expenditure for the service according to their own income, with a variable quota from zero up to a maximum of € 7.00 for a call at home, and € 8.40 for multiple calls (for citizens in the 6th range of income - over € 619.75). There is a total exemption for citizens who are in the 1st income range (up to € 335.70).

Service package

A service package is a group of different and flexible services which are requested from providers in case of fragile elderly people, and in the case of recreational and socializing activities and vacation therapy. The service package projects are built on the basis of specific target needs of users and are flexible on the basis of the specific needs of the assisted people and their families. The various packages are organized by the Social Services in collaboration with users and are managed in a flexible and responsible way by the provider, who takes total charge of services. Providers receive a standard monthly allotment for the packages, which makes it possible to deal with any unforeseen care services aside from those normally contemplated. Service is assured 24 hours a day, 365 days a year and is organized in such a way that it can be activated even in 24-48 hours, according to the need, and with no waiting list. In the year 2009, 1,841 users were enrolled in the program.

1.4 Other forms of accreditation in Parma

The availability of services offered through the accreditation system has already started in various departments of the City of Parma, such as the social services and assistance environment, in

sectors such as prevention, in promotion of well being and socialization, for example in the case of the “Well being in motion. Over 55 sports project” package offer, which consist of a series of movement activities guaranteed through accreditation of the providers managing the courses. Further experiences of accreditation by the City of Parma in the field of care services and at home support are the “Tagesmutter” project and the at home assistance for disabled people.

1.4.1 The “Tagesmutter” project

The City of Parma has given attention also to the new needs of working mothers and of new families, developing a system of accreditation of organizations supplying home assistance to minors which is similar to that required for home assistance for elderly and adults that are not completely autonomous because of pathologies of the geriatric type. With the Tagesmutter project the City Administration aims to promote active participation of suppliers and families in the field of development and programming of a **childcare service** which satisfies a social need of the population while creating at the same time a regulated social market to which citizens can resort. They can have a freedom of choice, granted that the utmost care and attention to the quality level of care service of the services offered by the accredited suppliers is in place. To guarantee and protect the quality of the offer in the Tagesmutter service, a specific **Register of Accredited Providers** is created. Accreditation becomes a tool chosen by the City Administration and has the following aims:

- To guarantee citizens free choice in selecting and using the service within a program of coordination of their own work time, caring time and family education;
- To expand and qualify the services offered, guaranteeing equal access to systems to all citizens;
- To increase the value and to develop the community resources orienting them toward a continuous qualification of the services offered and to the best possible level of satisfaction of the families.

More particularly, the finalities which the project wishes to achieve are:

- To engage the different parties with related interests in a relationship, on one side to satisfy the need to find assistance and care for their children, and on the other side, to find occupation while taking into consideration the different needs of women and of the families;
- To identify types of care open to the responsible initiative of professional female operators able to guarantee specific services to parents;
- To guarantee adequate and trustworthy service with characteristics of quality and professionalism which can be verified through valid tools;
- To promote a new model of service which has the organizational characteristics of flexibility (in the sense that it can be supplied with timing and modalities which respond to user needs), affordability (in that it is sustainable for the user families and less costly for Public Assistance), and transparency (from the point of view of documentation of costs and under the profile of quality verifiable through the operative conditions and the modalities of service);
- To guarantee and develop the quality of the supplier and the efficiency of the service through a qualified competition between the potential providers in full respect of the principle of equal opportunity;

- To simplify the organizational procedures in full respect of the rule of transparency, of streamlined service and of administrative functionality in order not to complicate the duties of users.

From January 2011 to December 2011, the project will include the issuing of economic benefits in the form of vouchers (service coupons) which are given by the City to families who meet certain prerequisites. Vouchers can be spent exclusively at accredited suppliers of the Tagesmutter service. The paradigms are similar.

1.4.2 Home assistance for adults and disabled people

The At Home Care Service is part of the basic social services.

It constitutes the primary and fundamental expression of the care service on the territory for protection of health and well being of disabled people who are not autonomous, and a secondary perspective of rehabilitation and prevention. It helps the personal autonomy of disabled people and the permanence at one's own home through care services of help, personal care, and house keeping. The care services privilege mostly the field of everyday life and home life, and are intended to be actions aimed at reaching objective and results with regards to the best possible well being of the person, within personalized projects.

The type of at home care services are varied:

- Personal care (help getting up, daily hygiene, bathing, help getting in bed, moving) and house keeping care
- Food service (supplying food and assistance in eating meals);
- Accompaniment and running of errands;
- Socializing activities.

Such care services are supplied exclusively by accredited subjects: those who are entitled to offering at home care assistance services following a procedure to verify that they possess the requisites defined by the City to guarantee the quality level. The social worker to whom the assistance request is made defines an agreement plan with the disabled persons and/or their family to take care of objectives and to suggest care services. When the agreement plan is stipulated this generates a "Service Coupon", a valid tool for the acquisition of assistance services with the suppliers chosen by the disabled person.

A service contract is stipulated between the user and the chosen provider. The latter will send a copy of the contract to the Disability Agency of the City of Parma which will activate to meet the chosen provider to deepen and to share the assistance project, and to agree on the time frame and the tools to verify the process and the result. The beneficiaries of the services are adult disabled people (age 18-64) who are residents of the City of Parma and have scarce or no family support, or families with serious impediments in giving the necessary care to the person with severe disability. Care services in favor of disabled adults (age 18-64) are free of charge.

Following a signaling of a need on the part of a citizen, an appointment is scheduled within a 45 day period and a first interview is made. Situations with adults coming from difficult hospital dismissals with severely compromised health, complex levels of assistance and adults with social



and health risks have a priority, and consequently the urgency code is activated. The maximum amount of time which lapses between the first interview and the activation of system is 30 days.

1.4.3 The “Staying Home With Support” project

The “Staying at Home with Support” project is designed for families who have children with disabilities, of ages between birth and the end of mandatory education. Within this project, among the various care services, there is a “Daily Family Support” which includes social, educational and assistance operators according to the different domiciliary help needs. This is aimed at giving the parent some relief and a break from the daily care of one’s child. This support is assured by the presence of operators employed by suppliers accredited by the City of Parma in a specific training process. The time lapse from making a request to the project referent person or the social worker of one’s area to the agreement on possible support actions is 20 days.

For this reason, in the next chapter we will deal with the model of accreditation for elderly people, since the characteristic can be generalized for the targets for minors and disabled persons (with the exception of small differences due to the different reference target).

2. ACCREDITATION IN PARMA: CHARACTERISTICS, FINALITIES AND WORKINGS

The At Home Care Service is a part of the basic Social Service. It represents the primary and most important expression of the care services performed on the territory to safeguard the health and well being of individuals who lack self-sufficiency. Actions favor the range of everyday life and household needs; they are not to be considered as a sum of services, but as actions which are coherent with reaching purposes and results to insure the best possible level of well being for the person within a personalized plan. The general objectives of the service are:

- To protect good physical conditions, giving particular attention to movement autonomy, to sensory ability and to degenerative pathological disorders;
- To promote individual autonomy, especially with regard to personal and house needs;
- To prevent social isolation and exclusion, also through caring for social and affective relationships.

Care services and services in favor of elderly people inside assisted living structures (housing communities and living structures with assistance services) are to be considered excluded from the present rules and regulations for managing the at home care field, since they evidently represent a different solution with a different kind of approach to assistance. Moreover, as indicated by regional law L.R. 5/94 and later on by law L.R. n. 2/2003, Cities and AUSL units are in charge of coordinating and issuing care services in a way that encourages the maximum coordination between the social and health services for the elderly. The Integrated Domestic Assistance (A.D.I.) belongs to this context and consists in the combination of various social assistance and sanitary actions which are provided at the home of elderly people who are not self-sufficient, usually to support the family in caring for them. This is done through providers which are authorized by the City after verification of the necessary requirements to carry on the service. The City administration, in order to comply with its role in this matter, considers the accreditation system as a tool to furnish services through the authorizing of third parties, to allow them to supply at home services to people who are not self-sufficient who reside in the City of Parma.

2.1 Definition of Accreditation system

“Accreditation” is a unit, a management model of the at home assistance Service which is designed for reliant, non-autonomous people, which is aimed at regulating a correct and efficient cooperation between public subjects and private suppliers and issuers of domiciliary services to users requesting them through precise rules. In particular, the finalities which this model pursues are:

1. To place the figure and role of the individual user at the center, in the light of their specific needs and with respect to their care plan and of their autonomous abilities to choose their caregivers. The user will be able to operate on the basis of the level of satisfaction received from the care service which the local Institution, in any case, organizes together with their structures;

2. To guarantee a high level of service quality offered to the citizens and users;
3. To guarantee and develop the quality of suppliers and the efficiency of care services through a qualified competition between possible suppliers in full respect of equal opportunities rules;
4. To optimize and coordinate the service network resources with special reference to correct integration of social health;
5. To improve and develop community resources oriented to satisfy the needs of citizens;
6. To have homogeneous management modalities for at home assistance services on the City territory;
7. To have homogeneous modalities for evaluation and checking.

2.2 Reference laws

The managing tool of “accreditation” is not ruled by a single normative contained in a single act issued by a single institutional level. A large part of the disciplinary regulation, which has a higher level of operational directions, is contained in regional sources and in deliberations of the City Council. In general, the normative sources which support the situation underlining the management model in question are the following:

- T.U. 18.August.2000 n. 267;
- D.P.C.M. 19 May 1995 “General Reference Scheme of reference for the public health services Chart”;
- D.Lgvo 31 March 1998, n. 112 “Conferring of administrative functions and duties by the State to Regions and local institutions, in respect of chapter I of law L. 15 March 1997, n. 59”;
- Basic document written by the Social Quality Group of the Ministry of Social Solidarity in 1999;
- Law system for implementation of an integrated system of care services and social services n. 328 of 8 November 2000;
- Regional Law of Emilia Romagna 12 October 1998, n. 34;
- D.P.R. 3 May 2001 n. 204 “National Plan of care services and of social services 2001 – 2003”;
- D.P.C.M. 30 March 2001 “Act of address and coordination on the system of entrusting services to the persons based on article 5 L.328/2000”;
- Regional Law of Emilia Romagna 3 February 1994 n.5 “Tutelage and support of elderly people – in favor of elderly people who lack autonomy”;
- Regional Law of Emilia Romagna 12 March 2003 n. 2 “Norms for promoting social citizenship and to implement an integrated system of social services and care services”;
- Regional Council Deliberation 16.04.2007 n. 509, “Regional Fund for lack of self-sufficiency – program to start in 2007 and to develop in 2007 – 2009 three year program”;
- Regional Council Deliberation 30.07.2007 n. 1206, “Regional Fund for lack of self-sufficiency. Implementation address and directives to apply law G.R. 509/2007”.
- Deliberation of the Regional Council of Emilia Romagna 29 May 2007 n. 772 “Approval of the criteria , of guidelines and of the list of services needed to activate the process of accreditation in the social and social health fields.

An important reference document to define the system of accreditation in Parma is the **Attachment to Parma City Council n. 180 del 26.02.2009**.

2.3 The parties involved

The system of accreditation, in the light of a plurality of parties involved, can be considered a system tending to develop a virtuous network in the territorial context of belonging, in order to:

- Develop the central role of the figure and activity of users and citizens in the light of their specific needs, in the scope of their assistance care plan and of their ability to autonomously determine the choice of providers, which will be able to operate also on the basis of the measure of satisfaction of such needs received from the service, with whom the local institutions cooperates in the organization and in the structuring;
- To guarantee a high level of quality of the services offered to citizens utilizing them;
- To guarantee and develop the quality of suppliers and the efficiency of care services through the presence of qualified competition between the possible suppliers, in full respect of equal opportunity rules;
- To promote the optimization and coordination of resources in the service network in particular with reference to a practical social health integration;
- To promote the value and development of community resources oriented to the highest satisfaction of citizen's needs;
- To guarantee homogeneous modalities in the management of services of at home assisted care on the territory of the City;
- To implement homogenous modalities for evaluation and quality control.

2.3.1 Users: individuals receiving services

The typology of subjects who potentially can be included in the category of service users is a diversified one. The principal categories of utilize can be found in contexts where it is necessary to have assistance furnished to subjects who are partially or completely reliant by suppliers who are external to the families to which they belong in a wide sense (parents, children, siblings, relatives in general). As an hypothesis, we can consider individuals affected by pathologies which are more or less temporary or permanent, like elderly people and adults lacking autonomy, and users with more or less severe disabilities; moreover, modern western society is characterized more and more by a dynamic aspect, by a precariousness and a complexity which demolish the timeframes and roles which once were consolidated in families and leads to develop a series of services to assist the families which target the minors. The accreditation system is structured to make the users (and their possible families of origin) free to choose a supplier to contact for the actual services of domiciliary assistance.

The Attachment to Parma City Council n. 180 del 26.02.2009, in its rules and regulations handout n.5 outlines three great categories of service beneficiaries:

1. Elderly people and adults with lack of autonomy because of pathologies equivalent to geriatric problems with an adequate family and friends network
2. Elderly people and adults with lack of autonomy because of pathologies equivalent to geriatric problems without an adequate family and friends network, but who are capable of making decisions for themselves.
3. Elderly people and adults with lack of autonomy because of pathologies equivalent to geriatric problems who are alone and that even though not declared incapacitated by law, have limited autonomy or elderly who have a reference family nucleus, but their family is not in condition to chose a care giver autonomously.

The courses of action are as follows:

1. **The first case is contemplated in following paragraph 2.3.2.**
2. **Elderly people and adults with lack of autonomy because of pathologies equivalent to geriatric problems without an adequate family and friends network, but who are capable of making decisions for themselves.**

These are elderly people who can make an autonomous choice with respect to choosing a supplier, even though they live alone and do not have direct relatives who take care of them. In this case it is the Social Worker responsible for the case who, without taking the place of the elderly, helps and supports them, aiding them in the choice. For this type of elderly people, a light responsibility is involved, in the measure of their abilities and level of autonomy. In some situations where there are direct relatives as for example grandchildren, who are not obliged to give economic support, but are present anyway with a role of vigilance, or next door neighbors or friends who take care of the elderly person, it is necessary to involve them and motivate them to aid a choice. In other situations, all belonging to this category group, but more at risk as far as the social network and daily life autonomy, the neighborhood Social Services for the Adults, the Minors and the Elderly takes the role of intermediary and represents the elderly in all of those actions that for various reason they are not able to carry on their own. In any case, the Social Worker presiding to the care plan will decide in each case when to delegate the care services to a supplier (for example, it may be opportune not to delegate to a third party accompanying an elderly person to a medical appointment or to diagnose important health problems).

- 3 **Elderly people and adults with lack of autonomy because of pathologies equivalent to geriatric problems who are alone and that even though not declared incapacitated by law, have limited autonomy or elderly who have a reference family nucleus, but their family is not in condition to chose a care giver autonomously.**

All of the elderly who are under the direct vigilance and care of the Social Services of the City belong to this category and can benefit, as far as choosing a provider is concerned, from a specially appointed Ethical Commission. We are referring to elderly people with psychiatric conditions which are more or less rooted, and an anomalous lifestyle; to elderly people who are so called "social cases" because of poverty and exclusion; to elderly alcoholics or those who depend on substances affecting the psyche; to elderly with disabling physical pathologies

and scarce cognitive abilities. The Social Services must necessarily take a role of “heavy” responsibility: the Social Worker responsible for the case, though having to distinguish in a clear way the evaluation of a need from the direct supplying of a service, strongly determines the acceptance of contract on the part of the supplier and the strategies of relationship with the user.

2.3.2 Relatives of users

The family of origin and the network of relatives in general play a very important role in the system providing at home assistance service. Evidently it is very likely that from the point of view of the final user, assistance is perceived as optimal if the care givers are their direct relatives. One of the actual critical elements of the care service of external assistants consists first of all in the impact and in the effort to adapt to the presence of a figure who does not belong to the family. Nonetheless, even in the case of the use of accredited care givers, the contribution given by the relative’s network turns out to be important and it improves services by making them more effective and less invasive. If the category of beneficiaries is made of **Elderly people and adults with lack of autonomy because of pathologies equivalent to geriatric problems with an adequate family and friends network** the family represents the central aspect of the care plan and it is the competent party for dialoguing both with the Social Services and with the supplier of care services and services. The elderly and his family have the possibility to choose the supplier from which they receive services, and are helped in the choice by a town service which is the mediator in a neutral position, without renouncing to a leading role in the market of opportunities. This leading role is expressed mainly in giving the family ample information about the Agencies who are on the market, on the requisites they have allowed them to be certified as quality suppliers, on the verification functions and the control functions operated by the City.

2.3.3 Public Institutions

The subject at the center of the management and supply of at home assistance services system is represented by the public administration to which users refer, according to the principle of subsidiary help. In the case of the City of Parma , the administration is the promoter, the manager and the warrant of the good working of the entire system through the paradigm of “**Accreditation**” which was created, experimented and implemented by the City itself. The objective is to give final users a service which is safe and whose quality is certified. To reach this objective, the City has a direct role in administration, verification, vigilance and control.

In its substance, the functioning structure is characterized by the following:

- citizens have the possibility to **CHOOSE** whether to purchase the care services in a private way, contacting the supplier directly, who will activate proposing the care services at the same price as the subsidized care services purchased through the City, or whether to contact the local Social Services for an evaluation of their situation,
- in the case that a citizen decide to refer to the local Social Services, a **PAI** is set up and shared by the citizen and the Service, and **SERVICE COUPONS** are issued: this is a personalized economic contribution to the project in favor of citizens who benefit from assistance care services. The following people can benefit from service coupons:

- Elderly people over 65 and adults who lack autonomy because of pathologies equivalent to the geriatric problems, who are residents in the City territory, and authorized by the Service for Adults, Minors and Elderly People to purchase services at “**legitimate**” suppliers;
 - Elderly people over 65 and adults who lack autonomy because of pathologies equivalent to the geriatric problems, who, having agreed on a personalized care plan with the Service for Adults, Minors and Elderly People and on a contract scheme set up by the same service, must contact and chose on their own autonomously one of the “**legitimate**” suppliers **listed in the Register**, in order to determine and sign a contract concerning the care services which they will receive in order to implement the care plan.
- The suppliers are **LEGITIMATED** (by “**ACCREDITATION**”) through their inclusion to a specific **REGISTER** created by the City of Parma: care services concerning the at home assistance service, authorized and supported through the **service coupons**, must be supplied exclusively by subjects who, on demand, are **legitimated** by recognition of predefined requisites and conditions, to warrant the potential quality level of the services that these can offer. These **legitimate** subjects are “**accredited**” through a validation procedure and can offer services and at home assistance. They are recognized by the **inscription to the special Register of suppliers** which is kept by the City administration.
 - A specific **EVALUATION COMMITTEE** is created to insure suppliers possess necessary requisites and are legitimate: a special Committee nominated by the City Council provides to evaluate the legitimation requests of all interested parties and to verify they possess requisites and quality and quantity standards required, as well as insuring their presence throughout all of the “accreditation” period. The Committee is composed by:
 - The Director of Social Services, who acts as the President;
 - The person in charge of the Adults, Minors and Elderly People Service;
 - The General Secretary or a person delegated by them.
 - The nomination of an **ETHICAL COMMITTEE** which will act as a tutor and will aid in the choice of a service supplier for at home assistance services in all of those situations where the elderly person, thug not being declared unable to decide by the law, has limited autonomy and it is alone and lacking support of a family and/or friends network to which they can refer. The Committee is formed by:
 - 1 geriatric doctor;
 - 1 social worker;
 - 1 person responsible for assistance activities.
 - **VERIFICATION AND CONTROL** which take place through monitoring reports and an eventual redefinition of PAI, through the gathering and monitoring of reports, the evaluation of perceived quality, which are all obtained through the local Social Services. The PAI verifications are made at the people’s domicile by a team, at meetings with the Referent person for the accredited supplier, and by direct control of the activities scheduled. The supplier is asked to: give a documentation of services, schedule weekly team meetings, do training of personnel, do self evaluation tests.

In conclusion:

1. The City Administration promotes the quality of life and the citizen chip rights through an integrated system of services. The integrated system encourages action synergy between all of the formal and informal community resources (social health services, health services and hospitals, volunteer workers, associations, etc.)
2. The City Administration guarantees the evaluation of a request for assistance and the actualization and verification of an assistance project through its own territorial services.
3. In order to encourage a larger use of services in time, the Administration promotes information campaign aimed at citizens.
4. The Adults, Minors and Elderly People Services of the City guarantee that elderly people and adults lacking autonomy because of pathologies equivalent to geriatric problems are recognized the right to be the protagonists participating actively to the structuring of their care plan and recognizing them the right to choose the supplier for their assistance services.
5. The City takes on itself the duty of protecting and aiding in the choice of an “accredited” supplier in all of those cases in which the citizen and/or their family are not in the conditions to act directly.
6. The **verifications and controls** happen according to what has been said above.

2.3.4 Care Givers and Organizations to which they belong

In order to reach the objectives specified above, the City of Parma has chosen the method of “accreditation” as the most important tool involving the private sector in order to manage and to actively furnish the necessary care services in an effective and efficient way. Elderly people over 65 and adults who lack autonomy because of pathologies equivalent to the geriatric problems who are residents of Parma, can choose the supplier who suits their needs best among those who are legitimate and listed in the specific Register which is kept by the City Administration.

All subjects (**profit and no-profit**) can be “**accredited**” granted they possess specific prerequisites and that are not in one of the conditions causing exclusion, and granted they declare to possess or to take upon themselves all of the obligations described in part “B” of the Attachment to the Deliberation of City Council Committee n. 180 del 26.02.2009 among the requisites indicated by law DGR 514/2009. These subjects must present a project in which the criteria of service quality are made clear, as well as the aspects and areas of improvement of care services in relation to the personalized assistance project (for example, a longer time span, more frequent services, use of support material, services like grocery shopping and accompanying on errands, etc.). Every subject aspiring to the “legitimate” can obtain accreditation on an individual basis or, as an alternative, as the component of a group or of a temporary grouping of companies, which is constituted according to the law.

Subjects aspiring to being “accredited”, besides showing a precise intention to cooperate to improve care services in favor of elderly people must possess the following **requirements**, as to guarantee the quality of services they intend to provide:

- **MUST BE REGISTERED WITH THE LOCAL CHAMBER OF COMMERCE, INDUSTRY, PROFESSIONAL TRADE AND AGRICULTURE;**

- **MUST HAVE AN ADEQUATE FINANCIAL AND ECONOMIC CAPACITY: A FINANCIAL SIZE SUITABLE AND APT WITH RESPECT TO THE SERVICES THAT THEY INTEND TO GIVE;**

- **EXPERIENCE:** direct experience in management of services of at home assistance in relations to Private or Public Institutions with the ability to issue supply services to an average monthly number of citizens and users (elderly people over 65 years of age and adults who lack autonomy because of pathologies equivalent to geriatric ones) calculated on the basis of a special procedure;

- **ORGANIZATION AND COMPANY SOLIDITY:**
 - a) **Income:** total income must not be inferior to a given value;
 - b) **Observance of CCNL rules:** must have applied integrally and fully the National Collective Contracts in vigor to employees and associates in all the various sectors for which the subjects who are requesting “accreditation” have operated. This, with special attention to minimum contract wages deriving by the same rules and to the correct applications of the normative on salaries, retirement fund contributions and insurance which rule the working relationships in this category.
 - c) **Human Resources.** In a certain period of time, they must have had a number of operators dedicated to basic assistance in the elderly people services which is at least equal to a percentage calculated on the basis of a specific formula.
 - d) **Meal Services:** they must be able to supply meals at the elderly people’s homes. The meals must be prepared, packaged and transported in full respect of all of the dispositions of the law regarding hygiene or relating to the service itself in any case, including those regulations issued after the “accreditation” of the supplier.
 - e) **Availability of Projects:** specific projects listed in point VI, built on a clear spirito f cooperation with the Institutions, to improve the care services in favor of elderly people and finalized to respond to the various particular conditions and needs of users.
 - f) **The actual availability or the acquisition within five days** from the date of communication of being declared legitimate of tools, goods and support services: this is asked to guarantee the quality of the service itself.
 - g) **Commitment** to supply quantity and quality services and to respect the clauses and conditions of services according to a specific scheme of procedures.
 - h) **Committment** to supply quantity and quality services in full respect of precise prices.
 - i) **Quantity of guaranteed care services:** to be able to supply a specific bulk quantity of services.

- **PURCHASING OF AN INSURANCE POLICY** against the risk of civil liability for damage to persons of things as a consequence of service activities.

Lack of above mentioned requirements implies exclusion from the admission procedure to the “accreditation” procedure, and to cancellation from the Register listing. The following situations will also cause exclusion from the accreditation procedure and from the Register:

- a) Conditions described by Article 38 del D.lgs 163/2006 and following modifications and text integrations.
- b) Actions causing prohibitions, decadence form status, or suspension according to what stated in the anti-mafia normative in vigor.
- c) Failing to present complete documentation, ore missing required certificates or acts which are complete and adequate in all of theirs parts to the conditions here indicated, with the exception of the possibility to integrate or to complete the documentation
- d) The validation Committee evaluates other factors which can exclude subjects fro the Register, in reference to what is indicated in this organizational project.

A different set of forms is required to be listed in the Register of Suppliers.

2.4 Procedures to access services

As mentioned earlier, in this paragraph we will deal with the procedure to access the at home assistance services supplied by “accredited” suppliers and designed for elderly people or adults who lack autonomy due to pathological conditions equivalent of geriatric condition. Clearly, the procedure is analogous to what concerns other targets of users involved in the accreditation system. What changes are some peculiar aspects of differentiation (for example, the City structure of reference).

In order to access the at home assistance services, citizens must contact the Elderly People Services of the City to obtain an **Personalized Care Plan (PAI)**.

The Personalized Care Plan (PAI) is written by the social worker responsible for the case and by the person in charge of the Assistance activities of the Elderly People Services of the City, thorough a multifaceted evaluation (~~VMD~~) of the elderly person, asking the opinion of the general medicine doctor (the doctor of the person requesting the service), involving, if necessary, other professionals (for example, the professional nurse, the rehab therapist, the mental health services) and availing themselves of the support of the Geriatric Evaluation Unit (UVG).

The Personalized Care Plan (PAI) highlights the autonomy and independence of the person, the principal problems reported, the risks related to these and the objectives to pursue through the activation of services. Then it indicates the type of services and care services that the elderly person needs (type, quantity, frequency). Based on the PAI, the elderly person will receive a voucher from the City, to purchase the services from a panel of suppliers who are accredited with the City Administration: the panel is a list of accredited suppliers with their respective data and a presentation of services.

The citizens, with their PAI and their vouchers, choose their providers freely and directly, and stipulate with them a contract which must observe the rules imposed by the City Administration mandatorily.

The citizen, granted the minimum standards of quantity and quality of social assistance services that the provider must supply, can receive, at the provider’s discretion, further additional care services of betterment, in a philosophy to develop the quality towards which the process is oriented. The element of competition between providers comes into play in this aspect.



The citizen can also request the accredited provider further additional care services aside those authorized by the Elderly People Services of the City, including improvements of services given by the accredited provider of choice, and whose costs are not included in the voucher and therefore are totally in charge of the citizen.

Whenever the person registers differences between the chart of services of the provider and the modalities of the assistance care service, he/she can report it to the social worker responsible for the case who will provide to inform the Director of Service who will evaluate the possibility to communicate a possible contestation to the service provider.

The citizens who own a voucher can change provider on their own discretion. In this case, they are obliged to communicate the change both to the provider and to the Adults, Minors and Elderly People Services with a seven working days notice, and the latter will issue a substitute voucher to spend at another provider.

All citizens receiving a voucher are requested a quota of participation to the costs of services based on income: this ranges from the first income range (up to €335,70) which is completely free of cost, to the sixth range (income over €619,75) which is required to contribute €7,00 for each domiciliary assistance care service and 8,40 for multiple care services.

It is possible that there are cases in which the elderly person or the family are not able to or are not in the conditions to autonomously access the service: participating to PAI, managing the vouchers and choosing the best and more advantageous supplier.

In this cases, as mentioned in previous paragraphs, a special Ethical Committee has been appointed by the City Council and it provides to take upon itself the duty to protect and assist the elderly person, who may not be declared incapable of action by law but may have limited autonomy and may be alone and without a family and/or friendship network, in choosing a provider for at home assistance services.

The Committee is composed by external members:

- 1 geriatric doctor
- 1 social worker
- 1 person in charge of assistance activities

The family doctor of the elderly is invited to take part to the Committee's meetings, together with the social worker responsible for the case.

Citizens residing in Parma or persons here domiciled who consider purchasing autonomously and entirely at their own expense the at home assistance services necessary to satisfy their request can also resort to providers accredited by the City Administration (citizens who are not entitled to vouchers).

They can contact accredited providers directly and these must provide the services at the same price they agreed upon when requesting to be accredited, keeping the same standards of quality and quantity of care services they submitted with application. In this case, the citizen contacts the accredited provider directly to request a chart illustrating the services.

Citizens who do not possess vouchers make an agreement for a personalized service and undersign a contract with the accredited provider. In the contracts the following are indicated: objectives, operators involved and their functions, total duration of program, activities included,

frequency of care services, the monthly cost estimate and the obligation for the provider to give immediate communication of any eventual radiation from the Register.

The citizens who do not benefit from vouchers, moreover, has a right to receive the information Chart about City services for the elderly, where are explained the functioning, the modalities of acceptance of assistance requests and the services offered. In such case, the provider is considered a partner in a service network and has an important role of information source for these services.

It must be noted that with the Regional Committee Deliberation 514/2009 “First implementation provision of the regional committee of article 23 of regional law 4/08 in matter of accreditation of social health services”, the region of Emilia Romagna systematically starts procedures in order to identify through accreditation the services and the social health structures required to cover the need expressed in the territorial programming. Also, this is done in order to allow a public service relationship between the subjects who are entitled to services of social health and the subject providers/suppliers of services, after the completion of procedures to demonstrate that the providers have the quality requirements to performs and supply the services. These relationships are regulated through a specific service contract.

Within these guidelines of reorganization of services the experience which has already started in the City of Parma, and which has a very detailed structuring, has a wider recognition and place.

The Social and Health Plan of the Emilia Romagna region for 2008-2010 inserts the process of accreditation in the policies of the new local welfare, which aim to accomplish a building process for the integrated local system of networking services. This is represented by a double integration between public and private subjects (in full respect of the programming functions, of commission, management and productions traceable to the different parties of the system), and by integration between sanitary competencies and social competencies.

Accreditation embodies a new modality of relationship between public and private subjects: the first are entitled to the function of programming and of commissioning, to which the third sector takes part as indicated by article 20 of regional law 2/2003, and the latter are called to respond to the need of public subjects to rely on service providers who have a specific technical and professional competence, organizational and entrepreneurial competence qualified on the basis of criteria and requisites which are certified through the system of accreditation. In such a way, private subjects enter fully into the dynamics of building the local welfare.

The DGR 514/09 indicates the type of care services and of social health services whose function is subordinate to this ruling and to the granting of an accreditation and in particular:

- At home assistance
- Assisted living for elderly with lack of autonomy (which includes the nursing homes and the RSA)
- Assisted Day care centers for the elderly
- Residential Social Rehabilitation center for disabled people
- Semi-Residential Social Rehabilitation center for disabled people

3. THE EUROPEAN ASPECTS

Though European analyses indicate that this is a generalized situation, in European Countries who are ProDomo partners (described shortly in the preface), the at home services are acquiring more and more importance on a social and economic level and everywhere they are being defined more and more as “services to the persons”. The development of the field is linked to factors as: prolonging of life span, increase of female occupation, lifestyles and family structuring, a search for balance between family and professional life, etc. Such social, economic and political changes determine new behaviors of the institutions and require new services to respond in a better way to the new needs of the population. The at home services include house keeping, help for elderly and disabled persons, child care. They have all a common characteristic: they take place at the person’s home and these, from a work request point of view, are considered to be “employers”, unless they request services to public or private organizations in the field. The training needs for such forms of employment and the actual performance of services indicate that it is necessary to bring about a re-evaluation of the condition of employment of the autonomous workers in this field, as well as that it is necessary to make an effort to achieve better qualification which is considered indispensable to give the users some guarantees.

In the previous chapter the system of qualified management of at home assistance services to people in need developed in the City of Parma has been outlined.

Following the phases of the ProDomo project, starting from the positive experience shown by the project, an analysis has been conducted of some European contexts to verify the characteristics of the different systems functioning in the various realities and to evaluate the presence of innovative elements to share with the partners from other Countries who take part in the project.

3.1 A comparison of contexts: emerging elements of singularity

In the second phase of the PRO-DOMO (Wp2) project a research has been conducted for every context of the partner Country to evidence the structural and organizational characteristics of the single systems of social care. In all of the experiences that have been considered, the existence and value of at home care systems, in particular for needy elderly, has emerged. The comparative analysis has defined aspects of interesting comparison. Among these common elements in different contexts have been registered and opportune modalities of sharing this data can be considered. From a comparative study of at home assistance services in Spain, Germany, Hungary, Slovenia, Great Britain, and a comparison with the Parma experience, it emerges that in all these countries there are accrediting services for service providers, more or less advanced and with various modalities and parties.

The Parma model nonetheless stands out for these elements:

- **Competitiveness and optimization of provider quality**
- **Absence of waiting lists**

The evidence of these particular traits, developed in the next paragraphs, generates the birth of the need to write and elaborate these guidelines, in order to make the modalities of the

accreditation system in Parma more easily understood. Since it is characterized by these peculiar elements, this way it can be proposed and eventually made possible to start the proper procedures to apply the system to a different contexts than the City of Parma.

3.1.1 Competition, quality of suppliers and personalization of care services

As resulting from the comparative analyses, and especially in consideration of the specific procedure established by the City of Parma to access services (illustrated in previous chapter 2, paragraph 2.4) if on one hand this resembles the German model, where the citizen can choose between public and private insurance who then employ their own providers and if the person is not satisfied of service they can decide to change, so, the Parma model as well allows to choose and change provider, but with a further innovation. In the German model based on insurance, the competition between providers is based on the difference of prices on the market (a risk factor which can have consequences on the services), while in the Parma model it is the City who sets the price at the origin and the providers are in competition on the quality of services, on personalization and additional performances with respect to those indicated by the accreditation. In such sense, on one side, the logic of bidding contracts or of state management, still in use in other countries where citizens cannot choose or change providers, is overcome, while on the other hand quality and personalizing are promoted in a positive way, a key factor on which the British model is evolving.

3.1.2 Zero-reduction of waiting lists

Another very important aspect which characterizes the Parma model is the fact that the City of Parma is able to manage the requests of users to receive necessary services through zero-time waiting lists. This way the prompt answer to help needs shown by citizens makes it possible to receive programmed care services and services issued in their fullest usefulness and effectiveness. The factors contributing to eliminate waiting lists to access at home care services are most of all linked to political choices within which the organizational assets and the service settings are made. The City of Parma has chosen to support home services through the development of services of direct assistance to the person, through the presence of semi-residential structures, and the availability of economic support of various natures, and forms of remote assistance. The at home assistance receives an allotment of yearly **economic resources** which is conspicuous and sufficient to face the need for at home assistance received and evaluated through the Social Services. This makes it possible to answer calls by activating services within about a week, and sometimes even less. Management of at home assistance through the model of accreditation does not define a limit of spending in the definition of the relationship with the provider, as is the case when a service is entrusted to a sole provider (through bidding or convention of service), and this makes it so that the only limitation for timely response is the amount of resources destined to service by the related section of the Institutional Budget. Corresponding to this political orientation, there is a **territorial organization** made up a total of 20 social workers and 10 people in charge of Assistance activities divided into four territorial units for the Elderly Service to citizens over 65 residing in the City of Parma. These numbers, even considering the new trend of requests which is increasing, today make it possible to activate operators and services in a short time. Moreover, the possibility to have more providers makes it so that organization capacity is greater and allows a response to citizens' requests in rather short time. In the definition of the

relationship between the Public Institution and the provider, the necessity for the provider to **activate service within 5 days** of the setting up of the contract with the citizen has been clearly indicated. Such a contract is stipulated at the moment in which the citizen goes to the chosen provider with a copy of the service coupon authorized by the Director of the City Services.

3.2 The figure of “family assistant”: the Italian experience

Informal care living represents the central approach to the analyses and the development of the best management methods for the at home assistance services. The policies in favor of domicile service, common between all parties, together with the increase of life expectancy and with the diffusion of senility imply the permanence at home of elderly who need a high level of competent assistance from their families. Such competence – both technical and relational – definitely involves the psychological and social spheres of the individual. The comparative study has evidenced all of the professional figures which are involved in the process of providing care services, and indicate that in all European countries there is a tendency to conform in the training process. The parties which are involved the most in this sense are external subjects and internal subjects with respect to the families of the users. Research shows the diffusion of the figure of the external **Family Assistants**. These represent a node more and more consolidated in the net of services, but still slightly formalized. In this perspective it is natural to wonder about the best way to support informal care giving and to accredit the care givers at different levels. If it is legitimate to think that the Family Assistants can be trained, supported and evaluated through accreditation programs, it is also feasible that family members can be involved in training programs, tutoring and psychological support more and more structured and that, in this context, the acquired skills can be translated into “work credits” for positions in services to the persons outside of the family.

Even though the Family Assistant is not the only figure which exists exclusively in the context of providers of social and health services for people in need, the research done regularly in diversified contexts in the territories of partners countries involved in the project and its comparison shows the importance aspect that these represent. This common connotation of the system and its diffusion, which is more or less recent depending on the country considered, is proven by the evidence of critical factors which can be found in each social typology of the figure of the Family Assistant of that country. The profession of Family Assistant is indeed often covered by foreign immigrants who work as care givers. Such phenomenon is particularly common in Italy, Spain, Germany, and England, as a job often done by immigrants, while in Slovenia and Hungary if it is done by local women. The partners have identified in this target of workers a weak link, transversally in all levels of services from the training point of view, the juridical and working contract perspective and the social aspect. For example, the phenomenon of unreported “under the table” salaries which involves parties which are not properly trained is more or less diffused. These workers can be a useful resource to the various service models, in a perspective of personalization and active cooperation with the institutions, and therefore when they are properly trained and protected to prevent forms of exploitation and to allow them to emerge from irregular work situations.

3.3.1 Emilia-Romagna Region

The reference laws of the Emilia Romagna Region and the local social policies which refer to it aim at the development of at home residence of persons lacking autonomy also through the recognition and the training of family assistants. These are considered resources able to respond and manage problems from the assistance perspective and the social health and relational perspective. On the regional level, the **DGR 1206/2007** law has indicated guidelines to favor the qualification and standardization of the work of the family assistants and **DGR 924/2003** law has defined the opportunities and the criteria for training programs to support family assistance at home.

3.3.2 District of Parma

On a local level, within some **Area Plans**, a project for qualification of the work of family assistants has been developed. The project is inserted into Area Plans and destined to family assistants, to elderly who are partially or completely lacking autonomy, and to the families of the Parma District has the following objectives:

1. To qualify the home care work of family assistants through the acquisition of the necessary knowledge and skills.
2. To support the elderly and the family in the choice of at home care, through the family assistant to care for and respond to lack of autonomy, insuring economic, social assistance and health support.
3. To favor the social inclusion process of both the family assistants and the elderly that they assist.
4. To improve the information level and the feedback in support of families and of family assistants, aiding the communication between the request and the offer of work.

Among the actions included in the Area Plans in order to achieve objectives the most important are:

with respect to objective 1) :

- a. To project and implement structured and continuous training programs, using various methods and tools including long distance training, through the active involvement of the institutions and of parties included in this present project.
- b. To encourage participation in training programs through information and awareness campaigns aimed both at the families and at the family assistants, including a possible support to continuity of care at home of the elderly.

With respect to objective 2) :

- c. To monitor the use of the check for care support and of the social check as a means to support regularization of the contract relationships.

With respect to objective 3) :

- d. To project and promote moments of social inclusion aimed at family assistants and elderly assisted by them, also in an integrated way between services and volunteer work.

With respect to objective 4) :

- e. To survey opportunities of connection between demand and offer on the territory and to develop and project philosophy aimed at organizing a meeting point for coordination and management.

We note that the City of Parma has been giving counseling to families and family assistants in home care services for several years. The service offers information varied according to the different sectors of services at the home and/or at the headquarters of the local services. The at home tutoring actions are implemented through personnel of the City Administration (RAA) who operate in the local social services, and through operators belonging to cooperatives accredited for at home assistance within a project shared by the Social Services.

3.3.3 City of Parma

On the basis of the considerations and of the elements expressed above, the City of Parma, having taken note of the important changes in family systems and of the requests of citizens in particular with respect to the needs for care of persons lacking autonomy and disabled adults, with the **City Council Deliberation n. 717/2009** has defined as an experimental tool the **guidelines for the institution of a REGISTER OF FAMILY ASSISTANTS** and for the realization of a related **desk**.

The finalities of the institution of a Register deal with:

- Being able to give more protection to disabled persons and elderly lacking autonomy, guaranteeing they can remain at home in condition of best possible well being.
- Qualification of the care work with elderly and disabled persons.
- Helping families in finding family assistants who are competent and trained.
- Favoring legality of assistance work.

In order to be listed in the Register the following **general** requisites are needed:

- Being age 18 or older.
- Having graduated from mandatory school.
- Being an Italian citizen or a member of a European Union Country or having a regular permit of residence.
- Not having been convicted of crimes in the past, or being under trial for crimes

And the following **specific requirements**:

- Possessing technical and relational skills related to the assistance work attested by certificates of attendance of a training course of at least 30 hours or through working documented experience of at least a total of 120 hours.
- To have a good knowledge of Italian language, certified, for foreign citizens, by an attendance certificate for language course of by tests and interviews to be done at the service desk.
- Physicians certification to be fit for work.
- A questionnaire is required to be listed in the Register. This registers also the worker's availability concerning hours, preferred areas, types of user targets.

Listing can be:

Permanent:

if the person possesses a certificate from a training program stating that they have completed at least 120 hours in the field of assistance.

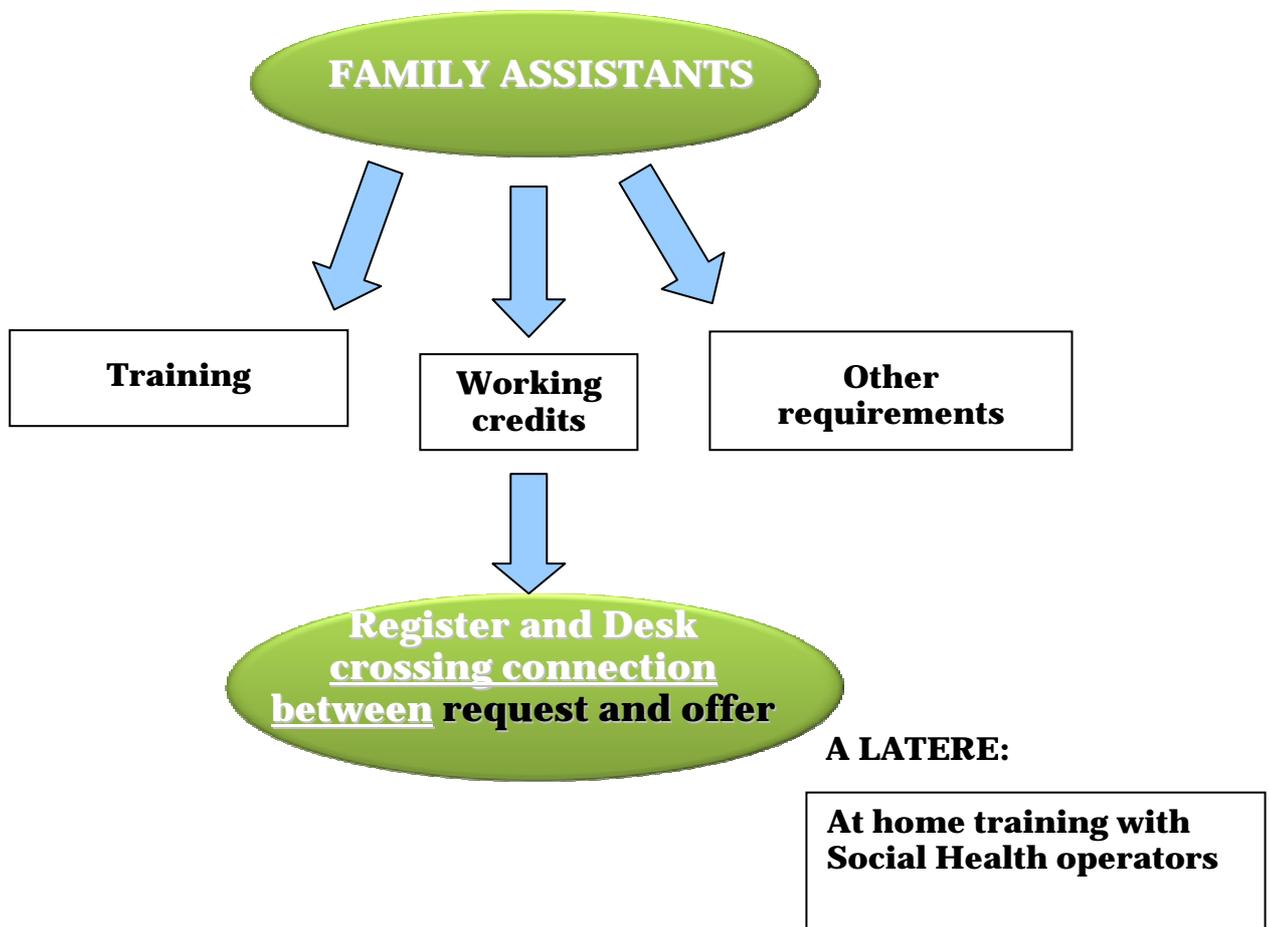
Temporary:

if the person possesses a certificate stating that they attended a 30 hour course or that they have a documented working activity of at least 120 hours in the field of assistance.

Subordinated:

If the person has a certificate stating they attended a training program for less than 30 hours or that they have a documented working activity of less than 120 hours in the field of assistance. The subordinate listing does not give immediate work opportunity but makes it possible to receive information on training activities related to the field of assistance work.

In the light of what has been said, the accreditation of Family Assistants of the City of Parma and of the Emilia Romagna Region which is at this time being introduced, shows itself to be a good practice and is particularly interesting for the PRO DOMO project.



4. Transferring of the System

AIMS

The aim of this section is to link the experiences, gained from the partners, about the potential to transfer the innovation of the Parma model, particularly with respect to the quality of home based care services provided by informal and unqualified care providers, with the aim of developing and managing their training and development of competences in health and social care.

Description of the activities:

Each partner hereby gives a summary of the potential for transferability of the model into practice into their countries.

UNITED KINGDOM

The UK experience, as outlined in their National report, can be analysed to show the following comparative elements with the Parma model features that might be applied for transferability of innovation:

- (1) **Adequate Educational Plan** – The sections in the report on the minimum standards for training and on the new QCF (**Qualifications and Credit Framework**) show that there are existing adequate educational plans in social care and that these are being currently improved. There is even a **Certificate in Personal Development & Learning for Unpaid Carers (City & Guilds)**. The sections on the new Skills Strategies show that there additional standards of excellence developed in the sector that could be rolled out to other parts of Europe or in an import of transferability from the UK to the other partners.
- (2) **Innovative and Qualified Services** - The sections on ‘Minimum standards’, ‘Shaping the Future’ and ‘Personalisation’ in the UK National Report, demonstrate how UK services have been reformed and the accreditation framework for assuring quality in service delivery. There are a number of case studies available to further demonstrate these elements and these will aid transfer of innovation.
- (3) **The Need to Govern Opportunities of Education and Development of Competences and Knowledge** – Again, the sections on the reforms to national vocational qualifications in Social Care will aid transferability in this area. The standards and Skills Strategies are outlined in the report.
- (4) **Managerial Means of “Accreditation”** – these are outlined in the report, under ‘Minimum Standards’, ‘Personalisation’ and ‘Shaping the Future’.
- (5) **Check, Supervise and Control in order to Allocate a Financial and Personal Contribution**
- (6) **Authorized, Validated and Subsidized Interventions are Given by Suppliers and Chosen by Beneficiaries of Welfare Services** – this is equivalent to the UK personalisation agenda and is covered in the report. There is flexibility in how this is delivered, in line with the particular individual support needs of the beneficiary. The section on personalisation in the UK National report outlines this further and there are, again, case studies available to offer more detail in this area.

Conclusion: Whilst the Parma model is very similar to the UK model and accreditation, personalisation and an adequate educational plan already exists in statutory provision and beginning to be transferred to informal provision, the UK partner has developed an innovative approach to target informal care givers (family members and friends) and, particularly young carers using social media delivery platforms that allows for increased transferability.

GERMANY

The following are the factors influencing the potential for transferability of the accreditation model:

- Care services are only paid for by care insurance, and only where the care services are provided by care institutions which have a “patient-centered care contract” with the care insurance (§72 Social Security Code XI).
- Care institutions which have a patient-centered care contract with care insurance are already accredited care institutions in Germany.
- Patients can’t get any money for care services provided by non-accredited institutions.
- Care contracts are signed up between care institutions and the federal associations of care insurances.
- In the Social Security Code eligibility criteria are laid down, that must be met by the care institutions before a care contract can be signed.
- The care contract includes the specification, form and amount of care service given to the patient.
- The system of accreditation of care giving institutions in Germany is already fixed in legislation (in the Social Security Code).
- Municipalities play no role in the process of accreditation; actors are the care insurance and the care providing institutions.
- Most municipalities provide registers of accredited care institutions (for example via internet, consulting service by phone or face to face in an office).

HUNGARY

The following are the factors influencing the potential for transferability of the accreditation model:

Hungary has 2 different types of client/patient help/support. You can read the main important differences below. But the patient or client can be the same person. The home care nurse does the special nursing implementations; the domestic nurse does the basic nursing tasks.

	Home care	Domestic care
Who orders it?	After leaving hospital, the family doctor	Family doctor, neighbour, family member, client
Who pays for it?	Health Insurance Company	The client
How much is the price?	Free of charge	It is dependent on client’s income
What is the task?	Only special nursing tasks	Basic help needs
Who is the provider?	Nurse – higher education graduate	Helper, nurse assistant – low education

How often?	4 time x 14 visit	Every working day
Who organize it?	Health Insurance company and home care service	Local government
What is the goal?	To shorten a stay in hospital	To help the client in his/her home
Who are the recipients?	A person needing special nursing	A person needing help with basic daily life tasks
How long is one care	Max 3 hour/day	No limit during 8am till 4pm
Who is the owner of this service?	It is private or local government or hospital	Local government

Accreditation process of Home care services

The Home care service must possess for the accreditation:

- independent office and rooms
- special equipments (determined by the law)
- registered nurses as employees.

If these conditions are fulfilled, the home care services apply for accreditation to the Public Health Institute, which checks everything on the spot. If it is satisfied with the conditions, it will provide the permit for the functioning. This process must be repeated every 3 years. The leader of the Home care service must be BSc nurse and the supervisor must be the family doctor.

Accreditation process of Domestic care services

The Domestic care services are functioned and checked by the social department of the local government, which is responsible for the social provision of the clients in the given district. Domestic care services do not need accreditation, because according to the Municipality Law, the municipality must provide domestic care service for the population in their district. The quality of work is guaranteed and checked by the municipality by itself. Domestic care tasks are performed by the nurse and social assistants, and the supervisor must be the family doctor.

SLOVENIA

These are the factors influencing transferability in Slovenia:

1. Social services decide about the entitlement to a family assistant for a person with support needs. In Slovenia a Family assistant can only be a person who has resigned from the register of the unemployed or labour market exclusively to become a family assistant or a person, working in a part-time working relationship.
2. It is considered, that a person left the labour market if he or she terminated the full-time employment by resignation or changed the contract to part-time with the same or different employer exclusively with the intention to become a family assistant.
3. A person is considered disabled in case: has been taken care of by a parent that has been receiving compensation for the lost income under regulations of parental care, before exercising the right for the family assistant

4. A person is determined as such under the regulations of the law on social care for mentally and physically challenged persons that need assistance in performing every day needs and duties
5. A commission for recognition of the right to a family assistance establishes that the person concerned suffers from a severe form of mental or physical disability and requires help and assistance in performing basic life needs which can be provided by a family assistant.
6. Family assistant is entitled to a partial compensation for the lost income in the amount of the minimum wage or the proportionate partial payment in case of a part-time employment. The disabled person and his/hers subjects for maintenance (spouse, children or any other person obligated to take care of him/her such as subjects to maintenance contracts) are obliged to fully or partially refund the municipality on monthly basis with the funds spent on family assistant. Family assistant rights are additionally funded with assets of a disabled person in the amount of his/her payment capacity and funds in the amount of subject contributions.
7. In case of a family assistant selection, the disabled person retains the right to supplement for outside help or service, that is granted on grounds of a written statement in addition to the application for the family assistant in which the disabled person permits the transfer of this supplement to the municipality account from where it is used to co-finance the rights of a family assistant.
8. Family assistant provides a disabled person with assistance in accordance with her/his needs and interests particularly:
 - accommodation, care, nutrition and household tasks
 - medical care in compliance with the designated personal doctor
 - accompanying and participating in various social activities
9. There already is a statutory, accredited training model for family assistants in Slovenia. This, however, is only a two day training course and therefore is basic in its scope and content.
10. There is an initial pre-assessment of entry level skills on commencing this training and an assessment of skills learned at the end.

In Slovenia, therefore, whilst there already is a model of formalised accredited training for family assistants, there potentially is scope to transfer the more comprehensive training model and the model of personalisation.

SPAIN

These are the key factors affecting transferability of the model in Spain:

1. According to a law of 1988 (2/1988, 4th April), the Social Services of the regional government provided a classification of social community and specialised services with the aim of defining an integrated and versatile care, in order to allow the beneficiaries to have better living conditions. In 2006, Law 29/2006, extended the protective action of the State and the Social Security System for the citizens affected by ageing, illness, disability or forms of limitation. This law provides a series of rights necessary to be fulfilled in order to receive the service: (a) to be in a dependency situation on one of the established levels for no less than three years; (b) to have lived in Spanish territory for five years; two of which must be immediately prior to the date of submitting the application form;

2. Law 39/2006 defined the promotion of personal autonomy and care to people in dependency situations, establishing the possibility of access to a Catalogue Service (including assistance at home) and benefits for those people for whom this situation has been recognised.
3. The System for Autonomy and Dependence Care (SAAD), which must ensure the basic conditions and forecast levels of protection in the care sectors, in accordance with this law. Moreover, a Territorial Council of the SAAD has also been created that regulates the basic conditions to guarantee citizenship equality in the right of promotion of personal autonomy and care to dependent people.
4. In the direct management system, the organisation, monitoring and supervision of services is carried out by local corporations, recruiting also directly among the staff of the municipality. In contrast, in the indirect management system, a local corporation provides beneficiaries with the resources necessary to hire caregivers directly. In the case of the Granada Council, the management (i.e. the functions of coordination, monitoring, supervision and overall evaluation of the service and staff) is done by the local government, while the provision of services at home is contracted from one company according to the regulations concerned (i.e. in Granada, an indirect system exists and a mixed system for delivering the care service). The contracted company must be available throughout the term of their accreditation as an entity providing the service through a very stable workforce to make the service viable.
5. The service of homecare can be carried out by: (a) non-professional carers (caregivers who look after those who are in a dependent situation, i.e. family members, not linked to a professionalized service); (b) professional carer (provided by municipalities or organisations with or without profit or self-employed); (c) personal assistants (service provided by staff that assist in tasks of daily life of individuals in dependency situations in order to promote independent living, to promote and enhance the individual's personal autonomy); and (d) third sector (private organisations which emerged from the civil or social initiative, meeting criteria of solidarity and with no profit interest).
6. The basic equipment for the service consists of social workers and auxiliary assistants at home. The social worker is asked to study, assess and manage the demand to aid the diagnosis and design the adequate project of intervention. During the assistance time, the social worker is also in charge of monitoring and assessing the adequacy and effectiveness of the service and to advice, monitor and evaluate interventions in relation to voluntary service. A final and important further task of social workers is to facilitate and to promote the training and retraining of home assistance staff. Home assistance staff members are people who are in charge of carrying out tasks organised by social workers.
7. The local authorities, through the several training plans, facilitate and promote the participation of professionals in training activities; their participation is very important as they can teach the tasks to develop within the carers' jobs. All professionals working within interdisciplinary teams of municipal social services have the qualifications and knowledge necessary for the appropriate development of its functions.
8. Home caregivers should develop their skills by means of a specific professional qualification that leads to the Professional Certificate of "Social and Health Care at Home" (which replaces the Certificate of Assistance at Home). Auxiliary staff of assistance at home, according to an Order of 2007 (15th November), must possess a Compulsory Secondary School degree, a diploma in Education Secondary School or a certification in Primary

Studies and have the professional qualification for the execution of their tasks, as laid down by a Royal Decree (331/1997) on the Certificate of professionalism of the occupation of auxiliary staff of assistance at home or according to the Royal Decree 295/2004 of 20 February on the professional certification for “Social and Health Care at Home”.

9. An innovation in the system is seen by the Royal Decree 1224/2009 of 17 July. This established the acknowledgement of professional skills of auxiliary home assistance staff, which were acquired not only through qualification but also through work experience. The Ministry of Education and the Ministry of Labour will issue a certificate of “recognition” after passing a national exam. Through the recognition, the regional government has the possibility to recognise skills of persons who learned the care assistance job through experience or in non-conventional work situations, thus reducing the number of black market workers and increasing the number of qualified carers.

In Spain, therefore, it can be seen that there is formalised, accredited training for all of the cross-sectoral team of professionals involved in home care. There is, however, some potential in transferring the training model to non-professional (family) care givers.