"Transfer of Accreditation Best Practice for at-home care service – the Innovative Aspects Integrated by the Cooperative Work of the Partnership"

Pro-Domo Project
REF. N.: LLP-LDV/TOI/09/IT/0456

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1. Preface

The population of Europe is ageing. There are more and more old and disabled people who need home care and home assistance. This was the starting point of ProDomo project.

This edition contains the work material of ProDomo Project. It lasted for 24 months (2009-2011) and was supported by the European Union as a LLP project.
The project's objective is to promote and develop home care services under the European Programme LLP – Sub programme Leonardo da Vinci Transfer of Innovation, starting from the good practice of the Municipality of Parma. With all partners' contribution, the project intends to develop a training tailored to those working figures that perform formal and informal care, focusing on weaker sections.
The project includes the involvement of International partners:

1. Greenhat Interactive Ltd (UK)
2. Instituto Municipal de Formacion y Empleo (ES)
3. Katholische Universitat Eichstatt-Ingolstadt (D)
4. Konfederacija Sindikatov 90 Slovenije (SL)
5. Parma Municipality (IT)
6. PRO.GES (IT)
7. Research Center for Documentation and Studies of Ferrara (IT)
8. University of Debrecen Faculty of Health (HU).

The priority objective of ProDomo project is to develop an innovative good practice, which can introduce a new way of organizing the house services, both on the users and on the workers sides, in order to transfer it in the European context. This practice has to be flexible and receptive according with other European partners' experiences and with the comparison of these experiences. A network will be activated: it will involve partners' countries, who will seek to develop innovative aspects for the various areas even after the end of the project. This network is activated and implemented with the support of local house services companies and institutions.

The partner countries believe that this two year work was hard but successful, and the results will be used and realized by the home care services in each partner country. Enjoy reading it!

2. Comparative study of home care systems to old people in Spain, Germany, Hungary, Slovenia, United Kingdom and comparison with Parma experience

ProDomo Project

The conclusion of the Work Package 2 (WP2) was the realization of a research mainly about the home healthcare sector and the targets and vocational needs for caregivers in all the six partners' countries. The ProDomo partners pick up information and best practices in their territory and specifically in: Municipality of Parma (IT); Granada City Council (ES); Region of Ingolstadt (DE); Birmingham City Council (UK); Nyíregyháza City Municipality (HU); Koper City Municipality (SLO). Objects of the next phase (WP3) is to produce a comparative analysis based on the various home healthcare services' situation so as to create a framework, to be complete or partially transferred, about the home healthcare workers competences development needs. The aim of the phase is to locate and exchange good experiences about the innovation and the quality of home healthcare services and vocational training needs, in order to create the conditions for a correct active labour market policies management and filling the actual training gaps. These activities are directed to reach a safe and high quality employability and to accreditate house healthcare workers competences.

The following document, realized by the Catholic University of Eichstaett - Ingolstadt (DE) in collaboration with the Centro di Documentazione e Studi Economici - CDS (IT), will present a summery of the reports draft by each of the ProDomo partners. The comparative analysis is composed of four main topics: general organisation of the home care and health sector; figures carrying out the care service; founding of the care service; and actual stand of the training for caregivers. At the end of each chapter, a table will visually compare the main content(s) of the chapter. Moreover, each national sub-chapter will be concluded with some key concepts, which will highlight its most important aspects.

1. Introduction

The ageing of population (a phenomenon presents in all the partners' country) creates a series of challenges for the community and local public agencies in order to guarantee more and more opportunities to self-sufficient elderly people and assistance to the non self-sufficient, basing their actions for one principle: people should be, as long as possible, aided in their homes (i.e. „ambulant before stationary“). In this sense home care/domiciliary[1] care enables people to be supported to remain in their own homes as an alternative to residential care or to short the time in hospital, helping or just supporting patients in their everyday activities, care of social contacts and health aspects.

1 There are some nomenclature differences, like home care, domiciliary care, domestic help service and social servicing.

In this context the concept of personalisation of the care service (to be understood as a good (new) way for the organisation of the care assistance) reinforces the idea that beneficiaries of the service (or their family) should be the starting to know what they need and how those needs can be best met. People can be responsible for them and can participate by taking decisions about what they require; in order to do that, they should have the right information and support. Moreover, through the personalisation of the service, we are approaching a so called humanisation of the care services; which means having qualified home caregivers, who, during their qualification, can improve not only specific competences but also the so called soft skills.

2. Welfare system, legislation and carers

2.1 How is the Security Service System (i.e. Home Care System) organised? How do citizens get Home Care Service?

ITALY

From 1972 the functions regarding the subjects of health has been transferred to a regional level, implemented in 2004 on a stronger federalist way: the Local Health Authority (ASL/USL) represents nowadays the executive arm of the Regional Sanitary System and the District represents the local knot where the integration of social-health activities are carried out2. Till 2001 the home-care services in Parma were characterised by outsourcing through three social cooperatives united in a temporary agency association that shared out the work of the city districts among themselves. Through the new introduced system, based on the accreditation of the health structures, new openings have been guaranteed to other subjects3 who can compete to offer services, as long as they possess the characteristics and guarantees requested by a specific commission4. The process of accreditation of the health structures is a process that leads to the recognition of the status of potential service suppliers in the health field and on behalf of the National Health Service, with the aim to achieve and maintain high quality levels but also fixed costs of the services. This model foresees the synergies5 within all the formal and informal resources of the community (health-social services, health and hospital services, voluntary work, organisations, profit agencies or cooperative groups, etc.). Through the accreditation process the suppliers, if chosen by the citizen, commit themselves to supplying care services at the price and conditions indicated by the Municipality of Parma, basing the competition on the various form of services offered (i.e. number of services and care packages) and their quality, and not on their costs. For the accreditation every supplier will be evaluated according to the following criteria: (a) organisation and business solidity (i.e. turnover, balance sheet, etc.); (b) employment (i.e. organisational skills, planning capacity, etc.); (c) quality of internal organisation (i.e. organisational structures, management and training of the staff, informational system, etc.); (d) quality of the carried out services (i.e. answer to

2 The Region Emilia-Romagna is organized in 38 districts.

3 T he Regional Health System works through a network that involves public and private structures managed by profit and non-profit agencies.

4 Composed by the director of the Local District Social Sector, the director of the Service for elderly people and the general Town Clerk.

5 In 2003, there was a first change in the organisation of the health-social system, with the aim to create a public network of residential and non residential care services, moving to municipalities the organisation of the social-health care services. Moreover the 2008 saw the introduction of a new three-years Health and Social Plan, based on the integration of social, health-social and health services.

individualised care plans, quality of relationship with the beneficiaries and their family, etc.).

In order to access the home care services citizens must contact the Elderly People's Service of the Municipality for the production of the Individualised Caring Plan (PAI). If the citizen and his/her family are unable to carry out all the procedures by themselves, the Municipality, through a commission6, will assume all the duties regarding protection and accompaniment in the choice of the right accredited supplier. The draft of the PAI is produced by social workers and by the responsible in charge of the care activities of the Elderly People's Service of the Municipality, along with the opinion of a general practitioner (the family doctor of the applicant) and if needed, involving other professionals (for example the professional nurse, the rehabilitation therapist, the psychiatric health service) and also making use of the evaluation geriatric unit service. The PAI indicates, through a multidimensional evaluation of the patient, the kind of services needed by the old person (typology, quantity, intensity). The validation commission examines the applications and evaluates them within 60 days of their receipt. On the basis of PAI, the beneficiary receives a voucher from the Municipality, which can be used to buy services from a panel of suppliers accredited by the Local Administration. The citizen, in possession of the PAI and the voucher, can choose his/her own supplier directly and freely, stipulating a contract that must follow the outline imposed by the Local Administration. Two are the home care services proposed by the Municipality, as alternative forms of assistance in care institutions or hospitals: the Integrated Home Assistance (ADI) and the Home Assistance Service (SAD).
KEY CONCEPTS: Local Health Authority (ASL/USL); District; Accreditation; Municipality as Service Quality Supervisor; Public and Private Sector's Synergy; Service Personalisation (PAI).

SPAIN
According to a law of 1988 (2/1988, 4th April) the Social Services of the regional government provided a classification of social communitarian and specialized services, defining the alter as the basic structure of public social services in Andalusia, with the aim to define an integrated and versatile care, in order to allowing the beneficiaries to have a better living conditions. In a second moment a further Decree (11/1992, 28th January) identified the nature and basic benefits of social communitarian services (included the assistance at home service), promoting decentralization in local administration so as competition for the management of community social services and accounted for delegation of the regional government to municipalities over 20.000 inhabitants.
In 2006 the Law 29/2006[7] extended the protective action of the State and the Social Security System about the citizens affected of ageing, illness, disability or forms of limitation. This law provides a series of rights, necessary to be hold in order to get the service: (a) to be in dependence situation in one of the established levels since no less than three years; (b) to live in Spanish territory for five years, two of which must be immediately prior to the date of submit the application form; (c) People without Spanish nationality are governed by Spanish on Rights and Freedoms of Foreigners in

6 Composed of one geriatric doctor (and in some cases the family doctor), one social worker and one person responsible for care activities.
7 The law gives definition of terms like: Autonomy, Dependency, Basic Activities of daily living, Support needs to personal autonomy stressing the importance of personal autonomy. So as definitions of professional and non professional care, professional assistance and third sectors.

Spain and their social integration, international treaties and agreements established with their country of origin; (d) Likewise, the Government may adopt protective measures in favour of the Spanish non-residents in Spain and the access conditions for returning Spanish immigrants. According to point (a), the priority of access is determined by the degree and level of dependency, and then by the applicant's financial capacity (based on incomes and patrimony).

The Law 39/2006 defined the promotion of personal autonomy and care to people in dependency situation[8], establishing the possibility of access to a Catalogue Service (including assistance at home) and benefits for those people, in whom it has been recognized this situation. The System for Autonomy and Dependence Care (SAAD), which must ensure the basic conditions and forecast levels of protection in the care sectors, refers to in this Act. Moreover it has been also created a Territorial Council of SAAD9 in order to: (a) recognize a new right of citizenship in national level through the collaboration and participation of all public administration and the guarantee of State General Administration; (b) regulate the basic conditions to guarantee the citizenship equality in the right of promotion of personal autonomy and care to dependent people. The government will determine a minimum level of protection for the beneficiaries of the system, which may be increased by agreements between the National Government and the regional government; although the Territorial Council of SAAD shall establish criteria to determine the strength of protection for each of the catalogue services, and if they are compatible, the regional government (Autonomous Communities) can define additional levels of protection. Catalogue Services are a priority and will be delivered through the public offer of the Social Services Network of each regional government, through public social service centres or private services accredited by the government.

According an Order of 2007 (15th November), which regulates the assistance at home service in the autonomous community of Andalusia, the assistance at home is public and their organization is the responsibility of Local Authorities of Andalusia, which can manage directly or indirectly. In the direct management, organization, monitoring and supervision of service is carried out by local corporations, recruiting also directly among the staff of the municipality. On the other side, in the indirect management, local corporation provides to beneficiaries the resources to make him/her hire caregivers directly to get assistance. In the case of Granada Council the management (i.e. the functions of coordination, monitoring, supervision and overall evaluation of the service and staff that develops) corresponds to the local government, while the provision of services at home, is contracted with a company, according to the regulations concerned (i.e. in Granada exists a indirect system and also a mix system for delivering the care service), which must be available throughout the term of their accreditation as an entity providing the service of a very stable workforce to make the service viable.
On national level it has been defined three dependence degrees[10] (s. note 8) based on the more or less autonomy or need of help of the beneficiary. The current average time for the assessment of dependency would be about three months. It is estimated within an average time of 12 to 18 months from application form to the perception of the service

8 Definition by the law: „Dependence is the permanent state in which they find people who, for reasons connected with age, illness or disability, and related to the lack or loss of physical, mental, intellectual or sensory autonomy, require care one or more other persons or substantial benefits to carry out basic activities of daily living or in the case of people with intellectual disabilities or mental illness, other support for personal autonomy".

9 Cooperation among public institutions, the intensity of the catalogue services, the conditions and amounts of financial benefits, criteria for participation of beneficiaries and the scale for the recognition of the dependency situation.

10 Moderate dependence, strict dependence, heavy dependence.

in the case that obtain an assessment of dependence with an enough degree and level. The "agility" of the system is broken at the time between the assessment of dependency and the development of PIA, e.g. what we have come to call "The Limbo of Dependency[11]", a strip in which people have a degree and level of dependence enough to be deserved of the right to receive support and that, however, are victims of a policy "to limit the expedients" in an excessive waiting situations.

KEY CONCEPTS: Regional Government and Delegation to Municipalities; (Territorial Council of) System of Autonomy and Dependence Care (SAAD); Direct and Indirect Management of Home Service; Public and Private Sector's Synergy; PIA

GERMANY

The State Insurance of Illness (1883) was developed as the first social insurance in Germany and in Europe by Bismarck; other social insurances followed in the next years: the insurance of accidents (1884), the insurance of pensions (1889), the insurance of unemployment (1927) and the insurance of care as part of the insurance of illness12 (1995). With the social insurance of care's introduction the last big gap of social insurances was closed and a new basis for the need of care's risk coverage was founded. The social insurance's duties are besides the benefits as well the prevention and rehabilitation; moreover the social insurance of care helps the needy and their affiliates13 to take care also of the personal and financial burdens. The insurance of illness is the only insurance with competition for members between the compulsory health insurance funds and the private insurance companies. The insurance of care is not an insurance at full value, it is more a social safety net in terms of auxiliary salvage, which does not make the personal contributions of the insured and other providers expendable. If no or fail benefits of the insurance of care are delivered and the needy or their affiliates who are liable of support have not enough personal contributions to take care of the remaining costs for a needed and adequate care, also the benefits of the social welfare may be used to take care of the individual fulfilment of demand.

The state gives the arrangement to self-governing corporate bodies and alliances, mostly to the state insurances of illness[14] and the hospital operator's alliances. The German system is dominated by small enterprises[15] which provide care assistance. The provided service in the health system is ambulant health care, hospitals, nursing homes and carriers of federal facilities. In addition even alliances of public welfare and private care providers are among the providers of care in Germany. The lawgiver sets the rules in which the insurances have to do their duties and the federal agencies administrate the corporate bodies; also the care provider's professionalism is supervised and regimented by the federal agencies. The public health care may allow care services (both at home or in care homes) only by care providers with who a care provision contract exists: only with the existence of this contract between public health care and care providers, the supplier may act and charge the actions to the public health care's account (i.e. are accredited care providers). A care provider is only allowed to get an accreditation for the health fund, if: (a) the company engages at least 4 employees; (b) the healthcare services as well as the representation of graduated nurses have work experience in

11 Since 2008 ca. 240,000 people has been kept in a situation of recognized dependency not receive any assistance at home (law 39/2006).

12 Members of state insurance of illness are automatic insured at the insurance of care.

13 88% of citizens have a state insurance, nearly 12% a private one.

14 The insurances of illness are corporate bodies under public law, which get a allowance by the state for doing federal works.

15 In general care providers aided 43 people who were needy of care.

ambulant and stationary places; (c) to full-time employees are engaged.

Benefits and conditions of the care insurance are regulated by the SGB XI. Which benefits are delivered to the needy, so as the quality of the care providers are assessed by the "Medical review board of the statutory health insurance funds" (MDK) – their duties are regulated in SGB V. The MDK is a common area of the state insurances and in every federal state organized as a autonomous joint venture. The MDK is funded by its carriers, the health and care funds on federal state level and their costs refer to the number of members. As the medical services do works for the health funds as well as for the insurance of care the health and care funds pay each 50 percent[16].
The federal states, the municipalities, the care facilities and the health funds have to work very close with the MDK's participation to assure a capable, local structured, close to home and concerted ambulant and stationary caring of the society. The federal states are in authority of an expostulation of a capable, numeral fair and commercial caring provision. The municipalities have to attend in terms of services for public (indemnification of the provision with fair social infrastructure) the socio-spatial design; the future's duty for the municipalities is, to upgrade the provision of care for the needy. Also networked bargains and false-works may only be regulated by municipalities. An important duty for the future related to municipalities will be the scheduling of work with the elderly to coordinate all offers of care and help for the elderly. The duty of the local authorities is written down in the German law concerning the care for the elderly.
To take care of the different demands the lawgiver has arranged three care levels: the term „care level" of the insurance of care complies with the custodial and budget-side necessity of help of at least of 90 minutes each day (Level 1) up to 5 hours per day (Level 3). The state insurance of care comes to aid, if common and constant to be done actions of daily life can't be performed enduring – estimated at least for 6 months - to the full extend in case of illness or handicap.
In 2008 some changes with the insurance of care were taken in hand. Of central importance are: (a) the upgrade of the benefits for people with handicaps; (b) the upgrade of the benefits with day- and night care; (c) the activity's dynamic sampling; (d) the introduction of a nursing care time for employees; (e) the upgrade of the quality management and development of the transparency. Moreover the coalition parties which carry the federal government have agreed (October 2009) on the plan to aim for a new, differentiated definition of high-maintenance[17] and to comprise the already existing approaches to the assessment. The new instrument aims for a broad regard of high-maintenance, so it avoids the cutback of high-maintenance to the need of help in some certain action of daily life. A main advancement was achieved with the new reform package on the care by affiliates. An employee may get up to 6 month of free time, if he or she cares for an affiliated in this time. This is called nursing care time.
KEY CONCEPTS: Care Insurances; Public and Private Sector's Synergy; Care Provision Contracts (i.e. Accreditation System); Municipalities as Care Service Organisers; Role of MDK.

ENGLAND (UK)

16 The state insurances of illness and care's total expenditure were in 2008 at circa 540 mill. Euro.

17 Since insurance of care's introduction it's animadverted that the term of high-maintenance is argued somatic too narrow and one-sided in the SGB XI. Prevalent aspects would be blanked out of the discussion and not enough allowed for, as for example the communication and social access and the need for common assistance, supervision and guidance, in particular for people with limited daily living skills. So there's a danger to segregate people from the benefits of SGB XI, for example people with dementia.

In 2007 the 'Our health, our care, our say' White Paper[18] and the Comprehensive Spending Review announcement outlined the key elements of a reformed adult social care system in England (due to the ageing of the society and the new more personalized expectations of beneficiaries). The Paper was above all unique in establishing a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator, recognising that real change would only be achieved through the participation of users and carers at every stage: it sought to be the first public service reform program to be co-produced, co-developed, co-evaluated. It acknowledged that Local government would need to spend resources differently and the Government should provide specific funding to support system-wide transformation through the Social Care Reform Grant. Local authority leadership accompanied by authentic partnership working with the local National Health Service (NHS), other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers. Local authorities and their partners would agree together how this funding would be spent to develop the personalised system. The personalisation of the care service, central point of the NMS, represents an innovative way of thinking the care process. The concept starts from the point of "thinking about public services and social care in an entirely different way – starting with the person rather than the service. It requires the transformation of adult social care" [19]. More in concrete personalisation means a service which: (a) finds new collaborative ways of working and developing partnerships, producing a range of services for people to choose in; (b) tailors support to people individual needs; (c) recognises and supports carers, enabling also them to maintain a life beyond their caring responsibilities; (d) accesses service and resources to everyone; (d) supports early intervention and prevention.

All the home care agencies so as the home care provisions are regulated against 27 standards, called National Minimum Standards (NMS), established by the Department of Health and regulated by the Care Quality Commission (CQC) since 2000[20]. Briefly and summarizing the standards ensure: (a) the access of the beneficiaries to information related to the service so as to the provider; (b) the personalisation of the service; (c) the transparency and the beneficiary's knowledge about the carers' skills and training levels; (d) the transparency about the functioning of the management, business and planning ability of the providers; (e) the high respect of the beneficiaries' privacy. Moreover the CQC points out five strategic priorities[21], two of which are based on a better and better joined up approach between health and social care so as an intensively partnership works with external agencies (i.e. health centres, leisure centres, etc.).
The majority of people in receipt of home care receive their services via local Social Services, which assesses need for help according to eligibility criteria related to the person's needs. It can exist two different way to value the eligibility of the beneficiaries: in the case of the "personalisation" of the service the competence is of the local government, which is carried out through "hubs"[22]; in the other case, the eligibility of the beneficiary will be done by local authorities through social services. If the beneficiary is eligible to receive a Home Care service, the Social Worker will arrange

18 Momentarily in discussion as it has been a change of government in May 2010.
19 Definition of the Social Care Institution for Excellence.
20 Home care providers met or exceeded 82% of National Minimum Standards in 2007-08.
21 The other points are: the beneficiary at the centre of the service; promoting high quality service, eliminating poor quality care.
22 They assess the people's needs and then allocate the work to the appropriate or chosen home care agency.

for this to be provided. The Social Worker will draw up a Care Plan with the older person taking into account their needs. After the service has been arranged by the Social Worker, a Home Care Organiser will visit in order to: (1) discuss and agree with the older person how best to provide them with a service using an Individual Service Statement; (2) undertake a risk assessment, which will look at Health and Safety for the older person and the staff member; (3) assess for any manual handling issues. The home care service is available throughout the day and evening. Most councils contract out the supply of home care services to the independent sector, which now provides over three quarters of public funded home care. Social care funding in England is due for a major government review and the current agenda is to ensure that service users who are eligible for state funded care are allocated an up-front "personal budget" that allows them to design their care packages more freely (i.e. employing their own staff, using a home care provider of their choice, etc.).

Actual situation[23]: The governmental shared vision for the transformation of adult social care, called 'Putting People First' (2008), expressed the hope that every local authority would create forums, networks and task groups which involved staff across all sectors, people who use services and carers as active participants in the change process. The document was followed by a Department of Health Adult Social Care Workforce Strategy Putting People First – Working to Make it Happen, which identified the key issues for the workforce as set out in Putting People First and goes on to develop these into broader, strategic priorities for the workforce[24]. The document also formed the basis of the wider stakeholder, whether public service or private and voluntary sector, engagement on the development of the strategy: less direct management control over people's lives by social care professionals, but still ensuring they carry out their duty to care. This approach recognises that people who access social care have different levels of capacity (i.e. some are able to exercise full choice and control and understand the consequences of their actions; others may need greater support and guidance in some areas of their lives to be able to participate as active and equal citizens).

Putting People First was then followed by the promised Government Green Paper "Shaping the Future" (2008); through this document the government recognizes an urgent need to begin the development of a new, more personalized and high-quality adult care system. Over the coming years, the role of local authorities will increase in importance in making sure that there are high-quality services available in their area, working closely with providers – including those from the third sector and private sector.

KEY CONCEPTS: Independent Sector; High Personalisation of Care Plan; National Minimum Standards (NMS); Increasing Role of Local Authorities; Private and Public Sector's Synergy.

HUNGARY

The home care services (i.e. the costs of the services, the framework for the eligibility of the assistance, the number of visits, the reporting system of produced services, etc.) are uniformed regulated on a national level since 1996 by a law act. Being ensured by the National Health Insurance Fund (NHIFA) is obligatory for every citizen, so that everyone has the right of free provisions in case of necessity. Moreover the NHIFA is

23 It is referred to the state of art before the election; due to the change occurring in the Parliament, the foreseen action of the previous government might not be undertaken by the new one.

24 Strategic priorities: Recruitment, retention and career pathways; Workforce skills development; Workforce remodelling – new models of personalised care; Leadership, Commissioning & Management Skills; Joint and integrated working; Regulation (Quality Improvement).

also responsible for the drawing up of the reporting system of purchased care services valid for all the country.
The providers, which belong to the Health Ministry, in order to be able to carry out home care sector must fulfil a inner quality assurance system. The operational standards are related to the assistance centre equipment, i.e. office rooms, computers, printers, so as to the completeness of nursing instruments and tools, i.e. nurse-bag. This means that the choosing of providers will be done only among providers that have been already prooved and accredited by the Public Health Institute. Within a settlements more providers organize, in competition with each other, the home care service, receiving government found form the NHIFA. The choose of the provider is a free decision of the patient, however, the funding is limited by a given number of visits, which as already mentioned, is nationally defined by a law act.
On the territory are present two different levels of home care activities, both defined by law acts: the home care assistance and the domestic care assistance. Regarding the home care assistance, the eligibility of the service is related to a independent and professional committee's decisions, composed by the family doctor, a nurse and eventually a social worker. The family doctor and the notary of the local government[25] submit instead the application for the request of domestic care activities, which are discussed and organized with the collaboration of a nurse or an nurse-assistant and a social worker. Once started, the process of home care (both for home care and domestic care), this will be continuously monitored through the leader of the home care service and the family doctor, who control the nursing activities every 14 visits, producing meanwhile an updated nursing plan for the beneficiary. Some limitations in delivering the assistance services are related to rural areas, in which the local authority doesn't have enough financial sources to complete the service.
KEY CONCEPTS: Roll of National Health Insurance Fund (NHIFA); Public and Private Sector's Synergy (i.e. only Accredited Service Suppliers).

SLOVENIA
In Slovenia various services and financial allowances are provided as a part of the existing Social Protection System (i.e. health, social security, pensions and disability insurance). However the system of long-term care for senior citizens (but also for other categories) is not uniformly regulated, with the result that care providers are not well coordinated and the consequently drop in the quality of the services. Generally services in the domestic living environment are still relatively badly developed, which poses an additional pressure on the prolongation of costly hospitalisation and extension of institutional forms of care.
Under the Social Assistance Act (SAA) of 2007, domestic assistance forms one of the social security services. It comprises the provision of social care (i.e. housework assistance, assistance in maintaining personal hygiene and assistance in maintaining social contacts) and medical assistance for persons with disability, elderly over 65 and chronically ill persons, substituting the institutional care. The service starts at the request of the beneficiary or his/her legal representative and it comprises two parts. The first part comprises the determination of service eligibility (proofed by social worker or head of home help), the preparation and the conclusion of the agreement on the extent, the duration and the method of service provision, the organisation of the key members of the environment and the implementation of the introductory meetings between the provider and the beneficiary or his/her family. The second part is the direct execution of

25 As the service is direct organize by the local government.

the (social and medical) service at the home of the beneficiary according to the agreed programme. The Rules on Standards and Norms of Social Security (Rules on Standards) stipulates that the direct execution of the service per beneficiary lasts approximately for up to 4 hours per day, or for up to 20 hours per week.

Domestic social help falls under the competence of municipalities: the Municipality[26] may select the service provider(s)[27] and by means of the amount of the municipal subsidy influences the price of the service paid by the user, influencing significantly the level of accessibility to the service. At the same time this means that various municipalities have quite varied policies regarding the implementation of domestic social help. In 2004 a modification of the national Social Security Act introduced an at least 50% obligatory subsidization of the service on the part of the municipality, made an important step towards a more stable financing of the service. The consequence of this change is that in municipalities there are no extreme high prices for the service as compared to 2003[28].

The majority of organizations (88,5%) providing domestic help have a status of public institution: in 2007, there were 63 public institutions providing domestic help, whereas in 2008, there were 69. These institutions were mainly centres for social work (71,1% of all providers) holding the status of a public institution and elderly homes (14 elderly home). Moreover a good proportion 11% (9) of domestic help providers was concessionaires (i.e. the municipality, the municipality covers a part of the costs related to the economic cost of aid worked at home) in 2008.

KEY CONCEPTS: Social Assistance Act (SAA); Rules on Standards and Norms of Social Security; Municipalities as Service Coordinators.

Summery Charts:

Tab. 1 Typologies of the home care service management (social-health services)

	IT	DE	HU	ES	UK	SLO
Public management						
Public/private management	**X***	**X***	**X***	**X***	**X***	**X***
Private management						

* Public accreditation of private care assistance structures

Tab. 2 Opportunity to change provides (in case of dissatisfaction) as level of beneficiaries' participation

	IT	DE	HU	ES	UK	SLO
Every time and easily	X	X	X			
Rarely but possible						

26 In 2007 there were 13 municipalities without any domestic care service.

27 In 2008 there were 78 providers of domestic help.

28 The differences in prices among municipalities exist, partially due to various municipalities' policies regarding this service, but partially the cause also lies in the fact that not all providers of domestic help employ "subsidized employees" on the basis of the measures of active employment policy.

Never						

Tab. 3 Typology of intervention carried out by accredited providers

	IT	DE	HU	ES	UK	SLO
Social assistance	X	X	X	X	X	X
Health assistance						
Integration social-health assistance	X	X	X	X	X	X

Tab. 4 Person(s) Responsible for the Eligibility of the Home Care Assistance

	IT	DE	HU	ES	UK	SLO
Commission (i.e. GP, social worker, nurse)	X*	X*	X*	X	X*	
Social Worker			X			X
GP/public servant			X			

* In collaboration with the beneficiary and or his/her family

2.2 Which professional or non professional figures carry out the home care service?

ITALY

The first place of care and nursing for the elderly remains the family, in particular covered by the female members. Although due to some transformation happening in the Italian families29 some changed related to the care organisation within the family have occurred. In this context, the 'do it yourself ' approach is gaining ground in families, promoted by the increase presence of huge numbers of women coming from the Eastern Europe, who offer to nurse old people at cost which are sustainable for families. The carer does not by herself/himself exhaust the entire process of assistance to elderly, but she/he answers to some prerogatives particularly important for families: (a) a service of alleviating the responsibility of care of the family members, especially for the female members of the family[30]; (b) the permanence of the person in his/her own house or within the family; (c) the cost, even if it weighs on the family budget, can be considered low (an average of 700-800 Euro per month31). About these figures, it will be often

29 I.e. the increase presence of women in the labour market and the consequent less time dedicate to care-assistance.

30 Women, who in the bosom of the family were destined to assume the responsibility of caring for the old person, often giving up to their job and important pension contributions; today, thanks to carers can keep on working and caring their family.

31 Excluding other costs such as incontinence pads, medication, equipment that eases the movement of the elderly person, and so on. The average total expense for an elderly person's assistance is of about 1.100-1.200 Euro per month.

criticise that although the profession of the carer32 could be improvised, on the other side the one of treatment33 needs specific vocational training. According to this point the municipality of Parma has defined the guidelines for the future Register for Family Assistants and its relative front-desk in an experimental way. The register, a public list of professionals in the home care assistance services, has the objective of ensuring the care and protection of old and disabled users, and of improving the quality of the service. The register presents itself as an instrument able to aid employment, offer qualification opportunities to registered staff and, consequently, to aid the discovery of undocumented work. The authorization to enter in the register will be given only either by being in possession of specific requirements or after taking part to a vocational course and the success in a final exam.

On the side of the professional assistance, as already mentioned, it's possible to distinguish two home care services, both related to an intensive help of voluntary workers: (a) the Integrated Home Assistance (ADI), organised by the Local Health Authority; and (b) the Home Assistance Service (SAD), which instead organised by the Municipality. The ADI supplies both health and social-aid help and it's for this reason based on professional health and social figures. The service is based on three different levels of care intensity, based on the needs of the patient; although every case is personally organize. In most of the cases is the family doctor who deicide for the activation of the service and the service is actual carried out by nurses and social workers with the help, in case of necessity, of some specialists (i.e. physiotherapists, specialised doctors). The service is guaranteed only during the day and only during working day.

The SAD-worker provides instead assistance for elderly people in carrying out their normal daily activities (i.e. personal hygiene, meals supply, social secretariat, home help, but also psychological, care and social support, so as organization of recreational events), with the aim of helping them remaining within their household. The assistance is carried out with the synergy work of social workers, responsible for the care assistance activities (RAA) and social-health assistance worker (OSS). The SAD is guaranteed 24 hours a day, 365 days a year and are organised in such a way that it can be activated even in 24-48 hours, with no waiting list for the beneficiaries.

KEY CONCEPTS: Family (Female Members); Sole Traders Caregivers (mainly Women from Eastern European Countries); Register of Carers; SAD; ADI; RAA; OSS; Social Workers; Volunteers.

SPAIN

The service of home care can be carried out by: (a) Non-Professional carer (caregivers who pay attention to persons in a dependent situation, i.e. members of the family 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 makes or collaborate in tasks of daily life of persons in dependency situation, in order to promote their independent living, promoting and enhancing their personal autonomy); (d) Third sector (private organizations which have emerged from the civil or social initiative, meeting criteria of solidarity and with no profit interest).

32 As a person that oversees, who actively cares someone.

33 An action/a subject that presuppose an evaluation of the status of need, an analysis of the resources so to order a therapeutic intervention plan.

In the Department of Social Welfare on the services of Social Services are working staff of different profiles, with specific actions and sector of intervention. Similarly, in each of the Municipal Centres of Social Services, work interdisciplinary teams, consisting of Social Workers, Psychologists, Educators, etc. In addition, to enable a comprehensive action, may participate other staff of social services (psychologists, educators, etc.) so as the required personals for administrative and organizational tasks. The Educator is supervising the guidance in the creation or modification of convivial habits to support integration and socialization of the user of home assistance service (i.e. promote and maintain personal autonomy, to encourage adequate habits of behaviour and to acquire basic skills for both personal developments as the family unit, at home and in their relationship with the community).
The basic equipment for the service will consist of social workers and auxiliary assistants at home. The Social Worker is asked to study, assess and manage the demand so as to elaborate the diagnosis and design the adequate project of intervention. During the assistance time, the social worker is also in charged to monitor and assess the adequacy and effectiveness of the service so as to advice, to carry out the monitoring and evaluation of interventions in relation to voluntary service. Moreover trying to coordinate the other services and resources of Social Services Network or to collaborate with other systems of social protection is also a task foreseen for social workers. Finally and important further task of social workers is to facilitate and to promote training and retraining of home assistance staff. Home assistances staff is people in charge of carrying out tasks organized by social workers. Auxiliary staff of home assistance have got the competencies to carry out the actions of domestic and personal character (i.e. integration in individual situations or in groups; facilitate to the users communication channels with their environment and with the technical staff in charge of the service; to fill in the documentation the register that corresponds in the model for the service; to participate in the coordination and monitoring service, providing the necessary information about users). The auxiliary of home assistance can be part-time public servants or eventually be “hired” for their services from private suppliers. They are mostly composed of women coming from South America, who have already practised either legally or not the work of carer.
KEY CONCEPTS: Family; Professional Private or Public Carers; Third Sector; Role of Social Worker; Auxiliary Staff (mainly Women from South America).

GERMANY
About one half of all needy people are aided at home by affiliates (mostly female figures) in Germany, the other half takes professional care. In both situations the needy are able to get benefits from the public health care. If a care service is taken the benefits will only be paid if it is a accredited service. Accredited services are governed by some special quality demands and inspections. So it is guaranteed that only qualified personnel are employed and that only proper aid and benefits are delivered. The costs of a 24 hour care demands on the care level and hence on the support expenses. The costs stay right now between 2.700 and 3.200 Euro.
If the care is provided by non accredited personnel (affiliates, neighbours etc.) or care providers, there only exists a claim for the public health care. The costs which are generated by the care can be brought in the health care, while you have to detect the costs by a bill of charges. If some medical actions accrue, like change of dressing, these are incurred, if allowed by the health insurance. Who has claim for benefits from the insurance of care has the basic choice of two forms of benefits. He can choose the so

called nursing allowance which can be used for the care by affiliates, neighbours or non accredited employees of care providers. Insofar he gets a monthly fixed amount. The needy person can also assign an accredited provider of care. As far as this providers takes care of the aiding the provider bills directly with the public health care, till the full amount, which depends on the care level. Insofar the needy person takes an ambulant care provider via self-organized care providers a combination of non cash benefits (cash benefits are possible). The part of the money decreases by the percentage, in which benefits of accredited providers are accessed. You can, for example, apply for 40% of the benefit money if you claim for 60% of the care benefits amount.

In 2005 there were about 11.000 accredited ambulant care providers in Germany, 57,6% as private and 40,6% as charitable ones. Public providers had – according to other provider's precedence relating to SGB XI – a lower contingent (1.8%). About 14.000 employees were engaged at these providers, the percentage of women was at 87.7% and respective the job-related qualifications the nurses are the main group. Ambulant care takes place in the household of the needy and a professional provider of care carries the local supply. Ambulant carers' benefits are provided by organizations of public welfare (Caritas, Bavaria Red Cross, outreach ministry, central welfare commission for the German Jews, etc.) as well as by communal welfare centres or private, commercial providers of care.
Nursing allowance is paid, if the needy is aided at home by affiliates or another self-chosen person (neighbours, friends) in a able way. Frequently the effort of caring affiliates is annealed by the needy of care.
At the ambulant sector worked in 2007 at all 236000 persons, 88% of those were female, 71% worked part time. 69% of the employees had their primarily work at the basic care and the main part had their education as health caregivers and nurses or as elderly care nurse. Compared to 2005 the impact of the ambulant services has grown, there was a boost at the employees for 10% (Federal Agency for Statistics).
Elderly care nurses work in many fields of activity, mainly in nursing homes, ambulant services, short time care services and daily care homes. They are also employed at geriatric gerontopsychiatric professional hospitals, hospitals, hospices or in facilities of guided living. They work on a team – with co-workers as well as professionals of other healthcare jobs or social works; so for example at the care and rehabilitation the work very close to the doctors.

The assignment of a caregiver from foreign, mostly female and from Eastern Europe is an alternative to the German nursing homes and ambulant care providers or the individual caring by affiliates, depending on the high costs of care in Germany. Often the assignment of a foreign caregiver is the only alternative for affiliates because a caring by care providers is too expensive. But one should inform very good before the assignment, because the legal position isn't clear yet. The caregiver should have a work permit given from the Federal Employment Agency and not only a tourist visa. If a caregiver comes to Germany for three months to work and then switches with another caregiver this could be an advice for illegal work with a tourist visa. It's very important to find a good agency or rather other office, to make sure to get qualified personnel and to assure the working communication even with different languages spoken. The needy of care have to fund the employment of caregivers from foreign by him but are allowed to spend the money for his individual care level on this case. Besides that he has to supply or fund an accommodation at least a room by 24-hour-care.

There are many private branch exchanges, which are specialized on the intercession of caregivers from foreign. These companies build the contact link up and take care of the formalities. The official way leads to the ZAV, the central intercession agency for foreign workers of the Federal Employment Agency. At the local Federal Employment Agency one can apply for a home help in case of the need of care. Since January 2010 they are allowed to do simple caring which contains also works for which they don't need a special education. The Agency checks the German job market and if there is no help to find a worker from foreign is searched of. The person concerned can also search for help by himself and announce it to the Agency. These helpers are allowed to stay in Germany for up to three years and have to get paid like German home helps, depending on the Federal State about 1300 Euro gross per month including social security taxes. Even on the internet many companies advertise to take those helps to Germany. They aren't allowed to work as caregivers officially but in most cases they do. There exists no sure numeral statistics about the number of illegal employed caregivers in Germany. Appraisals come from about 60000 up to 150000 caregivers in most cases from Eastern Europe which support the affiliates at the home care or rather take full care of the home aiding. A home help which lives in a German home is available 24/7 and works on the alignment of the affiliates or the needy of care works.
Another model of illegal employed caregivers is the employment over a care provider from foreign: in this case the caregiver from foreign is employed at a care provider in another country and is placed by a German office. Instructions by the German client are not allowed in this case but are daily use.
KEY CONCEPTS: Family (Female Members); Private Suppliers; Charitable Providers; Nursing Allowance; Foreign Caregivers (mainly Women from East European Countries); ZAV; Carers Recruitment through Providers Abroad.

ENGLAND (UK)
It is estimated that the domiciliary care workforce in England makes up around one third of the entire social care workforce. In 2003/4, an estimated 922.000 people were employed in 'core' social care as traditionally define (i.e. including local authority social services staff, residential, day and domiciliary care staff, agency staff and a limited number of National Health Service staff[34]); of these, an estimated 61% (ca. 559.000) were working in services for older people. In 2008 the service was provided, in England, by 4.960 home care registered agencies, of which 4.146 (84%) were based in the private and voluntary sector. The social care workforce is predominantly female (83%, increasing to 95% in sectors such as residential and domiciliary care) and mainly part-time working. The workforce includes people of all ages, but especially 35-49 year old who account for 40% of the total, compared with 35% under 35s and 25% 50s and over. However, settings for older people tend to employ older workers (compared to other care sectors): men aged 75 and over were more likely than women of the same age to be carers (4.6% compared with 2.4% respectively). Social workers' pay levels are among the lowest of the professional occupations, although recruitment problems seem to have put pressure on rates of pay and led to some improvement in recent years. The average pay of care workers is about £ 6.80 hourly; although the pay range of care workers is much wider, reflecting the diversity of seniority, experience, qualifications, settings and employer types among care workers.[35]

34 12% of employees in care sector are born outside the UK.
35 There is a little evidence to suggest that NVQ-qualified care workers are paid more than unqualified ones.

To emphasize is the importance of the independent sector as the main provider of social care services: ca. 65% of the home care workforce (nevertheless it continues not to be reflected in reliable statistics about the numbers of workers it employs). It is estimated that a total of 306.000[36] persons are employed in independent and 44.000 are employed by the local authorities. The number of workers in the statutory sector is also reported to have fallen as local authority in-house provision has decreased, so the total number of people employed across all sectors of domiciliary care in England is now estimated to be 163.000, compared to 202.500 in 2000. Each worker is nowadays delivering 25% more hours, on average.

Also in the UK is present the phenomenon related to the qualified carers, who working outside of their employment provide additional hours unofficially, paid by the older person or their family. It is also acknowledged about the existence of a robust black market of non-qualified home carers (friends, neighbours, etc.) but it is also extremely difficult to find information and statistics to quantify it (as by its definition, it is a market hidden from regulation authorities and no statistics are therefore available). Although the government recognises that family and friends play a vital role in caring for people who need care and support; informal or unpaid carers represent a huge share of total social care workforce capacity: in 2001, 4.8 million carers aged 16-74 an more than 340.000 people aged 65 and over provided 50 hours of unpaid care per week; most informal carers in England provide between one and 19 hours of care per week, a quarter of them provide round-the-clock care; a quarter of English families receive care from grandparents; in England there are 5 million older[37] volunteers in the care services; 4.2% of women aged 65 to 74 were providing unpaid care assistance compared to 3.8% of men in the same age group.

KEY CONCEPTS: Home Care Registered Agencies (Private and Voluntary); Independent Qualified Carers; Non Conventional Unpaid Carers (Family; Neighbours; Friends).

HUNGARY

The home care, which can be private or public, is paid by the Health Insurance Company and the service is delivered only by special and highly qualified nurses for yearly a maximal time of four cycles each composed of 14 visits, for a maximal three hours a day[38]. The home nursing service supplies both health and social help, and for this reason the service is based on professional health and social figures. In the majority of cases is the family doctor who deicide for the activation of the assistance and than the service is than concretely carried out by professional nurses in collaboration with the family doctor and, if needed, some specialists (i.e. physiotherapists, logopedist, dietetic experts). Nurses and caregivers are in most of the cases part-time employees or health care free-workers and the workers' salary is fixed differently by each provider, in case of private ones, or regulated by national rules in the case of public servants.

In alternative or eventually parallel to the home care service; the law foresees also the so called domestic care based on housework and daily life support activities. The service is organized by the local government, delivered by accredited suppliers and it's

36 271.000 are care workers in the private sector, the rest of them are engaged in the voluntary sector.

37 The definition varies from agencies to agencies: old age is usually 65+ and older 60+ but in some agencies the term old refers to 50 or 55.

38 In case the 14 visits cycle were not enough, the family doctor, in cooperation with a nurse, can decide to continue the service for further 14 visits.

ordered by the family doctor (sometimes on family's or on patient him/herself opinion). The costs are entirely incur from the beneficiaries and they depends on the client's income. The service foresees just basic need helps and it's for this reason carried out by helpers or nurse assistances with a lower (in comparison to the home carers) qualification level. The services are available form Monday to Saturday from 8am to 4pm[39]. The organisation of the assistance is carried out with the synergy work of social workers, family doctor and the patient's family and or the patient self. Domestic caregivers, i.e. the people who actually provide domestic aids, are not part of home care workers.
Even if the two figures are occupied in different tasks and have different status, there are often difficulties to differentiate between health and social sector's responsibilities, so that the two figures are often confused with each other. Generally the confusion is related to the fact that domestic carers complete the work of the professional carers in the after-care activities. Moreover a form of cooperation between home nursing carers and domestic carer is foreseen in so called home care packages, which includes a bright spectrum of health and social assistances.

Concluding the employers in home care are represented by the Council of Hungarian Health Care Workers and Community and Hospice Professional Care Branch, an organ that owns the data concerning the home care services and which produces every year an obligatory report about the home care services (i.e. the number of care patients, visits by genders and age-group, foundling's form of the activities, etc.).
Regarding the aspect of the informal carers, there is no formal recognition of these figures. The law acts foresee the possibility to give an allowance to family members, who are assisting a relative at home.
KEY CONCEPTS: Public and Private Home Care (free of charge); Public or Supplied Domestic Care Service (to be paid); Collaboration among Care Figures; Allowances; Not Conventional Care (Neighbours and/or Qualified Workers black paid).

SLOVENIA
In Slovenia part of the care service is provided by the institutional forms of health care in the form of non-acute hospital care; moreover in the framework of the social security system, the users are cared with various services, such as daily and all-day forms of institutional care, (social) assistance at home, the right to a home care assistant, care in sheltered housing and various social security programmes of personal assistance specific for disabled persons. The “burden” of social home care is supposed to be taken over by each local community; however, only the minimal possible extent is in fact currently being carried out. The fact is that the major part of the assistance in every-day life of a senior is placed on the senior’s family, particularly on the female members of the family.
The older population is growing and the state cannot satisfactorily meet the needs of senior citizens, so a common phenomenon in the sector of home care is taking place also in Slovenia: persons who need several hours of daily assistance, who often opt for neighbours, friends, ladies recommended by acquaintances performing the service of security and care on the basis of a “payment in hand”[40]. As well it is also necessary to mention various societies, such as the pensioners’ society, the society of deaf and hard

39 During the reaming time so as during the weekend private suppliers will provided the service. Although there is a lack of private providers.
40 There is no data about figures or percentages, but it's a growing phenomenon.

of hearing, and various organizations of disabled persons, which in the framework of their activity provide various forms of assistance to their members. Assistance in societies and various religious organisations is mainly based on volunteer work and aimed at preventing loneliness.

Considering the professional domestic social care services, they are provided by qualified professionals so as by qualified assistants and eventually by laymen, under the management of qualified professionals. Domestic social care is, in compliance with the Rules on Standards, aimed at persons who are provided with residential and other conditions for living in their living environment, but who, due to old age or severe disability cannot look after and care for themselves, neither can such care and nursing be provided by their relatives, or they have no possibilities to provide them. Domestic social care includes the co-operation[41] of the manager and the coordinator of the service, the provider of the service, the beneficiary, the responsible family members and volunteers.

A complementary form of domestic care is given by social servicing, which is identified as special services (i.e. housework, maintaining personal hygiene, companionship, etc.) used to give assistance to people with necessity, under them also to elderly, to help them in remaining at home as long as possible and to assist also elderly's relatives. Social services are not performed as a public service[42], which means that the beneficiary must pay the whole costs.
In addition to public institutions, which implement the domestic help service to the greatest extent, recently, in the field of senior care, the space has been open up to earn profit. More and more persons decide to become sole traders, providing either domestic social care or domestic medical care&nursing; a further category is defined by the so called “Senior security” assistant: people offering care assistance as supplementary work. For the personal care of elderly so as for the supplementary work of carer qualifications are required.
A home care assistant may also only be a person who, with the purpose of becoming a home care assistant, has cancelled his/her registration in the list of unemployed persons, or who has abandoned the labour market. The home care assistant may also be a person who is employed by the employer for a shorter working time compared to full working time. The home care assistant has the right to a partial payment for lost income at the level of a minimum wage or to a proportional part of the payment for lost income in the case of part-time work. The disabled person retains, in the event of choosing a home care assistant, the entitlement to the attendance allowance which he/she receives; however, on the basis of a written statement submitted with the application to enforce the right of a home care assistant, the person needing assistance allows that during the period when the assistance is provided by the home care assistant, the disbursement of this allowance is paid to the municipality which finances the home care assistant’s rights.

KEY CONCEPTS: Public Care Service (local communities' task); Family (Female Members); Non conventional Care Service (Neighbours/Friends black paid); Volunteers; Domestic Social Servicing (to be paid); Independent Caregivers.

41 According to the Rules on Standard it is foreseen one carer every five beneficiaries; one person responsible for the management of the service every 100 beneficiaries; and one person responsible for the determination of eligibility and preparation of the agreement every 200 beneficiaries.
42 Social services can be also implemented by those licensed to work with the Ministry of Labour, Family and Social Affairs.

Summery Chart

Tab. 5 Figures carrying out homecare assistance services

	IT	DE	HU	ES	UK	SLO
A figure which integrated social and health assistance	X	X	X		X	X
Social workers			X	X	X	X
Nurse-(assistant)		X	X	X	X	X
Relatives (*through allowances)	X*	X*	X*	X	X*	X
Persons not qualified external to the family	X	X	X	X	X	X
Qualified Persons working in black	X	X	X	X	X	X
Charity work associations	X	X			X	X
Independent workers qualified				X	X	X

2.3 How is the Home Care Service financed? Which costs compete for the beneficiary for the family?

ITALY

The Regional Health Service is funded by the resources derived from the IRAP revenue (regional tax on productive activities), from the regional additional to IRPEF (personal income tax), from the share of the excise on fuel and from a regional share of IVA (value-added tax). To these sources of finance must be added the Local Health Authorities' own incomes and the credit balance of the Health Mobility (reimbursement to the Local Health Service of the Emilia-Romagna region for the treatment services provided to citizens of other regions). Within the Regional Health Service great importance has been given to the home care sector[43] and, concerning it, in 2009 a target specific three-year regional fund (the Regional Fund for non-self sufficient people) has been created in order to increase the synergy among health, social-health and social services under the supervision of the municipalities.

The Municipality of Parma supplies an economic contribution, foreseen by the Region Emilia-Romagna, with the aim of maintaining the non self-sufficient citizens in their households. The allowance, which is assigned on the basis of the Individual Caring Plan (cf. cap. 2.1), can be used to buy services from a panel of suppliers accredited by the local administration and it can be paid to: (a) the beneficiary themselves, in case they can manage decisions about their care-assistance; (b) beneficiary's family, who guarantee social assistance service directly or through the help of non family members; (c) the beneficiary's guardian. The service-costs for the assistance are fixed by the local

43 Including principally: general practice assistance (57,2%), nursing care (36,4%), social welfare (4,9%) and specialist care (1,5%).

administration and they are the same for everyone living in the district of Parma44. The costs are determined by the hourly cost of agency of the employed operators, by the average of the annual cost of the vehicle used and by the cost of the operator's travel and by staff cost. The citizens contribute to the total service expenses according to their own income, with an amount that varies to a maximum of 6.89 € for every home assistance and 8,26 € for several home assistances (for citizens in the 6th income bracket - over 619.75 €) and which includes exemption for citizens falling within the 1st income bracket, which means up to 335.70 €.

KEY CONCEPTS: Health Service Public Financed; Allowance from Municipality; Municipality fix Service Costs; Beneficiaries' Contributions (for Social Services).

SPAIN

The implementation of the Community Social Services is, from 1998, carried out with the financial contribution of Ministry of Social Affair, through the Agreement "Programme for the development of Basic Benefits of Social Services of Local Administration", signed between the Ministry and regional government, which aims to ensure basic benefits to citizens from Andalusia in situation of care needs. In Andalusia, the Decree 203/2002 regulates the system of funding of social communitarian services, distinguishing the credits from the State and those from the Autonomous Community, but without setting the assumed share of funding local entities.

The economic contribution of the user will be made by paying the public price as provided for in the regulations. As stated in art. 22 of Order of November 15, 2007, which regulates the assistance at home service in Andalusia, to calculate the contribution of the individual user in the cost of the service, after determining the personal economic capacity: from 0 to 90 % of cost contribution, according to (ten) minimum salary classes of the beneficiaries(i.e. Cost defined by income and property). For the purpose of implementation of this table, the annual pro capital income has been determined by the criteria in the following article, will be divided by the number of members. The economic contribution of the user will be made by paying the public price as provided for in the regulations.

If care is not possible in any the services indicated in the Catalogue Service, it will join the economic benefit associated, which will be dedicated to covering the costs of the service foreseen under the Individual Care Programme. Exceptionally, you may receive financial benefit to be attended by no professional staff, if exists the appropriate conditions of coexistence and habitability of housing and it's established in the Individual Programme.

KEY WORDS: Social Services Public Financed; Beneficiaries' Contribution; Allowances.

GERMANY

In 2008 it has been spent for health and care a total of about the 10.7% of the GDP. The German health system is funded predominantly by the state insurance of illness' earnings and federal money. The social insurance is funded predominantly by fees and sometimes by taxes and it is funded by employers and employees at the same part. The fees are geared to the gross pay and gross wages: in 2010 the social insurance fees take about 31.25% - 33.35% of the wages of medium and low paid employees. With payment of contribution and premium pay the insured acquire a claim to get help if the

44 The same prices are guaranteed also for persons not entitled to the voucher.

get highly-maintenance, so that his/her business situation is irrelevant because the insurance of care benefits are delivered independent from income and asset.
The public health care bankrolls different benefits for the needy of care. These benefits are delivered as cash or non-cash benefits with which the basic care and budget-side supply is funded. The needed help can be delivered private and un-bureaucratic with the caring allowance. The non-cash benefits bankroll professional nurses; because this is much more costly than private help, the non-cash benefit's budget stands extensive over the number for the nursing allowance. Both kinds of benefits can be combined. Furthermore the insurance supports courses for care, renovations of flats, maintenance utilities, short term care and other.
According to the levels mentioned at page 5, there are foreseen also different public contributions, defined by the law, which are paid by the insurance for home care service. This refers both to allowances to be used for professional workers[45] so as to the allowances foreseen for the relatives[46] taking care of a needy. A contribution from the beneficiaries or from the family is also foreseen.
KEY CONCEPTS: Care Service Public Founded (Federal Founds and Insurance of Illness' Earnings); Fees from Wages (Employers and Employees contribute equally); Caring Allowances; Beneficiaries' Contribution.

ENGLAND (UK)
The social care is public financed from a combination of central government grants, council tax revenues, and user charges: in 2006 net spending by public authorities on care services for older people was 5,69 billion, while the private payment, including personal contributions to services partly founded by the state, is estimated to be 5,89 billion. Under Section 17 of the Health and Social Services and Social Security Adjudications Act (1983), local authorities are given discretionary powers to charge for non-residential social services. Moreover in 2001 the Department issued statutory guidance on charging for home-based care and non-residential social services to all local councils, keeping on a charging based on fairer and well designed charging policies. In particular, service users on low incomes are protected from charging and any charges levied on disability benefits are subject to an assessment of disability costs, to ensure that they are reasonable. Currently anyone with assets valued at over £ 23,500 receives no state assistance. In the current system, people who have the highest needs and lowest means get some help through the social care system or through the disability service. But by 2026 1,7 million more adults will need care and support: 20% of people will need care that costs less than £1,000 – but another 20% will need care that costs more than £50,000[47].
As in England the policy dealing with adult home care is based on an increasing of the personalisation of the care service, the individual budget[48] (IB) is considered a way to reach a higher autonomy level among beneficiaries. This way of payment is the alternative to Direct Payments, which is a means-tested cash payment, made in the place of regular social service provision to an individual who has been assessed as needing support. Following a financial assessment, those eligible can choose to take a direct

45 The highest public contribution, which means to care a person with high needs, was in 2007 1.432 Euro per month (cost for professional assistance are between 2.700 and 3.200 Euro pro month).
46 The highest public contribution, which means to care a person with high needs, was in 2007 665 Euro per month (cost for non professional care are ca. 1.200 Euro pro month).
47 Up to £100,000 could be the cost for a person spending years in care home. If someone is in a care home and no one is living in their house, they are expected to use their savings and the value of their house to pay for care and accommodation.
48 Till now piloted in 13 local authorities

payment and arrange for their own support instead; the money included in a direct payment only applies to social services. Unlike direct payments, an IB sets an overall budget for a range of services[49], not just from adult social care, from which the individual may choose to receive as cash or services or a mixture of both. IB holders are encouraged to devise support plans to help them meet desired outcomes and they can purchase support from social services, the private sector, voluntary or community groups or families and friends. Assistance with support planning may come from care managers, independent support planning/brokerage agencies, or family and friends. The local authority is primarily responsible for ensuring an appropriate range of support is available for people who use services.

KEY WORDS: Social Care Public Founded; Beneficiaries' Contribution; Protection low-incomes Users; Direct Payments vs. Individual Budgets (IB).

HUNGARY

In 2005 the total expenditure on health amounts on 8,5% of the GDP (Gross Domestic Product): for stationary care activities have been spent the 2,8% and for home care has been spent the 0,2% of the total health expenditure. In the same year the total expenditure on care for elderly amount to the 0,38% of the GDP.

The National Health Insurance Fund (NHIFA) is responsible for funding home care services: the Country Health Insurance Budget (i.e. NHIFA) sends the money to Regional Health Care Centre[50], which then divided the funds on County Health Insurance Centre. At this point, each county will transfer the money to the providers.

Care providers are funded by a fix amount of funding, which is established by the number of (insured) inhabitants of the settlements where the provider works, and so payments match the exactly reported number of visits, which means that the funding resources are provided to a preliminary determined monthly number of visits (Laid down in act 43/1999, Governmental Decree). The providers write a report after every month and send it to the County Health Insurance Centre; if the Insurance control result is positive the providers will get the money for their services (i.e. for every visit done).

The visits' financing are entirely different by the funder: in professional health care the visits are free of charge[51] (98,1% of professional health care visits are funded by NHIFA). On the other side, in case of domestic help patients have to pay directly for the service domestic help and the costs depend on the beneficiary's pension. But as normally the money is not enough to cover the complete costs of the service; the local government (to whom belongs the domestic care assistance and which gets the money from the state budget for the functioning of this service) supports the beneficiaries.

Moreover the health care and social services go parallel, which means that there is not a progressive and complementing system, with a direct influence about the aspects related to the founding of the services.

KEY CONCEPTS: Health Services founded by NHIFA (free of charge); Monthly Providers' Report; Domestic Help (to be paid).

SLOVENIA

49 Integrated community equipment service, Disabled facilities grants, Housing-related support, Access to work, Independent living fund.

50 Hungary has 7 regions and 19 counties.

51 Up to 56 visits pro year pro person.

Services and benefits related to home care assistance are partially financed by taxes[52] and partially by social insurance contributions[53]. Beneficiaries[54] themselves are obliged to pay for the costs of direct provision of domestic social care according to the agreed programme and the agreed extent. Beneficiaries who are incapable of making payment, or whose ability to pay does not reach the value of service, may file an application at the Centre for Social Work for a partial or total exemption from the payment for the service. Some group of persons for whom it is determined that foreign assistance is needed[55], may also obtain monetary benefits which enable them to obtain informal methods of assistance. Moreover for some groups of persons (i.e. elderly, people with disability, widow) it has been foreseen an attendance allowances, which means a monthly monetary income, paid by the government, in order to grantee care and assistance. The allowance is given after the opinion of institutions' experts[56] or, under the law, due to certain medical circumstances, stating that the said person in order to perform basic vital needs inevitably needs constant assistance and attendance by another person, valid also for relatives.

When determining the price of a standard domestic care service performed by public service, the total costs of the service are taken into account in the following way: the amount is reduced by the subsidy provided by the municipality (at least 50% of the total cost), and the residual balance is then reduced by the subsidy provided by the state. This subsidy is determined by the Government of the Republic of Slovenia within the framework of the measures of active employment policy. The provider of the service is paid by the Employment Service of Slovenia.

KEY CONCEPTS: Home Care Public Founded; Contribution by Social Insurance; Beneficiaries' Contributions; Partial or total Exemption for some Groups; Allowances.

Summery Chart

Tab. 6 Assistance service's Founding (Social-health services)

	IT	DE	HU	ES	UK	SLO
With beneficiaries' contribution	X	X	X**	X	X*	X
Without beneficiaries' contribution						

* For workers earning more than 23.000 no free state assistance

** In Hungary for the home care nursing the beneficiaries do not have to pay. For the domestic assistance the beneficiaries have to pay, this amount depends on the monthly pension.

52 Provided for in the state and municipal budgets.

53 Provided for in the framework of compulsory health insurance and compulsory retirement and disability insurance.

54 Persons liable for the payment of the cost of the service are, in addition to the beneficiary, also persons who are obliged to provide the beneficiary with means of subsistence as derived from the law or a contractual relationship.

55 As persons with disability, unemployed due to severe disability or war veterans.

56 Pension and disability insurances have their own medical commissions.

TRAINING: Which kind of training/qualification do the caregivers require? How is it structured?

ITALY

The caregivers' training for the Home Assistance Service is differentiated according to three main figures already mentioned: the social worker, the OSS and the RAA.
The social worker gets his/her qualification within a university curriculum, divided in Bachelor and Master. The obtained qualification allows the social workers to be employed in various assistance fields, one of which is the home care assistance for elderly people. The social worker is able to analyse and prevent situation potentially of discomfort and difficulties of social integration.
The OSS needs to attend a vocational training based on 1000 hours, divided in praxis and theory. If a person already posses some skills in the care field, can, through a skills-examination, just attend the necessary courses (i.e. not the entire curriculum) in order to the qualification. The gained qualification allowed the caregivers to work in various situations related with social-health assistance, among which also the care-assistance of elderly at home. The necessary knowledge refers to skills which allow medical tasks and care of the person (i.e. medicine giving, maintain personal hygiene), supporting tasks within the household (i.e. cooking, cleaning) but also social tasks (i.e. maintaining social contacts and social activities).
The RAA it's a specialisation based on previous qualifications in the sector of social-health assistance (i.e. OSS). In order to obtain this qualification, the person needs to attend a 200 hours course. The RAA knows the caregivers works and his/her roll is to organize the various activities or to work groups of social and OSS workers. The RAA has got the same skills and knowledge of OSS plus all the competences to organize the work of caregivers (i.e. of OSSs).

The provider of the home care services is responsible for the continual training of its staff and certified the qualification of its staff through self-evaluation; for this reason the Municipality is responsible for the controls of the quality of the service and the qualification of the staff. Additionally the beneficiaries, allowed to change providers, pointing out the reasons for their dissatisfaction, are doing a further indirect control on the qualification of the providers' staff (comporting a more detailed control from the Municipality on the qualification and skills of the providers' staff).

Relating to the independent caregivers the Municipality of Parma is planning a system of qualification in the sector of care-assistance, in order to support the families for the choice of the person. Family assistants who are of age, have completed their compulsory schooling, are European citizens or are in possession of a regular residence permit and have no criminal record can enrol in a public register presents by the Municipality. The register is a sort of public list of professionals accredited to work in the sector of (home) care assistance. The qualifications necessary for enrolment in the register are technical competence in assistance of elderly, certified by a training course of at least 30 hours or with a certified work experience of at least 120 hours. Necessary is also a good knowledge of Italian (which is to be certified from staff of the Municipality) and, finally, being in possession of a certificate of suitability for care assistance. In the case the candidate does not possess the right qualifications at moment of the enrolment in the register; he/she obtains information about educational activities in order to gain the necessary qualifications.

KEY CONCEPTS: University Curriculum 3+2 (social workers); Vocational Qualification (OSS); Specialisation (RAA); Suppliers responsible for Staffs' Training; Municipality as Qualification Controller; Training Course for Independent Caregivers' Qualification.

SPAIN

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. As for the Degrees, we have graduates (psychologist, sociologist, lawyers, etc.), Graduates Media (social workers, educators, etc.) and administrative staff.

Home caregivers should have a specific professional qualification to develop their functions, that develops the Professional Certificate of "Social and Health Care at Home" (which repeals the Certificate of Assistance at Home). Auxiliary staff of assistance at home, according a Order of 2007 (15th November), there must be at least the degree in Compulsory Secondary School, Diploma in Education Secondary School or Certification Primary Studies and have the professional qualification for the exercise of their functions, as laid down by a Royal Decree (331/1997), laying down 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, that develops professional certification for "Social and Health Care at Home".

In the case of Granada Council, as being a mixed management in which the service is carried out by a lending company, the home care staff must have a special training in assistance at home, which ensures an optimal level of quality and efficiency in service delivery. That is why, in addition to the training requirements specified in a Royal Decree (331/1997), the company will also provide additional and specific training considered appropriate to provide an adequate service. The training course is based on 425 hours, which mixed theory and praxis in the field of care-assistance.

An innovation in the system is seen through the Royal Decree 1224/2009 of 17 July. This has established the acknowledgement of professional skills of auxiliary in home assistance, which has been acquired not only through qualification but also through work experiences. The Ministry of Education and the Ministry of Labour will issue a "recognition" after the success in a national exams. Through the recognition the regional government have the possibilities to recognize skills of persons who have learnt the care assistance job through praxis, also in not conventional work situation, reducing in this the black market and increasing the qualified persons.

KEY CONCEPTS: Professionals in Training Activities; Home Caregivers through Professional Certificate; Auxiliary Staffs basic School level + Professional Qualification; "Recognition"; Local Authorities promote Training (carried out also by care companies).

GERMANY

The education for nurses or caregivers is regulated by the government and it is equal for all federal states and it last for 3 years. The education compasses about 2100 hours of theoretical and practical courses as well as about 2.500 hours just for practical

education[57]. Assumption for the admission of the education for an elderly care nurse is the intermediate second education level or a previous vocational education of at least two years. The theoretical education is given at public or private accredited schools specialised only for caregivers. In both cases, the schools collaborated very strong with facilities for the practical education of the students: the praxis takes place in stationary caring facilities and by ambulant care providers. Other parts of education, for example in hospitals with geriatric balance points are also possible. The practical education's carrier concludes a contract with the students and pays an adequate fee for the whole time of the education. The education can be completed either in a full time or in a extra-occupational form. The education is aimed with regards to the knowledge and abilities, which are needed at the autonomous, integral and individual care, advice and assistance of elderly people in stationary facilities and in ambulant care.

Education's topics are for example duties and conceptions at the care of elderly (inclusion of theoretic base, care of elderly, gerontological funded work, communication, medical diagnostics and therapy, documentation, development of quality), the support of the elderly at life design, judicial and institutional basic conditions of nursing, nursing as a job (to develop a job-related self-image, to manage slumps and to master difficult social situations, to gain the own health).

In stationary and ambulant facilities of the elderly nursing not only the praxis will be actually learned but also the theoretic knowledge is enforced. That contains the teaching of institutional and judicial base and professional draft, the work with the elderly and take over of partial work including the advice, support and assistance and the work with the medical diagnostics and therapy under guidance or rather charge, help at the daily structuring, design of daily life and the gain of social contacts as well as individual autonomous work in projects, for example at the development of home care situations. The education of ambulant care normally takes place during the education of a professional nurse as a special education or in case of a following further training. In the ambulant care the caregivers are more self-concentrated than in a hospital as colleagues or a doctor in duty are not at their beck and call at every time; therefore in this working field a special education and a good quality of work is needed. To make the grade and to reach those goals some special personal and functional modes are needed as well as interpersonal skills.

Professional competence is for example: current knowledge on the different disease patterns; knowledge of the adequate care actions; knowledge of the actions in case of accident; knowledge and execution of bedding techniques; right exposure to medicine; knowledge of the effectiveness of medicine; right exposure to drip-feeding; right exposure to hygienic directives; knowledge of a documentation of care; knowledge of a compiling of a plan for care; knowledge of the insurance of care; knowledge of regulatory affairs

Interpersonal skills clasp items like: ability to communicate with patients; ability to communicate with patients' affiliates; respect of the patient's privacy; ability to cooperate with other careers.

Who takes care of an affiliated, he/she needs advice and instruction to obviate the danger of a physical or mental discharge and to assure a good quality of the care. In Germany more and more institutions, clubs and care providers offer such courses and orientations for free for caring affiliates. Topics of these courses are for example modes of mobilization or bedding, spine-friendly lifting (for example from hospital bed to the wheelchair), diet, devices and rehabilitation measures, insurance of care and judicial

57 Since 01.08.2003 the educational for caregivers for elderly has been implemented.

questions. Besides the agency of these relevant topics the attendants get the possibility of get to now animations for their home situation, to communicate about their care situations and to inform on discharge supplies. The supply of those free courses is fixed by law in Germany, depending to § 45, SGB XI the public health care have to supply those courses for affiliates and honorary caregivers for free.

KEY CONCEPTS: Paid Training; Praxis, Theory and Soft Skills; Extra Training for Home Carers; Free Courses for Relatives.

ENGLAND (UK)

One of the most important aspects of improving quality of the service is supporting the caregivers with suitable skills competences and training activities; for this reason the renewing of the care system foresees also that the training minimal standards are to change soon. The workforce will face big challenges over the coming years: more people will need care and caregivers may need different skills to support more and more personalized services. The Department of Health recently published a strategy on the future of the care and support workforce.

The most important provider for the establishment of training and qualification standards in the UK is the licensed by the government "Skill for Care and Development"(SfC&D), an alliance of six organisations[58], collaborating, on national and regional level, both with social care employers so as training providers. The institution ensures a national framework for one million social care staff in England, providing over £25 million in funding to support improved training and qualifications for managers[59] and staff. SfC&D created also an overview of what the priorities are, used extensively at national and regional level to inform their own planning and their agreements with delivery partners. Priority 1: Leadership, management and human resource planning. Aim: To improve the quality, effectiveness and efficiency of managers, human resource practitioners and leaders at all levels within the adult social care sector in order to meet the needs of people who use services, and carers; Priority 2: Ensuring good employability and progression skills. Aim: To improve retention and increase recruitment across the adult social care sector, to deliver personalised care in a diversity of settings; Priority 3: Developing the skills of the social care workforce of the future. Aim: To use workforce intelligence, skills development and support systems to train and develop a diverse workforce to meet the needs of people who use services, and carers; Priority 4: Developing new types of working. Aim: To develop a workforce that is flexible, can work across services and support self care and personalized services; Priority 5: Improving the skills and enhancing the role of commissioners. Aim: To develop the skills and knowledge of commissioners of social care services and workforce development to ensure the quality of service delivery.

Additionally an agreement, the Sector Skills Agreement (SSA), between employers, providers and funders of learning provision, the government and the Sector Skills Council[60], maps out what skills employers need their workforce to have and how these skills will be developed. Through five stages, the SSA has the aim is to influence the supply of relevant training and to develop appropriate skills for the care givers. Hire briefly the stages: (1) Assessing current and future skills needs of the workforce; (2)

58 Care Council for Wales, Children's Workforce Development Council, General Social Care Council, Northern Ireland Social Care Council, Scottish Social Services Council, and Skills for Care.

59 Also the qualification for managers in the care system is based on a national framework (National Qualification Frameworks).

60 Skill for Care and Development is the Sector Skill Council for social care.

Identifying and assessing current training and development provision; (3) Analysing gaps and engaging employers, workers, people who use services, and carers in market testing options for change, solutions and priorities; (4) Developing agreements between the sector skills council, employers and other partners; (5) Developing an action plan.
The SSA outlines also some generic skills, currently identified as requirements: Literacy, language and numeracy (i.e. skills for life), Skills which prepare new entrants into the workforce, Core skills (i.e. moving and handling, medication and food hygiene, etc.), Communication and interpersonal skills (i.e. managing multidisciplinary and cross-agency teams, adopting flexible approaches, etc.), Information and communication technology skills (i.e. make use of assistive technology, ICT applications for e-learning), Skills to deliver a more preventative approach to service delivery (i.e. helping people living independently), Skills which help develop a critical approach to reflective practice (i.e. learning from current best practice[61]), Leadership and management skills, Commissioning and procurement skills (i.e. identification of the right skills for the workforces), Skills for people who use services, and carers, Skills for Life needs in social care, Skills in commissioning workforce development.
Among all these skills and competences, it results to be from very high importance: practice knowledge and experience related to care-assistance, good use of English so as soft skills like right personal and attitude.

By suppliers newly appointed workers delivering personal care who do not already hold a relevant care qualification are required to demonstrate their competence and register for the relevant National Vocational Qualification[62] (NVQ) in care award within the first six months of employment and complete the full award within three years. Moreover since 2008, the national minimum standards defined higher criteria relative the required qualification of their staff[63]. These targets are reviewed every two years. It is also expected that authorities should improve massively, so that 50% of the workers should be working towards a qualification if not already having one.
Unqualified staff, employed for less than 2 years at the commencement of the application of the standards, is phased into the relevant NVQ in care over the following 2 years and complete the award within 3 years. On the other side most social care jobs do not require to have any qualifications or training before starting[64]. When you begin working in social care you will be given introduction training which takes place in the first twelve weeks of your new job, using national standards adapted to where you work, in order to get basic knowledge and skills; your manager will lead most of the training (also external trainers may be involved in specialist areas). This training will ensure that you know how to do your job properly and safely. Induction training gives you professional recognition, and then you may work towards the relevant NVQ.
The NVQ in Health and Social Care foresees three levels[65] of qualification: Level 2 aimed at those who support and assist individuals with their physical or emotional care, daily living needs or maintaining their independence. It is extremely relevant for home care assistants, community support assistants, healthcare assistants, and residential or day service assistants; Level 3 aimed at individuals who often work without direct supervision or on their own, perhaps in a user's own home; Level 4 aimed at people in supervisory or management roles. These qualifications are work based awards and

61 National Occupational Standards describe best practice by bringing together skills, knowledge and values.
62 In particularly the NVQ in Health and Social Care and the NVQ in Leadership and Management for Care Services.
63 Also personal on the managerial undertakes periodic management training.
64 The only precondition is to have no criminal record.
65 There is also a level 1, which is considered a foundation qualification. All the care staffs have to attain level 2.

learners' skills and knowledge are assessed in the workplace whilst they are working directly with individuals and colleagues. They must be working in a real health or social care setting on a full or part time basis and in paid or voluntary work. If learners require any additional training prior to assessment this can be based in or out of the workplace or by distance or e-learning.

Changes in training and qualification: NVQs are about to be replaced by the Qualifications and Credit Framework (QFC), which will be compatible with (but not replaced by) the European Qualifications Framework for mobility and cross-referencing of training standards. Units are being developed at different levels; learners can undertake units to reflect their role, certain aspects of which may be diverse through rules of combination. The QFC recognises smaller steps of learning and enables learners to build up qualifications bit by bit, helping also learners to achieve skills and qualifications that meet industry needs. Additionally it enables work-based training to be recognised and formally accredited – rather than only official ones. A further change, not related with the QFC, is the build up of a new diploma curriculum (called Society Health and Development Diploma) addressed to 14-19 years old pupils. The aim is to encourage more people in continuing learning and gaining easier qualifications in the sector of care-assistance.

KEY CONCEPTS: Priorities of SfC&D; SSA (necessary skills for carers); Importance of Soft Skills; Training during the Job; Qualification "Bit by Bit"; E-learning for Carers; Qualifications and Credit Framework (QFC).

HUNGARY

The necessary education and professional levels are defined in national law acts, which distinguish between home nursings' (competent for professional home care assistance) and home helps' (competent for domestic help and social care) qualification. In order to practice home care assistance is necessary to have a general nursing qualification.

So in the home nursing is required an upper level of education (Bachelor and Master level). Otherwise in the domestic care is not required the high level education, but it is required only the basic level education, which is composed by a two-year education program (in professional secondary schools). This difference is based on the fact that in the domestic care the nurse/helper/nurse assistant provide, as already said, basic needs for the beneficiary (i.e. hygiene needs, feeding, moving, clothing, house-cleaning, shopping, and ironing, etc.); while in the home care the nurse provides the professional nursing implementations.

Every Hungarian health workers when qualified will get from the Health Ministry Office (HMO) the basic licence. After this during the next 5years they have the collect 100 credit points, and the certificate from these points have to send again to the HMO in order to get the functional licence. Every year in the job means 15 points, this certificate is given by the work-place, and these points come from the practice. The missing points have to collect from the theory training, eg. go to the conference, give a presentation on the conference, or participate on the theoretical training. This certificate is given by the organizer after the training, and, since 1997, these certificates have to be renew, by every health workers, every five years.

The Public Health Institute use to organize so often the training for these nurses to explain the new documentation, or the new methods; moreover the nursing schools also use to organize the refresh training from the new methods, from the communication, from the new nursing-implementation. Additionally the pharmacy companies use to

organize meeting to explain the new medication. Generally it is possible to say that the companies public funded pay for the obligatory education of their workers; on the other hand, private ones, rarely pay for education costs.
KEY CONCEPTS: University Curriculum (home nursing); VQT (home help); Recertification (Credits on the workplace); Public Companies, Nursing School and Pharmacy Companies provide Training (private care suppliers rarely).

SLOVENIA
The framework for the definition of the minimum standards related to the necessary qualification so as the principles of the service is defined in the SAA in compliance with the Rules on Standards. The types and degrees of educational programmes which provide the appropriate qualification for social care services are determined by the Social Chamber. In Slovenia, there are 21 various institutions, collected in an annex, which carry out training for social care which is used as a preparation in the process of obtaining a national vocational qualification.
Domestic social care is provided by qualified professionals, which means, according the SAA, workers who have finished higher school or high degree schools of education for social work, have completed the traineeships and have passed a professional examination in the field of social welfare[66]. On the other side the direct execution of the social service at the beneficiary's home is performed by a qualified assistant, who, according to the SAA, are those who have finished at least the secondary vocational or secondary professional school for social work or care and have attended a training course. This foresees 120 hours in pedagogic seminars, including theoretical and practical parts, as also practical training. The candidate should be at least 25 years old and should have at least 5 years of professional or non-professional (i.e. through work skills achieved through health care assistance for relatives, neighbours, etc.) experience in the field of care.
Under the management of a qualified professional, the service at the beneficiary's home may also be performed, as already mentioned, by laymen with at least primary education and who have completed additional training for social work according to a verified programme, according to the Rules on Standards. The SAA defines as well the necessary qualification for the management and coordination of the service.
KEY CONCEPTS: University Curriculum (domestic social care workers); VQT + Training Course (social servicing workers); Qualification for Service Management.

Summery Charts

Tab. 7 Art of qualification related to social workers

	IT	DE	HU	ES	UK	SLO
Social Workers with University diploma	X		X			

66 Related to persons who have a degree in: psychology, pedagogy, administration, law, sociology, work therapy and theology;
who have one year of work experience in social welfare, have completed traineeships and have passed the professional
examination of the Social Security Agreement.

Social workers with secondary education		X		X	X	X
Social workers with qualification		X	X Social assistant	X	X	X

Tab. 8 Art of qualification related to social-health workers

	IT	DE	HU	ES	UK	SLO
Social-health workers with University diploma			X	X	X	
Social-health workers with secondary education	X	X		X	X	X
Social-health workers with qualification		X				

CONCLUSION

In order to get some points of observation for the ProDomo partners (but also for other stakeholders) related to the next phases (valorisation and testing of one or more parts of the research), we list some aspects which, according to us, can be considered as interesting and innovative starting points for further contemplations. These aspects are taken both from the model of Parma so as from the reports relative to the other partners' countries, according to the philosophy of ideas' exchange, basis for the Leonardo da Vinci – Transfer of Innovation Projects.

1.1 The process of accreditation foresees collaboration between the Municipality of Parma, the (private) care assistance suppliers and the beneficiaries themselves. The assistance service is a process that tends, together with maintaining an high quality level and on the same time fixed costs of the service, also a direct participation of the clients (or his/her family) for the definition of the service's content.

1.2 By the Municipality of Parma a register (i.e. a public list of professionals) will be create as guarantee (under the supervision of the Municipality itself) about the qualification and level of competences of the independent caregivers. Additionally the Municipality will offer the possibility for this work force to fulfil the necessary requisites (i.e. competences, soft skills, etc.) through vocational training courses.

1.3 The Municipality of Parma will summarizing define the cost of the services, control the quality of the suppliers so as the qualification of their staffs and supervise the vocational training course mentioned in point (b).

1.4 In Spain, Germany, UK, Hungary and Slovenia the Social Security System or Acts (in the case of Slovenia) which are nationally valid and which

foresee an intense interaction among the various actors (i.e. national and local governments, municipalities, care facilities, etc.) related to the care service. Using an extract of the English report the care service should be "co-produced, co-developed, co-evaluated".

1.5 In the countries mentioned in point (d) all the suppliers which organise and carry out care assistance have to be accredited in order to practise the assistance service (not accredited structure can practise but any kind of allowance given by the government can not be use by such providers).

1.6 Generally speaking in all the partners' countries there is the tendency to the direction of subsidiary of the care service, moving the competence of the care assistance to institution closer to the final users. In Germany, for example, the Municipalities will the duty to coordination of all the offers of care and help addressed to elderly present on their territory (a sort of front-desk).

1.7 The care system in England is strongly oriented to a higher personalisation of the service, having beneficiaries (or his/her relatives) a very active roll in the definition of the service: "thinking about the public services and social care in an entirely different way – starting from the person rather from the service". In this direction goes the so called Individual Budget as a way to improve the personalisation of the service: the beneficiary is more autonomy in the deciding in which kind of service (i.e. local authority adult social care, disabled facilities, housing-related support, independent living assistance) is going to use his/her credit (i.e. budget given by the government). In order to guarantee constant supervision of the care service, the care staffs and the good procedures of the personalisation, it has been established the National Minimum Standards and the Care Quality Commission.

1.8 In Hungary there is a very strong cooperation between nurse (mostly health assistance) and social workers (mostly social assistance). Although in Hungary and also in Germany the home care staffs are trained in order to compact the two areas of intervention (medical and social) within a single figure.

◦ Within Hungarian care suppliers the staffs have to, in order to be updated, re-qualified every 5 years. The re-qualification, measured in credits is composed of a theoretical part (i.e. training courses, taking part to seminars, etc.) and a praxis part. The credits relative to this last part are accumulated through normal work on the workplace.

a) In Germany the presence of a consistent number of foreign carers (some qualified some not), has produced the launch of various private agencies specialised in qualified caregivers from East Europe (mostly Poland, Slovakia, Slovenia and Hungary), guaranteeing their competences, qualifications and skills (also soft skills, i.e. level of the language).

1.9 In Spain and Slovenia the carers who have the competences accumulated through work experiences but, as lacking of a qualification, can only work in the black market have now a change. The government of the two countries foresees to acknowledge as "working credits" the cumulated experience; this will allow these persons to obtain a final qualification and practise freely

their job. So for example in Spain through the skills previously accumulated the caregivers, after being tested by a Ministry Commission (Education and Labour), will receive the necessary qualification to practise the job.

1.10 Related to the growing phenomenon of carers coming from abroad and the related problematic of the acknowledgement of their qualification, in the UK there will be created a framework, called Qualifications and Credit Framework, which should support and facilitate the care workforce mobility within Europe. The QCF is based on a system which recognises also small steps of learning, in order to personalised the learning path and let the worker built up his/her qualification bit by bit (which facilitate working and learning).

1.11 Concluding, about the training of carers, in Germany the Healthcare Insurances have to, according to a national law, organise free of charge courses and orientation seminars for relatives caring affiliates. The topics are mainly: mobilization or bedding, spine-friendly lifting, diet, devices and rehabilitation measures, insurance of care and judicial questions.

3. Guidelines for promoting innovative aspects of the best practice of „work accreditation" for at-home care services

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 may 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* 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.

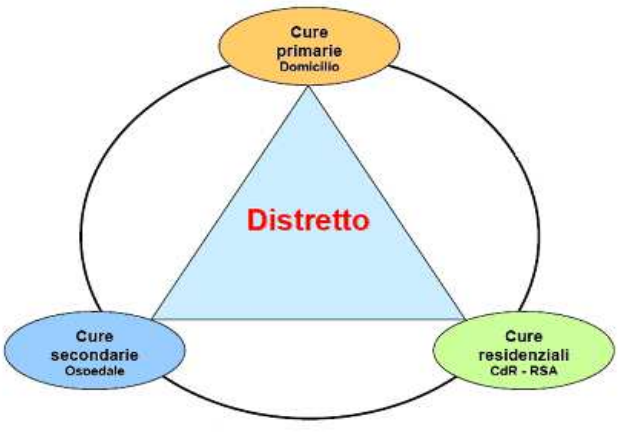


Fig.1 - District Functioning

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 periods. 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 contribute 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 (age18-64) 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 friend's 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 choose 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 friend's 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 I 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 of 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 that 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 COMMITEE** 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 o fan 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 o fan "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 posses 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 clear spirit of 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) **Commitment** 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 mandatory.
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.

It 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 context than the City of Parma.

3.1.1 COMPETITION, QUALITY OF SUPPLIERS AND PERSONALIZATION OF CARE SERVICES

As resulting form 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 chose 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 fro 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 of 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.

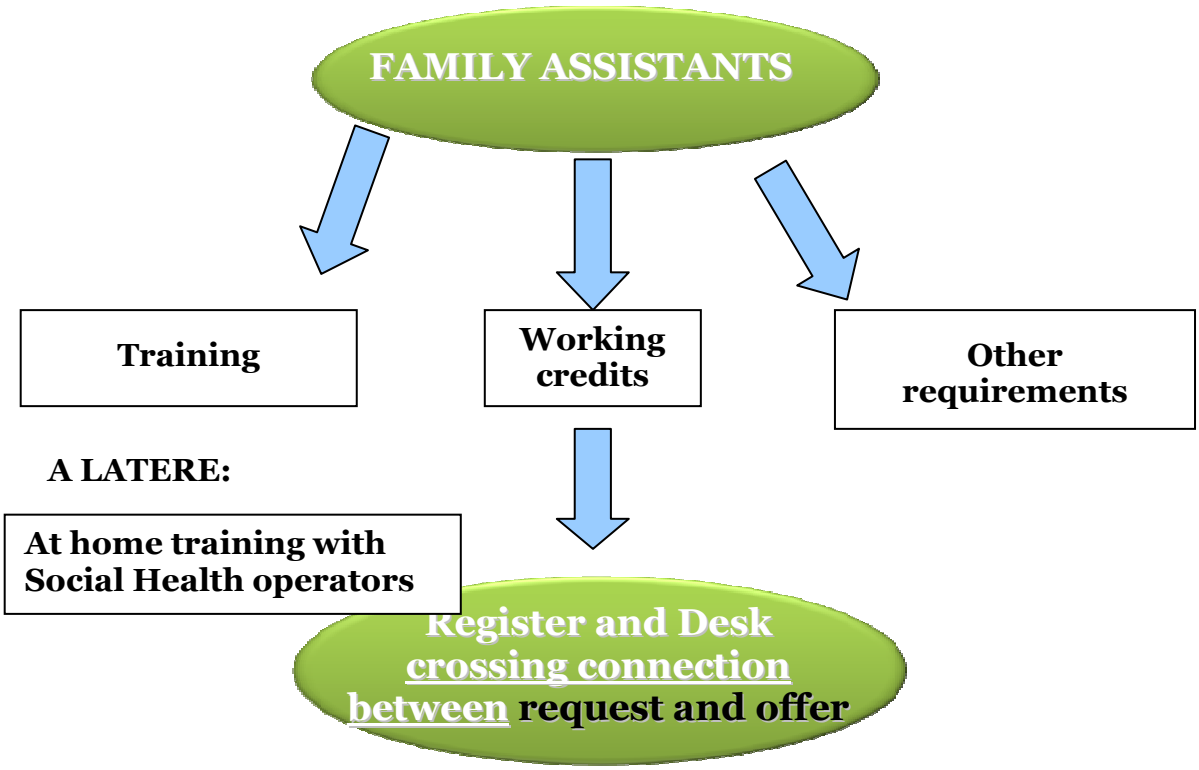
Temporary:

- 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 - Guidelines for promoting innovative aspects of the good practice of accreditation for the work of care services provided in the home

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 and (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.

4. Training model for family assistants

4.1 Introduction

The lengthening of life span, the increased number of elderly people who are not self-sufficient, the increase in female occupation rate, the increase of family units composed by elderly couples and elderly who remain alone, the search for balance between family life and professional life, are all factors which have brought about an increase in the need for at home care and assistance and a decrease of the possibility for families to care for the elderly on their own.

Family assistants are found to be working in households with persons (of any age) who need assistance and/or care, in situations when their autonomy is compromised. They can be in some cases family members or other people recruited directly by the families through institutional or non-institutional channels.

Families choose to have at home care to preserve the family and domestic dimension of life, since this makes it possible for people with special needs to receive assistance and care while continuing to live in their own home, keeping their habits and affective ties.

The field of informal care offers a notable occupational opportunity and is constantly on the rise and therefore it is necessary to activate training services which are accredited by institutions to teach these operators and to grant them full professional and social recognition.

Caregivers within the family, are for the most part lay persons with low professional profile but highly motivated because of the relational, occupational, or emotional reasons.

The ProDomo project proposes, through the constitution of a training model, to define (and then to transfer) a good practice of professional training, of competence and skill development and their certified accreditation for those working figures who cover a role of care taker in private at home care so that their work can receive full social and professional approval and be considered as a real added value and resource for the family itself.

4.2 Informal Caregivers

Lay person care givers are working figures who work in the field of home assistance. They provide assistance and care to the elderly and non self-sufficient people with physical, mental, social disabilities or experiencing social unease. They manage the relationship with the assisted person and his/her family (if not a family member) and carry out hygiene-related activities as well as housework tasks.

Family assistants work in both public and private sectors.

The main tasks of family assistants are:

- Household duties
- Wash laundry
- Prepare meals and assist in feeding
- Minor home maintenance repairs
- Deliver personal care and hygiene
- Accompany the assisted person/family member to medical visits or hospital admissions with appropriate means
- Administrative paperwork such as filling in forms and paying bills and if necessary to accompany the elderly on site with appropriate means

- Promote socializing activities
- Spend leisure time for recreational activities in community care centres
- Provide social assistance

The knowledge and skills that family assistants should have are:

- Ability to identify needs and physical, psychological and healing problems of persons with disabilities and/or non self-sufficient elderly people
- Communication, interpersonal and social skills, enabling adequate interpersonal relationship with the assisted person/family member and the family unit
- Skills aimed at improving the living environment, home security and independence
- Elements of gerontology, geriatrics and disability issues
- Skills related to the care and hygiene of the person and the environment
- Elements of nutrition education
- Elements of First Aid
- Knowledge of the Social and Health Services Network
- Ethical issues and legislation related to the role of informal care.

4.3 Target group

The Pro Domo project has highlighted the different kind of family assistants in the European partner countries.

Italy

In Italy family assistants are, for the most part, immigrant women recruited directly by the families through non-institutional channels.
In recent years, the use of private care givers has had an ever greater role. The changes that have affected the contemporary family (the aging population resulting in a greater need for health care workers, lower fertility rates, the weakening of informal support networks, the growing participation of women in the work force and the related transition of tasks and roles within the family) have led to an increased demand for care services and assistance to which the current welfare system cannot meet in terms of quantity and quality.
What characterizes the people who currently provide these private care giver services in Italy is that they are female, foreign immigrants, relatively young, more aware of their roles, less inclined to cohabitation and more interested in settling permanently in Italy. They are also frequently employed in the black market (S. Pasquinelli, G. Rusmini Istituto per la Ricerca Sociale, Badanti, la nuova generazione-Caratteristiche e tendenze del lavoro privato di cura, nov. 2008, www.qualificare.info).
According to statistics, only one caregiver out of three has an employment contract. To help this system of private informal care giving to emerge as a true profession is not an easy goal.
The provision of these private care giver services through the black market continues to expand as it is still convenient both for the private care giver and the family. However, this black market system leads to irregular employment, little job security, lack of training and technical expertise and poor coordination of care. (S. Pasquinelli, G. Rusmini, I sostegni al lavoro privato di cura,www.qualificare.info, ottobre 2009).
Training courses and certification of private care givers is an important element in ensuring a basic level of competence and quality, in promoting better coordination of

care between the various entities that provide health care and in giving these private care givers a path for job security and professional growth .

Germany

Persons, who care for elderly people in their home environment, without having an (accredited) professional qualification. Mostly of those persons are female, between 25 and 50 years old, foreign immigrants (manly form Eastern Europe countries) with middle to low (German) language competences.

Hungary

In Hungary the target group consists of people from two different areas.
Unemployed people and volunteers are involved. Their motivation is that they want to know more about home care nursing.
Volunteers/helpers who are family members at the same time. Their motivation is that they want to learn the nursing skills in order to look after their relatives/neighbours.

It is true for both type of participants that they are lay people. The target group is not homogeneous, because they differ in age and educational level. Due to these differences, their learning abilities, achievement and personal skills will be different.
After completing the training course they will be able to provide basic nursing/caring activities.
We hope that the members of the target group will continue their vocational education at a higher level and get higher and registered qualification (LLL).

Slovenia

Centres for social services decide about the entitlement. Family assistant is a person, providing help for the disabled person, when in need. Family assistant is not obligated to cover the material expenses for the life of the disabled person.
Family assistant can only be a person, which has resigned from the register of the unemployed or labour market exclusively to become a family assistant. Family assistant can also be a person, working in a part-time working relationship.
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 or if the sole trader or a single-partner company, which does not employ any other person, ceases operations (proving so with the confirmation of the cancellation from business and judicial registers), exclusively with the intention to become a family assistant. Termination of the employment contract or resignation from the register of the unemployed with the intention to become a family assistant to a disabled person cannot be ground for culpable exclusion from acquisition of rights under employment regulations and insurance in case of unemployment.
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
- 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
- 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.

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

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.

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.

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. Solvency and subject contributions are determined in accordance with the terms of the law of social care. In case their assets are not sufficient to cover all the family assistant rights, the difference is covered by the municipality. Subject that is a family assistant at the same time is not obligated to contribute to the payment of family assistant rights.

In case a disabled person possesses a real estate, a ban on disposal or mortgaging can be issued in favour of the municipality that finances the rights of a family assistant in accordance with the terms of the law of social care.

The areas are not clearly marked, the education is performed on a general areas, but with a certain emphasis on distance learning, which we find very positive and welcome. Regardless of the fact, that many people are not able to use a computer, there are many who actually can and it is my belief that this area is worth some additional research and prepare a n educational plan. Usually the interaction student:teacher and/or mentor is very important, but with this type of tutoring and that many candidates at once it has to be a bit sacrificed. The idea of instructional DVDs to be integrated in the learning process it seems very good.

The inflow of the foreign work-force means we encounter another issue, that is the language barrier, with communication being the essential element of performing home care. Teaching most common phrases, used in everyday communication and care is considered, as it is a very interesting and useful tool that still needs to be refined.

At the moment there is no great inflow of the foreign work-force, but monitoring the events and guidelines from the EU and the world, we have to anticipate this process and integrate these people into our home-care system as the percentage of elderly people is steadily growing through the years.

Educational program, that we forwarded can be presented, in our opinion is good as it covers a wider area, not just the medical point of view, but also social and judicial.

Something similar like a model that is used in the Italian city of Parma will be part of the upcoming Slovenian “law on long-term care”. Their model has a lot of similarities, the social services worker has the first contact, but is part of a commission, that in cooperation with a doctor and a representative of the municipality, prepares a personal plan for elderly person, which has to be completed in 30 days. As all the needs of the person are determined and accounted for, the beneficiaries get a voucher and choose a contractor by themselves. There is obviously a lot of suppliers unlike in Slovenia, and the prices are very similar between suppliers.

In Slovenia there is a rigorous distinction between public and private sector. Public sector is getting a subsidized hour fee, which is not the case with private sector (except the ones that have a concession), therefore our fee is significantly lower at 4,90 EUR per hour as opposed to private structure of Bit Vizija at 11,50 EUR per hour.

People that need help can contact the suppliers directly and cover all the expenses by themselves. We are interested in finding out whether is it a common practice, that hospitals discharge a patient in need of assistance and notifies the designated supplier that must provide service on the very next day. What's the procedure that determines the eligibility and how is the assistance organized? The fact is, that they do not have waiting lines as we do and it is probably the fact that the private sector is completely under developed.
That is why we would like to know how do promote the service. It would be very helpful if we had a list of suppliers that are verified and monitored, which would result in easy choice from the customer side. The other interesting aspect is ability to connect private and public sector.

They have three subgroups of elderly people and they are treated accordingly: in the first group are elderly with a family/social network, on the second there are the ones, that do not have it, but are still capable of making their own decisions and in the third group there are the ones unable to make their own decisions. In our country the home-care for people from the third group is provided by public sector by appointing a guardian for special circumstances that coordinates all the efforts.

There is mentioned a family assistant, but there is no record of a specific education for him/her. We see the potential in a distance learning program. This would be all for now – in the end we would like to emphasize, that in our opinion we have a valid system in Slovenia, but not effective as it could be because of the under developed private sector (mainly because of a lack of subsidies from municipalities and/or the state).

Spain

The target group chosen for the training model are family carers and people with low professional profiles who are providing home health and care services within the family or community sphere, usually in hidden economies and who have already experience on the job, but not professional training nor qualifications in the home care services field who usually have problems in accessing training due to their assistance timetables, being many times in risk of social exclusion.

The reason for targeting this group lies on the fact that for those individuals that are already providing services (continuously or with layoffs) directly through the city councils or through the accredited private business or have their competences

recognized some via by the Spanish authorities, it exists the official procedure of training and obtaining the accreditation mentioned in precedent paragraphs.

Transferibility

The legal framework of home care service providers is fully regulated in Spain through national and regional legislation. As a public service, for those people that fulfil the requirements established by law and have the right to be looked after at home, the organization is the responsibility of Local Authorities of Andalusia, which can manage the service directly (Local Councils) or indirectly (providing the resources for families and people in need of home care services to get them from accredited private companies). In both cases, the recruitment of assistants and carers and their requirements and qualifications are also regulated by law.
Despite the existence of this system, increasingly everyday, the Spanish society demands more health and care services for users that most cases do not qualify for a public funding or support. In these cases, the informal carers are the people providing these services, most of the times in a non regulated environment. These workers are mainly mature immigrant women from Latin-American and Magreb countries, with a low professional profile and many times without residence and/or working permits. This group of people are the one in needed of a training and qualification program as the one proposed by Prodomo and to whom the transferability of the system (training and obtaining a qualification) will be highly beneficial under three aspects:

- Professionalization of the sector by providing training and recognition of working experience to present informal carers.
- Help to regulate the situation of de facto carers giving them possibility of access to the formal and regulated sector of health care and assistance in the home.
- Provision of a better quality service to the community and especially to the people looked after that are not within the scope of beneficiaries of the public services.
- Contribution to this activity to emerge from the shadow economy.

Nevertheless, there is a fact that cannot be let aside as the lack of competence of the local authorities to accredit formal training or qualifications.

United Kingdom

The UK has a well established training model and structure for professional carers but an area where there is a gap is in respect to informal family carers. In the UK there are are an estimated six million unpaid carers of which are large number are young carers, and that every day 6,000 people take on a caring responsibility.

Informal carers very often have to give up work to enable them to undertake their caring duties or in the case of young carers they either struggle to gain qualifications at school or in some cases drop out therefore making it difficult for them to gain employment when they are able to take on paid work.

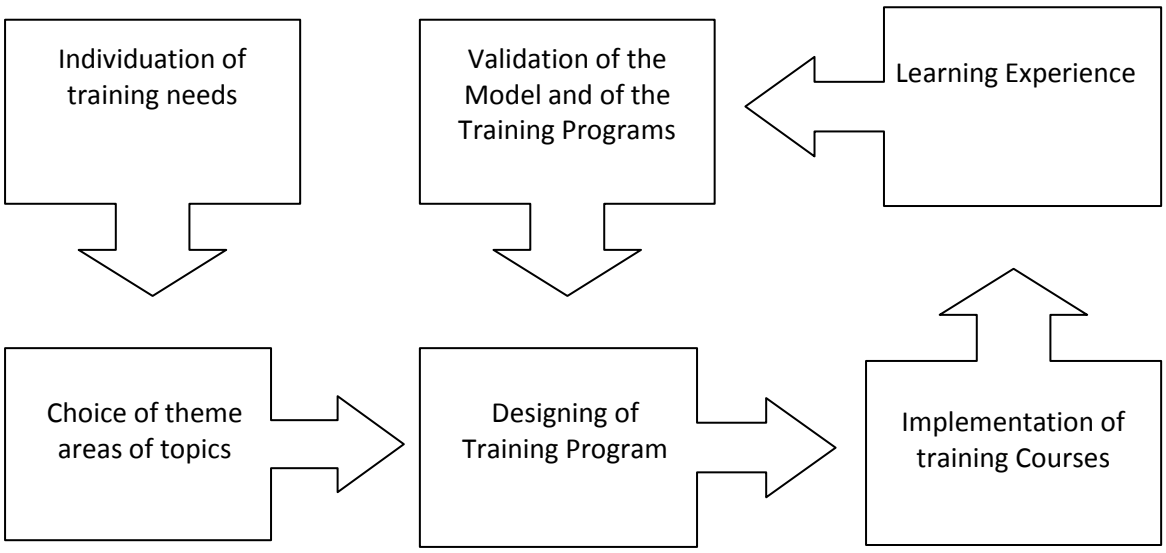
This is why we chose this target group, it is hoped that by developing a flexible training model that can be used by a wide range of people, it will support carers to accredit the

skills they have as well as provide training in new skills that will then support them to gain employment when they are ready. This will also supplement the training that is available already within the care sector and give a number of people more options when looking at which training model is appropriate to their needs.

4.4 The process of model development and objectives

On the basis of the results of the comparative analysis of the different European partner countries (as explained above), and according to the project proposal, the partnership is aimed at developing a training model for non-professional family assistants in order to promote the activation of institutionally accredited services for the training of these working figures so that they can receive full social and professional approval.
The objective then is to offer workers engaged in an at home care job (housekeeping, personal care, baby sitting at home, assisting the elderly or disabled people at home) a chance to gain certified skills recognized as a training and professional credit, so they can be recognized as belonging to a professional category regulated by institutional laws.
Secondly, the aim is to stabilize employment and help it to emerge from the scenario of "under the table" and irregular work by giving people tools to improve their employment possibilities and a mobility in the professional Market of work which can be efficiently managed to meet the need for work (which is expressed not only by the companies who deal with at home care services, but also by private parties.)
Based on the training model, the aim of the project is to trigger a process that makes it possible to gain competence and skills which are usable as cumulative education credits together with their working experience, and can be utilized to access future programs of professional advancement and improvement.
This way, the persons participating in the program are involved in paths inspired by the principle of lifelong training and in particular, in Work-life Long Learning.

The process of model development



4.5 Training Model –Methodology

Drawn by IMFE Ayuntamiento de Granada –ES

This model has been based on the drafts, reviewing and proposals of the training model previous, simultaneous and subsequent to Granada meeting. This draft also intends to bring together the different partners contributions in the debates in Granada as well as incorporates parts of the Spanish Certificate in Home Social and Health Care (Royal Decree 1379/2008, 1st August).

The contents included in this training model are has taken into account the contents proposed by England, Germany and Spain (the only ones received at the time of finishing this final draft of the Training Model). The Training Modules and the Didactic Units appear in grey for each country to introduce their thematic areas and didactic units according to their territory needs.

An estimated duration is given as an example on the basis of the characteristics of the target group debated and agreed in the last meeting in Granada (short, monothematic, supple, easy to complete dedicating short periods of time during "working days" and adapted to the trainees needs and availabilities). The duration is indicated in the form of a minimum/maximum range.

This final draft of the Training Model is presented in the following chart:

- ✓ Target group (profile of the trainee)
- ✓ Objectives of the course
- ✓ Outline Content
- ✓ Structure
- ✓ Duration
- ✓ Enrolment
- ✓ Face to face sessions
- ✓ Training methodology
- ✓ Training modules
- ✓ Didactic Units
- ✓ Review and Assessment
- ✓ Equipment required
- ✓ Minimum requirements for trainers
- ✓ Training of the trainers
- ✓ Obtaining qualifications

The Training Model for Family Assistant – Spain
Drawn by IMFE Ayuntamiento de Granada –ES

CATEGORY	DESCRIPTION	EXAMPLE
Target group (profile of the trainee)	Family carers (adults and young carers), people (young and adults) with low professional profiles who provide these services within the family or community sphere, usually in underground economies and who have already experience on the job, but not professional training nor qualifications in the home care services field and who usually have problems in accessing training.	
Objectives of the course	To define which basic and fundamental knowledge must be acquired in order to become efficient in the field: that is, reaching a level of professional competence.	This course aims to gain the knowledge, develop and improve the skills needed in the caring and supporting role for those people that are already carers or those that wish to develop a career in the care industry.
Outline Content	Explain the fields of know-how on which the skills of the didactic units are based.	The course covers a wide range of areas such as everyday care (personal hygiene, nutritional needs...), safety, emergencies management, social and emotional support, development of the family assistant and effective communication.
Structure	1. Initial assessment of the level competencies 2. Training Plan for the trainee 3. Mapping of individual courses	

	4. Giving the actual training 5. Review and Assessment	

CATEGORY	DESCRIPTION	EXAMPLE
Duration		60-100 hours
Enrolment		Example: One course every quarter during the year.
Face to face sessions	**At the beginning,** to introduce the training course, the study plan, the teachers, the tutors, the teaching materials, and to make the initial assessment of entry level skills and to define the personalized plan; **During the course** to monitor and check the objectives and learning; **At the end of course** for final evaluation and certification of acquired skills.	NA
Review and Assessment	The trainees will have an external expert support and the tools for self-assessing and reviewing	1. Progress against the trainees' development goals 2. Trainees' achievements 3. Reviewing trainees' learning plan. 4. Reviewing trainees' personal development goals.
Equipment required	• A DVD player for Distance Courses • Computer, Internet, e-mail for E-learning (Online) Courses (at home or using the community resources)	NA
Minimum requirements Trainers	• National Qualification according to each country. • Minimum experience in the health and social care sector (eg. 3 years) • Training qualification and training experience in the field. • Personal qualities or circumstances	NA
Minimum requirements Target Group	• Being age 18 or older. • Having graduated from mandatory school. • Being an Italian citizen of 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	NA
Training of the trainers	Training will take place in person, distance, blended learning and on-line courses and will deal	NA

	with developing the ability to transmit one's own experience, to organize and manage training courses and in particular: • To project, plan, and program the training activities; • To set up, select and elaborate teaching materials; • To acquire competencies in class management, in setting teaching tools and didactic methods; • To set up evaluation procedure for the participants' skills; • Ability to design personalized training courses.	
Recognized Certificate of Professional Qualification / Certificate of Competence	This issue depends on the country in which the course is validated.	In Spain this type of training cannot be accredited, due to the existence of a Qualification Path already well design by Labour and Educational authorities. At a local level it could be considered as a *plus* for people who want to work in the care sector at local or province level.

CATEGORY	DESCRIPTION
Training methodology	The method by which training is delivered has to be based on the needs of the trainees. Distance/e-learning or blended training course, ***out of sync*** mode and communication with trainers/tutors takes place through telephone, e-mail and/or a fax machine for those who own one. **Training phases** **BEGINNING OF TRAINING** 1. Initial meeting to verify skills and make a preliminary assessment of the trainees competences entering the program; 2. Definition of a professional training plan establishing a personalized learning course; 3. Presentation of teaching material to trainees (FAD or DVDs) which are set up for the training and of the tutors to which they can refer; 4. Meeting the teachers and the tutors to which trainees can refer.

TRAINING

5. Use of the materials indicated in training plan with the help of tutors in a class or long distance;
6. One or more meetings in person between the trainees and the tutor to monitor learning and check development;

EVALUATION

7. On-going, which can be managed at long distance by tutors or by the trainees themselves by means of an auto-evaluation;
8. Final evaluation in person with a set of tests to be performed to evaluate the skills that have been learned.

RECOGNITION

9. The accreditation of learning with public authorities for recognition of the continuous learning credit. Beginning of the training.

Training methods

- Lessons
- Case analyses
- Simulations
- Films/videos
- Practical exercises
- Internship or work-study

Methodology and evaluation tools

To define the methods to adopt to evaluate that the skills indicated by the didactic unit have been effectively achieved.
The following tools can be used:

- written test;
- interviews;
- practical test;
- case simulation;
- performance in simulation test.

Training for Family Assistants – Italy
Drawn by MUNICIPALITY OF PARMA – IT

The PRO DOMO project was presented by the Municipality of Parma to ISFOL – the National Agency of the European Programme Leonardo da Vinci - in February 2009.
The need to make a comparison at European level on the issue of informal caregivers was declared by the Municipality of Parma at the end of 2008, and led to the exchange of best practices with other European countries, with different customs and traditions but common needs.
The project was selected by the European Commission and funded in June 2009.
Since the start of the project, the Municipality of Parma, on the one hand, has focused on the research and comparison of best practices at European level and, on the other hand, has followed the directives of the Emilia - Romagna Region concerning the informal caregivers.
One of the most significant documents for the development of the training model for family assistants has been the Regional Committee Resolution n. 2375 of 2009 "GUIDELINES FOR INNOVATION AND DEVELOPMENT OF UPDATING AND CONTACT ACTIVITIES FOR FAMILY ASSISTANTS. IMPLEMENTATION OF SUPPORTING ACTIVITIES".
The resolution sets out the guidelines for training of family assistants. The comparison with the other European partners has revealed that training areas are quite homogeneous. The major difference essentially concerns the target audience.
The training course for family assistants outlined by the Municipality of Parma, Pro.Ges and CDS, follows strictly the Regional guidelines, to which further remarks have been added regarding relational dynamics and the need for family assistants to be considered as family members.

The Training Program for Family Assistants - Italy
Drawn by MUNICIPALITY OF PARMA – IT

Training modules	Introduction to the course	1. Aims and Objectives of the training model 2. How to use the training model to develop your knowledge. 3. How to use the learning materials. 4. Initial assessment of skills and qualifications. 5. Define your development goals. 6. Define your learning plan.
	Preparatory Unit language of the country and specific vocabulary in the care field.	This unit is indispensable for immigrants. The general objective is to give the possibility of strengthening the linguistic and communication abilities by privileging learning of the specific glossary of the field of care work. Module 2. Inclusion in the context
		Module 3. Care and Assistance
	Technical and	Module 3. Care and Assistance

	Vocational skills Personal and practical skills	
Didactic Units	1. Language	As for the learning of the Italian language, this unit is an essential preliminary study. Italian language courses are adjusted according to the specific needs of workers involved. The general objective is to give the possibility of strengthening the linguistic and communication abilities by privileging learning of the specific glossary of the field of care work.
	2. Inclusion in the context	1. Social and institutional context (elements of "civic-mindedness education, organization of the state and social health system, the legislative and professional context, health care, customs and traditions) and dynamics of inclusion in the family unit; 2. Social and work rules (the work role, rules of coexistence, rights, duties, opportunities, principles of professional ethics, rules on immigration, employment contract, security aspects, reconciling supply and demand, educational opportunities;) 3. Everyday life with the elderly (the relationship with the family doctor, working with professionals, pharmacy, etc).
	3. Care and Assistance	1. Relation and Communication (relational dynamics, management of conflict, respect and empowerment of the elderly, relational aspects (emotional support) 2. Cognitive stimulation (learning how to interact daily to stimulate the attention, interest, memory, including games and recreational activities for the maintenance of spare capacity, leisure activities to promote social interaction) 3. Mobility (knowledge and skills to assist the person in movements, elements of anatomy, mobilization techniques, risk prevention) 4. Hygiene (personal hygiene, health and safety of environments) 5. Nutrition (elements of diet science, assistance in preparing meals and in feeding and local food traditions) 6. Dementia (symptoms and strategies of interaction) 7. Security and emergency management

Module: 3. Care and Assistance
Didactic Unit: Relation and Communication

Objective	To know how to relate to the assisted person and his/her family. The main objective of this module is to provide skills to effectively relate to the assisted person and his/her family and manage properly those situations that can create conflict and stress. At the end of the training course trainees should be able to manage face-face communication with the person and his/her family, ask for information, explain and agree on everyday care activities, manage all various communication functions (reassure, comfort, encourage, seek and obtain cooperation) through verbal and non verbal codes, know the social context and how to move within the territory.
Duration:	40 hours
Initial assessment of entry level skills	Self assessment of entry level skills Entry test Name_____ Surname_____ Date _____ 0 = I know nothing of it 50 = I know enough about the topic 100 = I know the topic very well How much do you think you know about the following topics? A – interpersonal communication l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 B – verbal communication l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 C – non verbal communication l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 D – active listening l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 E – problem solving l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100

Contents	✓ Communication strategies; ✓ Verbal and non verbal communication: identify implicit needs; ✓ Conflict management, analysis of elements that can create conflict, assertiveness as a useful tool to prevent stress and properly manage relationships; ✓ Cognitive stimulation; ✓ Space-time disorientation: what it is and what causes it (elements of geriatrics);
Methodology	Sharing a common basic language, active lectures, case studies, discussions, videos
Assessment Test	The effectiveness and quality of learning will be checked by the trainer by observing the participants during classroom activities. The communication and methodologies which will be adopted by the trainer during the classroom activities will represent in itself an assessment tool. Learning situations such as case studies and led-group discussions will encourage the communication between trainees and trainer and allow feedback on the level of learning achieved. By these training procedures the trainer will be able to supervise the training process and measure the effectiveness and quality of training during all training period. Self-assessment tests will be scheduled.

The Training Program for Family Assistants - Germany
Drawn by UNIVERSITY OF EICHSTATT – INGOLSTADT – D

Training modules	Introduction to the course	1. Aims and Objectives of the training model 2. How to use the training model to develop your knowledge. 3. How to use the learning materials. 4. Initial assessment of skills and qualifications. 5. Define your development goals. 6. Define your learning plan.
	Preparatory Unit language of the country and specific vocabulary in the care field.	This unit is indispensable for immigrants. The general objective is to give the possibility of strengthening the linguistic and communication abilities by privileging learning of the specific glossary of the field of care work.
	Technical and Vocational skills	Module 1. Mission and Concept of Care (Your self and the other)
		Module 2. Help elderly in every-day life arrangement (Caring Elderly)
	Personal and practical skills	Module 3 – Caregiver as a Job (Communication, supporting and advising)
Didactic Units	1. Mission and Concept of Care (Your self and the other)	1.12 Basic principle of elderly-care theory (some briefly sociological concepts) 1.13 Legal and institutional elderly care's framework 1.14 Planning and evaluating Elderly-care actions (how to deal with the care process) 1.15 Caring elderly (methodological and medical concepts about the care process) 1.16 Guiding, advising and carrying on communication related with care actions (communication with the cared person but also with his/her family) 1.17 Assisting and understanding medical diagnostic and medical therapy.
	2. Help elderly in every-day life arrangement (Caring Elderly)	2.1 Considering living as elderly and their social networks (some briefly sociological concepts) 2.2 Helping elderly in maintaining their living environment (nutrition, managing the physical environment, etc.) 2.3 Assisting elderly in every-day life activities and in self organising activities (free time as important activities, meeting other elderly, etc.)

	3. Caregiver as a Job (Communication, supporting and advising)	3.1 Developing a job-related self-concept (some briefly sociological and psychological concepts) 3.2 Learning how to learn (how to study further, new learning technologies, etc.) 3.3 Coping with cries and difficult social situation (tension in the relation elderly and carer; violence during the care process, etc.) Maintain Care giver own health (safety at work; preventing carer stress; etc.)

Module: 3.3 Communication and language barriers
Didactic Unit: 3. Caregivers as a job

Objective	To give learners the possibility to experience the impact of language barriers in senior care situations.
Duration:	45 minutes
Initial assessment of entry level skills	-
Contents	Common experiences in language barriers' situations within senior care processes.
Methodology	In-class lecture. In small groups learners consider a short scene: A foreign elderly care nurse has to communicate with a person in need of care. They don't speak a common language. After acting the scenes, the group is asked to arrange a common reflection Important: Learners should work in small groups.
Assessment Test	-

Reflection: What kind of difficulties have arisen as a result of the fact, that a linguistic communication has not been possible?
What kind of feelings have been caused during the role play by this language barrier?

Source: Manual for a culture-sensitive training in elderly care (2005). Developed at the university of applied sciences of Hanover, financed by the Federal Ministry of Family Affairs, Senior, Citizens, Women and Youth.

The Training Program for Family Assistants - Hungary
Drawn by UNIVERSITY OF DEBRECEN – HU

<table>
<tr><td rowspan="4">Training module</td><td>Introduction to the course</td><td colspan="2">1. Aims and Objectives of the training model
2. How to use the training model to develop your knowledge.
3. How to use the learning materials.
4. Initial assessment of skills and qualifications.
5. Define your development goals.
6. Define your learning plan.</td></tr>
<tr><td>Specific skills in the care field.</td><td colspan="2" rowspan="2">This unit is indispensable for unemployed people The general objective is to give the possibility of strengthening the professional and communication abilities by privileging learning of the specific skills of the field of care work.

Module 1. The carer’s role and the responsibilities</td></tr>
<tr><td rowspan="2">Technical and Vocational skills</td></tr>
<tr><td>Module 2. Support elderly in everyday life</td></tr>
<tr><td>Personal and practical skills</td><td colspan="2">Module 3 – Personal improvement</td></tr>
<tr><td rowspan="3">Didactic Unit:</td><td>Module 1
The carer’s role and responsibilities</td><td>1.1. Definition of the nursing and caring
1.2. The role of the carers in the prevention of the physical and emotional changes of the elderly
1.3. Legal and ethical aspect of the elderly care</td></tr>
<tr><td>Module 2
Support elderly in everyday life</td><td>2.1 Learning more about physical, mental and social functions of the elderly
2.2 Fulfilling the human needs (by Maslow Pyramid)
2.3 Maintaining Active Daily Life (ADL)
2.4 Assisting self-organized activities
2.5 Rehabilitation
2.6 Quality of nursing
2.7 Mobility and mobilization
2.8 Aid equipments and using them
2.9 Feeding/nutrition
2.10 Hygiene needs</td></tr>
<tr><td>Module 3
Personal improvement</td><td>3.1 Acquiring problem solving skills
3.2 Communication skills
3.3 Time-management
3.4 Decision-making techniques
3.5 Coping with loss
3.6 Life Long Learning (LLL)</td></tr>
</table>

Module 2. Support elderly in everyday life
DIDACTIC UNIT (Demo for validation)

Objective:	To know how to relate to the assisted person and his/her family. The main objective of this module is to provide skills to effectively relate to the assisted person and his/her family and manage properly those situations that can be implemented from human needs. At the end of the training course trainees should be able to implement the basic human needs with the person and his/her family, ask for information, explain and show the nursing implementations in everyday care activities.
Duration:	40 hours
Initial assessment:	Self assessment of entry level skills Entry test Name_____ Surname_____ Date _____ 0 = I know nothing of it 50 = I know enough about the topic 100 = I know the topic very well How much do you think you know about the following topics? A – basic human needs l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 B – assisting/helping active daily life l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 C – rehabilitation methods l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100 D – quality of nursing l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l 0 30 50 70 100
Contents:	• Learning more about physical, mental and social functions of the elderly • Fulfilling the human needs (by Maslow Pyramid) • Maintaining Active Daily Life (ADL) • Assisting self-organized activities • Rehabilitation • Quality of nursing • Mobility and mobilization • Aid equipments and using them • Feeding/nutrition • Hygiene needs

Methodology:	• Lessons • Case analyses • Simulations • Films/videos • Practical exercises • Internship or work-study
Assessment Tests	The effectiveness and quality of learning will be checked by the trainer by observing the participants during classroom activities. The basic human needs and nursing implementation will be adopted by the trainer during the classroom activities will represent in itself an assessment tool. Learning situations such as case studies and led-group practice will improve/develop the nursing skills and allow feedback on the level of learning achieved. By these training procedures the trainer will be able to supervise the training process and measure the effectiveness and quality of training during all training period. Self-assessment tests will be scheduled.

Module 2 – The Caring Role
Didactic Unit: 2.1 - Everyday Care

2.1	**Everyday Care**
Aims	Identify the main /important tasks in everyday care of an individual
Learning objectives	To be able to identify what is a main / important task To understand why you need to prioritise tasks Why these tasks are important to the individual.
Content	Assistance in getting up in the morning and to bed at night or when resting. Personal care Toileting care
Assessment of skills taught	Prepare a daily care plan

Identify the main / important tasks in everyday care

Aims:

- This unit will help you to recognise the main / important tasks in everyday care

Learning Objectives:
NB Nutrition and Food Preparation is a separate unit

- To be able to identify what is a main / important task
- Be able to identify what are important everyday tasks:
- To understand why you need to prioritise tasks
- Why these tasks are important to the individual.

Content:

- Assistance in getting up in the morning and to get to bed at night or when needing to rest.
- Assistance with personal washing
- Assistance in using the bathroom

Teaching Strategies:

- Role play scenario of everyday caring situations
- Instruction identifying important tasks
- Interview video clip showing experienced carer to discuss how identified tasks are carried out
- Task to allow learner to discuss why it is important for an individual to have assistance in carrying out everyday tasks

Previous Knowledge:

- N/A

Resources:

- Computer
- DVDs
- Flip chart and pens

Assessment Criteria:

- Prepare a prioritised care plan for a typical day

Summary:
By using outlined teaching strategies and the knowledge of a professional to recap skills, learning outcomes can be measured and recognised.

The Training Program for Family Assistants - Slovenia
Drawn by KS90 – Slovenia

EDUCATION PLAN FOR A FAMILY ASSISTANT TRAINING:

Day 1:

1. Presentation of the program
2. Legislation (disabled persons and family assistants right and obligations)
   - acquisition of the regulations of the disabled persons and family assistants
   - identification of the disabled person's needs, correct response and communication
3. Building of a social network for a disabled person
4. Social case centre's representatives rights and duties as family assistants
5. Code of moral principles in social care services
6. Ensuring the right to appeal and object in social care services
7. General characteristics and individual necessities of a disabled person
8. Behaviour and communication between family assistant and a disabled person
9. Basic knowledge about medical care and social medicine.
10. Responsibilities and duties of a family assistant: accommodation, organisation of the living space, household duties, care and food;
11. Immediate help to a disabled person in social services tasks.

Day 2:

1. Course of action in the examples of deterioration of a health condition or with acute illnesses
2. Distinction between medical care and social care; Medical care is performed by the chosen personal doctor
3. Family assistant's participation in disabled person's integration in narrow and broad social networks
4. Knowledge and skill for enhancing a clients strength
5. Possibilities, purpose and meaning of disabled persons integration in cultural, educational, religious and other forms of activities
6. Acquainting with alternative forms of taking care of disabled persons
7. First-aid procedures in typical situations and strengthening of a users social skills
8. Formal and informal communication with a disabled person and overcoming stressful situations.
9. Form completion and certification of a seminar attendance.

Module: User's social integration
DIDACTIC UNIT (Demo for validation)

Objective	Handling user's wishes, recognizing capabilities, trained to motivate user in suitable activities. At the end of the educational process the candidate should be skilled in motivating user to maintain independence and self-care
Duration:	24 hours
Initial assessment of entry level skills	Self assessment of entry level skills Entry test Name_____ Surname_____Date _____ 0 = I know nothing of it 50 = I know enough about the topic 100 = I know the topic very well How much do you think you know about the following topics: A – about specific needs in older age l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l----l 0 30 50 70 100 B – about different kinds of assistance for the elderly performed by non-government bodies (for example Red Cross) l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l----l 0 30 50 70 100 C – about free-time activities organised at the user's home l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l----l 0 30 50 70 100 D – about active listening l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l----l 0 30 50 70 100 E – about verbal communication l-----l-----l-----l-----l-----l-----l-----l-----l-----l-----l----l 0 30 50 70 100
Contents	• Encouraging user to retain self-sufficiency; • user integration (defining needs and activities planning) • assisting user in environmental integration • cooperation with organisation of free-time activities at the user's home (basics of a creative work) • socializing (reading, walking) • accompanying user (with urgent tasks, entering interest groups, cultural events or similar)
Methodology	Active lectures, case studies, discussions, videos

Assessment Test	All participants must present the course of action following the users wish to attend a cultural event (s. a. person on a wheelchair). They must also explain the meaning of encouraging self-sufficiency on a real example (s. a. changing clothes or washing disabled people); presents free-time activities; in a conversation with the user tries to expose users interests and consider users capabilities and wishes

The Training Program for Family Assistants - Spain
Drawn by IMFE – ES

Training modules	Introduction to the course	1. Aims and Objectives of the training model 2. How to use the training model to develop your knowledge. 3. How to use the learning materials. 4. Initial assessment of skills and qualifications. 5. Define your development goals. 6. Define your learning plan.
	Preparatory Unit language of the country and specific vocabulary in the care field.	This unit is indispensable for immigrants. The general objective is to give the possibility of strengthening the linguistic and communication abilities by privileging learning of the specific glossary of the field of care work.
	Technical and Vocational skills	Module 1. Home Hygiene and Health Care
		Module 2. Home Physical and Social Care Module 3. Domiciliary support and nutrition of the family
	Personal and practical skills	
Didactic Units	1. Home Hygiene and Health Care	1.4. Characteristics and needs of hygiene and health care of people needed of care and support 1.5. Managing food and medication of people cared for at home. 1.6. At home improvement of the physical capacities and first aid for people needed of care.
	2. Home Psychical and Social Care	2.1 Home maintenance and psycho-social rehabilitation. 2.2 Everyday care. 2.3 Interrelation, communication and observation with the person cared of and his/her environment.
	3. Domiciliary support and nutrition of the family	3.1 Management, food shopping and cooking within the living unit. 3.2 Maintenance, cleaning and organization of the house.

The Training Program for Family Assistants – United Kingdom
Drawn by GREENHAT INTERACTIVE LTD – UK

Training modules	Introduction to the course	1. Aims and Objectives of the training model 2. How to use the training model to develop your knowledge. 3. How to use the learning materials. 4. Initial assessment of skills and qualifications. 5. Define your development goals. 6. Define your learning plan.
	Preparatory Unit language of the country and specific vocabulary in the care field.	This unit is indispensable for immigrants. The general objective is to give the possibility of strengthening the linguistic and communication abilities by privileging learning of the specific glossary of the field of care work.
	Technical and Vocational skills	Module 1. The Caring Role
		Module 2. The Supporting Role
	Personal and practical skills	Module 3 – Your Own Personal Development and Progression.
Didactic Units	1. The Caring Role	1.1. Everyday care – feeding, dressing, food preparation and hygiene etc 1.2. Safety matters and managing the physical environment – lifting and handling, accessibility etc 1.3. Managing medication 1.4. Dealing with emergencies 1.5. Nutrition and food hygiene 1.6. Maintaining mobility 1.7. Personal and continence care 1.8. Maintaining dignity 1.9. Managing difficult behaviour
	2. The Supporting Role	2.1 Emotional support 2.2 Maintaining independence 2.3 Dealing with authority 2.4 Managing money 2.5 Accessing resources and services 2.6 Maintaining wellbeing

	3. Your Own Personal Development and Progression	3.1 Understanding your own emotions as a Carer 3.2 Coping with loss 3.3 Communication skills 3.4 Time management 3.5 Balancing your role as a carer with your own needs 3.6 Understanding and managing changing family relationships 3.7 Identifying transferable skills 3.8 Future Choices

5. REPORT - "The methodology of testing and validation of the training model, in light of its integration in the accreditation system of home-care work"

Italy

1. VALIDATION OF THE TRAINING MODEL

From training model to training curriculum

The ProDomo project aims to transfer the innovative aspects of the home care service accreditation system in the European countries involved in the project so to link them on the issue of the elderly.
The comparative research developed at European level revealed that home care services in all partner countries use informal caregivers. These work in the care market and are drawn from many different backgrounds depending on the country of reference. The partnership has therefore focused on the issue of training and support for these working figures in order to improve and recognize their skills. The validation of the training model is part of WP 5: "Testing and transferability of the ProDomo accreditation system".
For the implementation of this phase, in each partner country, specific evaluation groups have been established. Evaluation groups include experts in vocational training, social and health facilities, members of local authorities, representatives of utility/service companies, voluntary associations whose targets are the elderly, disabled people and others who need home-care assistance, as well as social partner representatives, family organizations, and union representatives in the care sector.
The aim is to spread the model which has been developed and to validate it through a direct comparison with the stakeholders involved.
This step is essential in order to design a training curriculum for the identified target groups that aims to meet the needs of those informal figures working in the home care services labor market and who urgently need professional qualifications, upgrades to their skills, and mentoring.

2. EVALUATION GROUPS

In the last partners' meeting held in Granada (Spain), after having defined the European training model together, it was decided to:

- Develop a distinctive curriculum for each partner tailored to each national target group;
- Validate and integrate the European training model with feedback received from stakeholders' meetings (so-called Evaluation Groups).

The meetings are opportunities to disseminate and spread knowledge about the ProDomo project.

The Municipality of Parma, as project coordinator, has organized both face-to-face meetings (with representatives of local institutions) as well as collective meetings, depending on the type of stakeholders involved.
The establishment of "evaluation groups" and the planning of meetings have been defined in agreement with the Social Services Sector.

The Stakeholders groups are the following:

- Institutions (please see paragraph 2.1)
- Associations and cooperatives (please see paragraph 2.1);
- Unions (please see paragraph 2.1);
- Families

Stakeholders have been involved through:

- Telephone contacts;
- Emails or fax;
- Sending of documentation: i.e. training model, PPT presentation of the ProDomo project, the results achieved so far, the stakeholder questionnaire (MOD 17 – Quality Plan).

The Stakeholder Questionnaire (MOD 17) is a template specifically designed for gathering suggestions and comments by stakeholders, with respect to the European training model and the training activities for informal caregivers that might be organized.

2.1 STAKEHOLDERS

ISTITUTIONS

Regione Emilia – Romagna (Social Sector);
Provincia di Parma (Social Sector);
Provincia di Parma (Training Sector);
Provincia di Parma (Job Centre);
AUSL

UNIONS

CGIL Funzione Pubblica, CISL Fisascat, UIL

TRAINING CENTRES

CESVIP, IRECOOP, FORMA FUTURO, IAL, CIOFS, ENAIP, AGRIFORMA, WORKOPP

ACCREDITED SUPPLIERS IN THE FIELD OF HOME CARE SERVICES

AURORA DOMUS, SOCIETA' DOLCE

ASSOCIATIONS

AUSER
SER.MO.SOL.
Comitato Comunale Anziani – *Elderly Municipal Committee*
Coordinamento Provinciale Centri Sociali, Comitati Anziani e Orti – *Provincial Social Centre, Elderly Commitee*
Comitato Anziani Parma Centro – *Parma Elderly Committee*
Comitato di Volontariato Bizzozero – *Voluntary Committee Bizzozero*
AIMA
FAMIGLIA
FORUM ASS. FAMILIARI
FORUM SOLIDARIETA'
Vagamonde (Rose e Pane)
Pozzo di Sicar

OTHER ENTITIES

LEGACOOP Parma
CONFCOOPERATIVE
CONSORZIO DI SOLIDARIETA' SOCIALE
Cooperativa sociale Dal Mondo

2.2 QUESTIONNAIRE

PRO-DOMO PROJECT

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

MOD.17	STAKEHOLDER QUESTIONNAIRE

1. STAKEHOLDER DATA

Name_____**Title**_____

Organization_____

Street_____**City**_____**State**_____

Phone number_____ Fax number_____ **Email_____**

2. QUESTIONS

Do you think education and training is an important issue in the field of informal care work?

What do you think are the educational and training needs in the field of informal care work?

What are the main difficulties to be faced in carrying out education and training activities and what suggestions do you have to address them (related for example to the methodology used, costs, time etc)?

What do you think are the most successful methods in carrying out education and training activities in the field of informal care work?

What do you think are the most appropriate tools in the performance of education and training activities in the field of informal care work?
☐ **CD** ☐ **DVD** ☐ **TERRESTRIAL DIGITAL TV PLATFORM** ☐ **COMPUTER** ☐ **USB KEYS** ☐ **OTHER (SPECIFY theoretical and practical training)**

Do you think the use of social networks is important to deliver distance training in the field of informal care work?
☐ **YES** **GIVE REASONS** ☐ **NO** **GIVE REASONS**

Would you be willing to promote and publicize education and training activities in the field of informal care work?
☐ **YES** **IF YES, HOW?** ☐ **NO**

Comments and suggestions

3. OBSERVATIONS

3.1 THE ISSUE OF EDUCATION AND TRAINING IN THE FIELD OF INFORMAL CARE WORK

Do you think education and training is an important issue in the field of informal care work?
Regarding training, it is widely believed that it is crucial both for the development of the informal caregivers' professional skills and for the supply of high quality service. For this reason, education and training should aimed at both obtaining professional skills to be spent effectively in the labour market and defining professional profiles. As regards the training contents, in addition to practical and psychological related issues, it has been highlighted the need to include the subject of safety, privacy and employment law. Here are some of the most significant answers: Education and training in the field of informal care work is a strategic priority; it is fundamental to support families and provide quality services; it is necessary to improve health

care services; it is essential for the development of informal caregivers' professional skills (obtaining professional qualifications to spend in the care market and for other employment opportunities).

3.2 TRAINING NEEDS

What do you think are the educational and training needs in the field of informal care work?

The training needs in the field of informal care work which have been mentioned by stakeholders are already included in the proposed training model and they can be summarised as follows:

- Italian Language (preliminary to the training path)
- Taking charge of the assisted person(s) (relational abilities; psychology)
- Care and assistance (hygiene; mobilization; nutrition; emergencies and safety management).

However, particular attention has also been given to the safety issue. It is also important the information about Associations and/or networks about country of origin and the development of one's dignity and role consciousness (through the creation of work/ support groups).

3.3 DIFFICULTIES IN CARRYING OUT EDUCATION AND TRAINING ACTIVITIES

What are the main difficulties to be faced in carrying out education and training activities and what suggestions do you have to address them (related for example to the methodology used, costs, time etc)?

With regard to the current Italian situation, where the home care work is carried out mostly by immigrant women, one of the biggest difficulties to deal with is the limited fluency in the Italian language by those performing the home care work. In addition, these informal home care givers are non-homogenous in terms of level of education and cultural competency.
With reference to the need for training these informal home care givers, it will be a challenge to find trainers who are both experts in their field but also excellent teachers and communicators.
It is important to promote training activities for informal caregivers through informal networks.
Training courses should provide credits or allowances to informal caregivers, who often have difficulties to self-financing. In addition the families for whom the informal home care givers work for are unwilling to pay for and support their training.
Another critical issue concerns the balance of life/work/training.

3.4 METHODOLOGY

What do you think are the most successful methods in carrying out education and training

activities in the field of informal care work?

The most successful methods for carrying out the needed training for these informal home care givers would include:

- Classroom training along with group activities focusing on direct experience done in a simple and understandable manner which takes into count the varying education levels and language proficiencies of the informal home care givers;
- Distance learning (using DVD, CD) with tutor available to give feedback;
- Expert mentoring with on the job training and skills assessment.

Experts may be managers of social and health services and/or senior family assistants. The duration of the course can be variable depending on the objective and the type of professional qualification to be achieved.
It is worth mentioning as a crucial element, the integration of training for informal caregivers into the wider network of health services (as provided for by the Emilia Romagna Regional Council Resolution 1206/2007). Training shall include direct experience and expert mentoring.

In addition to training, specific and tailored counseling shall be provided to family assistants by those who are directly responsible for the care of the person(s) in need (OSS, RAA, physicians, nurses, social workers, physiotherapists among others). This could be achieved through individual counseling at home, and through other tools.
Here are the most significant observations:

- Tailored training curriculum;
- Training approach based on direct experience and best practices exchange;
- Classroom training with short interactive modules;
- Group activities for the comparison of experiences;
- Learning material easy to understand;
- Experts mentoring;
- Tutors at home, also senior family assistants, possibly of the same culture;
- Distance learning along with classroom training performed by trainers working in training centres;
- Follow up phase, monitoring and update.

3.5 MOST APPROPRIATE TOOLS

What do you think are the most appropriate tools in the performance of education and training activities in the field of informal care work?

Older generations are not familiar with social networks. The most suggested tool is the DVD (with interactive movies) or the CD as they allow to balance life with time for work and training.

Computers, digital terrestrial television (e-learning platform), web site, USB are also considered

as interesting tools.

Do you think the use of social networks is important to deliver distance training in the field of informal care work?
Older generations are not familiar with social networks.

Would you be willing to promote and publicize education and training activities in the field of informal care work?
The stakeholders suggested the following ways to promote training activities: - Involving a large number of stakeholders, - Using different means of dissemination; - Reaching local communities of immigrants who often work in the care market; - Through financed training and public announcement; - Promotional materials such as posters, brochures, emails; - Through training centers' websites - By word of mouth; - Through voluntary associations dealing with similar subjects.

3.6 COMMENTS AND SUGGESTIONS

Comments and suggestions
The involvement of families is essential to make them feel supported and help them understand the importance of education and training for informal caregivers and encourage them to participate in training activities. It is believed that families need: - Training and information - Free support to family members - Financial support - Help desk and caregivers register The harmonization between entities providing health care services is required to bring informal caregivers into the network of health care services. Furthermore, it is useful to create meeting points both real and virtual (e.g. associations,

facebook)
It is also necessary to develop an help desk providing information to families about various issues related to home care work and a register of informal caregivers so to help the meeting between demand and supply.

4. FURTHER OBSERVATIONS

On the basis of data collected, the project working group has decided to slightly change the training model in order to include the findings arising from various meetings. In particular, the methodology has been integrated adding expert mentoring (Emilia Romagna region Resolution n. 1206).
In fact, expert mentoring should be provided to informal caregivers in addition to training. Expert mentoring is designed to provide informal caregivers with training and information tailored to their real needs. It is recommended to include, in addition to distance learning, meetings for comparing and exchanging experiences. Thus, informal caregivers could become more aware of their caring role.
Meetings allow trainers to verify by observing participants, the quality of training provided.

Germany

Report of the interview conducted with a stakeholder´s representative (04/08/11) who is responsible for the training in the field of first aid and social care

Most important training program of the stakeholder:
Training as nursing service assistant (basic qualification in the field of care), 120 hours (thereof 55 hours practical exercises), 4 weeks (different modes of the training: block instruction; lessons in the evening or weekend lessons). Costs for participants: 420 €.
After that course participants complete a 14 days work experience.
Working fields after the course:

- nursing home
- assistance services and visiting service for elderly
- neighbourly help
- care at home

Examples of practical exercises (attached the original document):

- Matters of hygienic disinfection
- functions of nursing bed
- handling with wheel chairs
- washing in bed
- bandages
- etc.

Opinions of the interviewee about the ProDomo training model:

- too much theoretical contents
- lack of practical exercises
- important contents: communication with the patient and its family; basic knowledge of medical diagnoses
- online training respectively computers play not a very important role in the care training – although there are good and helpful videos that are used: reflection in the group after watching the video is important to have the possibility to practice the seen examples.

==> The best way to learn caring processes is to experience care situations by your own (role plays), for example being washed, shaving a foreign person etc.
Interesting comment of the interviewee:
- It´s supposable to take part of the course also for someone living illegal in Germany: for the course
registration it´s necessary only to provide an address in the country.
- The interviewee underlined the language barrier as main problem among foreign care givers:
- "It´s not only about body-related activities – it´s also about the (verbal) interaction between care
givers and patient." (social aspect of care)

Neither via letter nor via email we have been successful to organize a stakeholder meeting. For this, we have conducted an face-to-face interview with a representative of the above mentioned institutions.

Hungary

1. Validation of the training model

From training model to training curriculum

The ProDomo project aims to transfer the innovative aspects of the home care service accreditation system in the European countries involved in the project so to link them on the issue of the elderly.

The research developed in Hungary revealed that home care services use registered caregivers, but families employ caregivers, who are not trained, not registered, they are informal caregivers. With the help of the ProDomo project it is designed that these informal caregivers will learn basic skills and knowledge, through which they will be able to assist the clients in a better and a more qualified way. The validation of the training model is part of WP 5, "Testing and transferability of the ProDomo accreditation system."

To implement this, special evaluation groups have been established. Evaluation groups include experts in vocational training, social and health facilities, members of local authorities, representatives of local service companies, representatives of voluntary associations whose targets are the elderly, disabled people and others who need home-care assistance.

The aim is to spread the model which has been developed and to validate it. A training curriculum has been designed for the identified target groups, which aims to meet the needs of those informal caregivers, who work in the home care services labour market and who need professional qualifications and mentoring.

2. Evaluation groups

After the meeting in Granada(Spain), where we defined the European training model, we decided to:

- work out the national curriculum for the target group in Hungary
- validate and integrate the European training model with the suggestions received from stakeholders

The meetings are opportunities to spread knowledge about the ProDomo project. We organized face to face meetings with the representatives of home care services.

The stakeholders groups are the following:

- home care services
- NGOs
- Local Red Cross Association
- Job Centres
- Local Government Social Services

Stakeholders have been involved through:

- telephone calls
- emails
- sending documentations
- showing PPT presentation of the ProDomo project
- the stakeholders questionnaire (MOD 17)

The stakeholder questionnaire is specifically designed for collecting suggestions and comments from stakeholders, with respect to the European training model and the training activities to be organized for informal caregivers.

2.1. Stakeholders

	Organization
1.	Holistic Plusz Eü. Kft.
2.	Home care service
3.	Szatmári Betegápoló Kft.
4.	Home care service
5.	Demeter és Társa Bt.
6.	Home care service
7.	Felsőszabolcsi Betegápoló Kft.
8.	Sana Szolg. Bt.
9.	City Red Cross Association
10.	Job centre
11.	NGOs
12.	Local Government Social Service

4. Observations

a. The issue of education and training in the field of informal care work

Do you think education and training is an important issue in the field of informal care work?
The training is very important for the informal caregivers in order to provide high quality service. Our aim is that lay people should obtain higher knowledge in patient care, because they should be trained/skilled workers. Here are some of the most significant answers: Lay people do not have any professional practice for the assistance of the client/patient, with this training they will be able to learn the manual practical activities.

b. Training needs

What do you think are the educational and training needs in the field of informal care work?

The Hungarian language is not needed because this country does not have any immigrants, who would appear in the labour market.

According to the stakeholders opinion the training program should involve:

- moving/mobilization
- feeding/nutrition
- hygiene needs
- emergency and safety environment issues
- psychological and ethical issues
- communication skills

3.3. Difficulties in carrying out education and training activities

What are the main difficulties to be faced in carrying out education and training activities and what suggestions do you have to address them (related for example to the methodology used, costs, time etc)?
Our target groups members are family members and voluntary helpers who will learn the basic skills (basic nursing implementation skills) during the training and with this knowledge they will be able to help/support the clients/patients. The target members do not want to pay any money for the training, because they are mainly unemployed people without any income. Our plan is the training will be free for the participants. It will be very difficult to detect these lay people because they are not registered and even if they work, they do it illegally.

3.4. Methodology

What do you think are the most successful methods in carrying out education and training activities in the field of informal care work?
- Training courses tailored to carers' specific needs and best practices exchange **- Classroom training with group activities focusing on direct experience done in a simple and understandable way which takes into consideration the various education levels of informal home care givers.**

- Distance learning (DVD, CD) along with classroom training with tutor/teachers working in nursing/health school.

- To show the movie from the home care. To show the movie from the old people help in his/her home.

- To combine the theoretical and practical training.

- Expert mentoring

- The basic nursing implementations should be shown and practiced in the demonstrational room

3.5. Most appropriate tools

What do you think are the most appropriate tools in the performance of education and training activities in the field of informal care work?
Older generations are not familiar with social networks. The most suggested tool is the DVD (with interactive movies) or the CD as they allow to balance life with time for work and training. Computers will be available in the school for the participants.

Do you think the use of social networks is important to deliver distance training in the field of informal care work?
This training course widens the target group members' information/knowledge of the social networks **The social network is important to get in contact with the informal care givers.**

Would you be willing to promote and publicize education and training activities in the field of informal care work?
The stakeholders suggested the following ways to promote training activities: - involving a large number of stakeholders - using different means of the dissemination - through public announcement - promotional materials such as posters, brochures, emails - by words of mouth - through the voluntary associations working in similar areas - by organizing meetings, conferences - by publicizing the education/training in the family doctors' waiting room

3.6. Comments and suggestions

Comments and suggestions
The involvement of families is important to make them feel supported and help them understand the importance of education/training for the informal caregivers and encourage them to participate in the training g activities. Families need: - training and information - free support to family members - financial support - help desk and caregivers register Our aim/plan with this training program is to bring the demands closer to the home care services supply.

5. Further observations

On the basis of data collected, the project working group has decided to include meetings for the informal caregivers in order to compare and exchange experiences.

Slovenia

1. Validation of the training model

From training model to training curriculum
The Pro Domo project aims to transfer the innovative aspects of the home care service accreditation system in the European countries involved in the project so to link them on the issue of the elderly.
The research developed in Slovenia revealed that home care services use registered caregivers, but families employ caregivers, who are not trained, not registered, they are informal caregivers.
The aim is to spread the model which has been developed and to validate it. A training curriculum has been designed for the identified target groups, which aims to meet the needs of those informal caregivers, who work in the home care services labour market and who need professional qualifications and mentoring.

2. Evaluation groups

After the meeting in Granada(Spain), where we defined the European training model, we decided to:

- work out the national curriculum for the target group in Slovenia
- validate and integrate the European training model with the suggestions received from stakeholders

The meetings are opportunities to spread knowledge about the ProDomo project. We organized face to face meetings with the representatives of home care services.

The stakeholders groups are the following:

- Local Government Social Services
- Different Trade unions organization

Stakeholders have been involved through:

- sending documentations
- showing PPT presentation of the ProDomo project
- the stakeholders questionnaire (MOD 17)

The stakeholder questionnaire is specifically designed for collecting suggestions and comments from stakeholders, with respect to the European training model and the training activities to be organized for informal caregivers.

3. Stakeholders

	Organization
1.	Obalni sindikat GIT
2.	Obalni sindikat delavcev gradbene dejav.
3.	Sindikat trgovine KS90
4.	Sindikat ŠAK

5.	Obalna sindikalna organizacija
6.	Center za socialno delo Koper
7.	KS90

4. Observations

Do you think education and training is an important issue in the field of informal care work?
Education in a field of informal care work is very important because things are constantly changing, so it must also be complemented by the perspective of different disciplines.

What do you think are the educational and training needs in the field of informal care work?
It is essential to good knowledge of problems of the elderly and the psychology of dealing with people who are dependent on foreign care. In recent times, we perceive more and more violence against the elderly; it is also in this direction need to educate. In practical education, care for introducing kinestetika.
What are the main difficulties to be faced in carrying out education and training activities and what suggestions do you have to address them (related for example to the methodology used, costs, time etc)?
Difficulties in finding staff to meet the interdisciplinary nature of such work, as the basic experience of having been such a person should acquire in working with people in a social or health facilities. Such experiences are an essential basis for further understanding of specific (and specialized) educational content. The problem is practical training in social care, home users, because users do not allow entry into their homes, which are repetitive and its foreign people. Six-month rate is not sufficient for quality provision of home care. Education should be more systematic and a duration of at least a year and a half to two years.

What do you think are the most successful methods in carrying out education and training activities in the field of informal care work?
In particular, close coordination of content between theoretical work and direct practice in working with people. Transfer of good practice to younger, inexperienced, and checking skills by using modern technical methods. The most effective is practical field training under the guidance of experienced and qualified social worker. It is also important supervision.

What do you think are the most appropriate tools in the performance of education and training activities in the field of informal care work?
x CD **x DVD** **x TERRESTRIAL DIGITAL TV PLATFORM** **x COMPUTER** **x USB KEYS** **X OTHER** The most appropriate tool for delivering educational content via a lecture with slides. It is important that the contents are given in an understandable way, as the supplier of the profession of social choices in most people with a low educational level.

Do you think the use of social networks is important to deliver distance training in the field of informal care work?
X YES In the context of social networks can take a direct exchange of information, experiences, questions and answers between the parties as well as the transfer of good practices. Participants can constantly learn about new literature, while a professional manager can help guide and keep eliminates potential problems of individuals. **☐ NO** **GIVE REASONS** **☐ NON SO**

Would you be willing to promote and publicize education and training activities in the field of informal care work?
X YES **IF YES, HOW?** Advertising can be directly related to social networks and the classical, through leaflets, professional seminars, meetings, etc.. **☐ NO**

Spain

1. EVALUATION GROUPS

In the PRODOMO's partner meeting held in Granada on the 17th March 2011, in the Identification of the Stakeholders as evaluation group for the training model proposed, IMFE identified the following:

- Local Administration
- Registered Social Health
- Care providers
- Non-profit organizations
- Lay people caregivers

As dissemination and evaluation of the PRODOMO training model has been made by IMFE within the *Pacto Local por la Conciliación de la vida laboral, familiar y personal*, Local Agreement for the Reconcilitaion of Work, Private and Family Life and in particular within the internal working group of „Foster and support to professionalization of the at home health and care of non autonomous people assistance services".

The stakeholders involved in this Agreement and/or Working Group participants where PRODOMO Training Model was disseminated and evaluated were the following:

LOCAL ADMINISTRATION

- Woman Local Council (City Council of Granada) -*Consejo Municipal de la Mujer-*
- Equal Opportunities Councilarship of the City Council of Granada. *Concejalía de igualdad de Oportunidades del Ayuntamiento de Granada*
- IMFE. Training and Employement Local Institute of the City Council of Granada. IMFE Instituto Municipal de Formación y Empleo del Ayuntamiento de Granada.

UNIONS

- CSIF-Granada Trade Union. *Central Sindical Independiente de Funcionarios de Granada.*
- UGT- Granada. Trade Union.
- CCOO Granada. Trade Unión.

TRAINING CENTRES

- Equal Opportunities Unit. University of Granada. *Unidad de Igualdad de Oportunidades de la. Universidad de Granada.*
- IMFE

ACCREDITED SUPPLIERS IN THE FIELD OF HOME CARE SERVICES

- Federation of Associations of Home assistants

ASSOCIATIONS

- Red Cross of Granada. *Cruz Roja de Granada.*
- FEGRADI. Phisical and Organic Disable People Federation of Granada. *Federación Granadina de Personas con discapacidad física y Orgánica.*
- Gipsy Foundation of Granada. *Fundación Secretariado Gitano de Granada.*

OTHER ENTITIES

- Home and Family Assistants.

The stakeholders have participated in the evaluation of the PRODOMO Training Model mainly by the discussion and debate after presentation by IMFE of the proposed model in the last June meeting by the Head of the Training Department, Ana Zuheros on behalf of IMFE –coordinator of the working group „Foster and support to professionalization of the at home health and care of non autonomous people assistance services" and as well partner in the PRODOMO project. The base for the evaluation has been the Model 17 STAKEHOLDER QUESTIONNAIRE.

This working group is highly representative in the city of Granada with influence and decision making power in some cases; it is very specialized in all matters, issues and policies on health and care home assistance services (both sides of the coin from public and private sector and from the workers and/or informal carers side) and PRODOMO was already disseminated in previous meetings and workshops dealing with professionalization of health and care home assistance services.

The result of the evaluation can be integrated and summarized in a single questioner model as the one used for the evaluation.

2. Observations

2.1. The issue of education and training in the field of informal care work

Do you think education and training is an important issue in the field of informal care work?
The professionalization and training of adults delivering care services (especially Latin-American and North Moroccan women) is a need and it should be a public task to be assumed by the Public Administration and very especially by the Public Employment Services (PES).

2.2. Training needs

What do you think are the educational and training needs in the field of informal care work?
The informal carers, mainly migrant women, need education and training in very many subjects related to the at home health and care assistance. Despite their experience already in this type of jobs there are very many gaps in their knowledge and skills, especially when facing the care of people suffering from mental and physical disabilities. The education and training that should be provided relates in general to the main syllabus of the Vocational (Professional) Certificates already existing in Spain into the formal vocational training system, that is: • Hygiene and Health Care • Phsycosocial support • House maintenance • Nutritional aspects • Safety matters (Labour Risks Assesment and Prevention) • Legislation • Workers rights

2.3. Diffficulties in carrying out education and training activities

What are the main difficulties to be faced in carrying out education and training activities and what suggestions do you have to address them (related for example to the methodology used, costs, time etc)?
• The lack of flexible training courses that may allow informal carers to follow the course. • The legal situation of work and residence of many of the present informal carers makes difficult the access to formal education and training. • The educational and professional profile of the informal carers is usually (mainly women) and they do not have studying habits. • Informal carers usually, and especially the ones pay by the hour, cannot afford to stop working certain hours to attend a course, even if the latter is free. • The not recognition of their experience do not motivate the informal carers to emerge from the hidden economy and make the effort to improve their competences.

2.4. Methodology

What do you think are the most successful methods in carrying out education and training activities in the field of informal care work?
The general informal carer needs direct contact with trainers, tutors and colleagues (face-to face sessions, telephone , e-mail communication…) and quite an amount of

support and guidance in the beginning of any training action to be offered to them.

- Group sessions at timetable and dates (weekend) adapted to their working duties are very important in the beginning and as a follow-up short after the starting.
- Tutoring of experts is important too.
- Visual training resources (videos on line or DVD) and self-evaluations and assessments methods are considered key issues.
- Visits to public and private institutions providing the health and care service in the community with meeting agenda to interact with legal workers that will share their experience as Professional Carers is considered important also.
- Videos of local (easily recognizable of part of their daily lives) authorities or business executives that explain the needs and advantages of becoming a Professional carer.
- Final Evaluation and delivering of not only a standard training certificate, but a Graded Competences Assessment Certificate including social skills assesment to present it in its case to future employers.
- For certain individuals, include as a premium, to make a Video Curriculum as a Professional Carer to disseminate amongst their family, friends and employers.

2.5. Most appropriate tools

What do you think are the most appropriate tools in the performance of education and training activities in the field of informal care work?
Taking into account the profile of the present informal carers all tools that allow interactive playing (on-line tests with immediate results –grades- obtained, simple questionnaires provided to check on comprehension of the training delivered by DVD…) are considered very positive and motivating in the learning process of the training offered to the informal carers.

Do you think the use of social networks is important to deliver distance training in the field of informal care work?
May be not at present (usually the face to face, groups meeting, telephone and e-mail communications are the most effective ITC resources used now) but to offer a blended system of resources will be suitable and social networks could be implemented step by step.

Would you be willing to promote and publicize education and training activities in the field of informal care work?
All stakeholders have shown their unanimous opinion that despite of lacking the competences in education and vocational training, the stakeholders of “The Pact”, support the transfer of the proposed PRODOMO model to the different technical staff

(VET Trainers, Employment Guidance and Advisors, Labor Market Insertion experts...) to be integrated in the Work Plans from September 2011 on.

2.6. Comments and suggestions

Comments and suggestions
Dissemination and improvement of the PRODOMO Training Model will be carried out after the project end date.

3. FURTHER OBSERVATIONS

Taking into account the present debate about the establishment of the two clear occupations (The carer and the Home Assistant) totally differentiated and each one with the chart of duties and rights framework, the model to be experimentated from September 2011 on, will be adpated consequently to the changes operated in Public Institutions, Private Business and Legislation.

United Kingdom

1. VALIDATION OF THE TRAINING MODEL
From training model to training curriculum

The research in the UK showed that currently professional home care services have a clear training route and professional development in place.

There were clearly identified gaps though in the need to provide a training model for informal carers such as young carers and family carers. These groups very often had difficulty when entering employment due to the gaps they had in either their work history or education history. This clearly gave them a disadvantage when looking to take up employment even though a lot of them clearly had a lot of skills. The training model that the UK partners aimed to develop within the Pro-Domo project will hopefully not only provide good quality training but it will also help to accredit the skills that the respective carers gained whilst undertaking their caring responsibilities.

The model that has been developed is aimed to be delivered in a number of different ways, it could take the form of a traditional training curriculum, a taught curriculum as well as being available as e-learning.

2. Evaluation Groups

The groups that were identified as stakeholders covered a wide range of carers as well as professionals that work in the field of either providing services to family carers through to commissioning managers for the local authority who are responsible for providing services to carers.

The stakeholder groups that we worked with covered a wide age range as well; they were consulted through stakeholder events, meetings, telephone calls and email.

2.1 Stakeholders

An example of our stakeholders was as follows;

- Young Carers
- Young Carers support staff
- Adult Carers
- Adult Carers support groups
- Carers support service commissioning manager

3. Observations

Do you think education and training is an important issue in the field of informal care work?

Yes, I think it is very important, particularly for those who have missed out on education due to their caring role.

What do you think are the educational and training needs in the field of informal care work?

Certificated and nationally recognized training/ education.

What are the main difficulties to be faced in carrying out education and training activities and what suggestions do you have to address them (related for example to the methodology used, costs, time etc)?

Lack of time to attend college or university. Unable to meet strict deadlines due to unpredictable nature of caring. Unable to leave cared-for person so cannot attend an education setting.

Education can be too expensive; many carers are living on a very low income.

What do you think are the most successful methods in carrying out education and training activities in the field of informal care work?

Distance learning where carers are able to learn from home, and where there is flexibility in deadlines/ they can work at a place that fits in with their caring role.

Do you think the use of social networks is important to deliver distance training in the field of informal care work?

YES
GIVE REASONS- it will allow carers to support one another
NO
GIVE REASONS

NON SO

Further Observations

Would you be willing to promote and publicize education and training activities in the field of informal care work?
✓ **YES** **IF YES, HOW? Link from our young carers website. Inform carers during visits.** ☐ **NO**

What do you think are the most appropriate tools in the performance of education and training activities in the field of informal care work?
☐ **CD** ☐ **DVD** ☐ **TERRESTRIAL DIGITAL TV PLATFORM** ✓**COMPUTER** ☐ **USB KEYS** ☐ **OTHER (SPECIFY _____)**

The data we have gathered as well as the comments received from our stakeholders clearly showed that there was a great need for this training model. This model was therefore developed with this information in mind.

6. Conclusions

This ProDomo project cooperation among partner countries has been very useful and exciting. At the kick off meeting the partners introduced the situation of home care services in their own countries. The steps of the project were accepted. After this meeting every partner wrote a national report about the varieties of home care services and the German partner prepared a comparative analysis from these national reports. The other results are:
-guidelines were worked out for promoting innovative aspects of the best practice of work accreditation for at-home care work
-training model and didactic units for family assistants were worked out.

The objective was to share the results and to divulge them in their countries. The partners are committed about the good practice transfer through the implementation of a training action, which was organized in training materials linked with each other and which satisfied their recipients' needs.

Inside of the project the training was highlighted for the home assistants for the best practice.
Training courses are designed for lay people who after the training could become professional carers.

The project's activities were monitored by the Quality management plan and by the Exploitation plan.

The partners of the project hope that the recipients of care work together with their families as well the operators involved would be more satisfied with the quality of the services provided for them.

The main parts of the ProDomo project were disseminated at a final conference in Parma on 23rd September 2011.

The most important topics of the project can be found in this edition.

7. Acknowledgements

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