Effective Long-Term Care underpinned by Data and IT

Roundtable

Malmö, Sweden, 16 June 2023

EY

Building a better working world

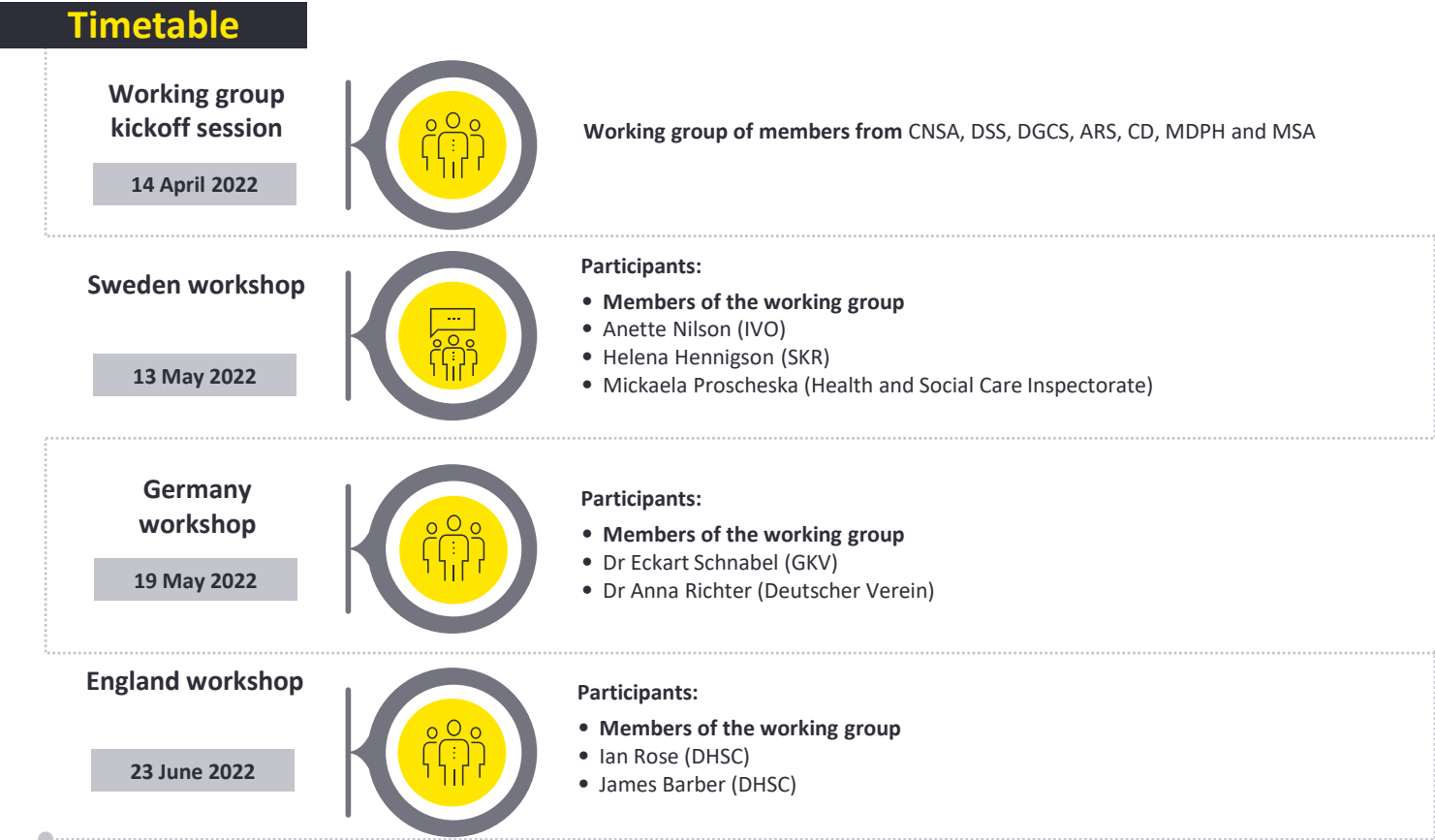# Thematic panel discussion: overview

Session speakers

- Emmanuel Gagneux, Vice Président of the National Association of Social Services' Directors, France

- Jordan Holland, Head of Strategy, Adult Social Care Technology and Data, Department of Health and Social Care, UK Government, England

- Irmelind Kirchner, Policy Advisor, Care Policy and Services Section, Health Services Department, AOK-Bundesverband, Germany

- Michaela Prochazka, Coordinator for Elderly Issues and Programme Officer at the National Board of Health and Welfare (Socialstyrelsen), Sweden

- **Moderator**

- Jessica Chamba, Partner, Health and Social Sector and EY Global Deputy Human Services, France

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Introduction to the project

Objectives of the study

Analyzing and drawing on beneficial and transposable practices implemented in other countries concerning **relationships with the partners responsible for implementing autonomy policies** at the local level, as well as the **conditions for monitoring and steering decentralized multi-operator policies.**

Identifying practices that inspire the transformation and functioning of the branch, notably involving issues of the **governance, evaluation** and steering of the policies implemented

Timetable

Working group kickoff session **14 April 2022**		**Working group of members from** CNSA, DSS, DGCS, ARS, CD, MDPH and MSA
Sweden workshop **13 May 2022**		**Participants:** • **Members of the working group** • Anette Nilson (IVO) • Helena Hennigson (SKR) • Mickaela Proscheska (Health and Social Care Inspectorate)
Germany workshop **19 May 2022**		**Participants:** • **Members of the working group** • Dr Eckart Schnabel (GKV) • Dr Anna Richter (Deutscher Verein)
England workshop **23 June 2022**		**Participants:** • **Members of the working group** • Ian Rose (DHSC) • James Barber (DHSC)

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Key learnings from the benchmark (1/2)

The local level has been identified as being the best placed to understand the needs and issues of the users in its area, by adapting the guidelines proposed at the national level. In particular, local institutions can best articulate different public policies as a result.

Local authorities have considerable independence; they manage the offer and the granting of aid, sometimes via their own financing.

The national level plays a crucial role in orienting players and standardizing quality. It acts and reacts to guarantee the principle of equity of access to rights and the overall consistency of the support offer provided by communicating on common guidelines and by actions to monitor the achievement of common objectives (surveys, indicator feedback, inspection visits, etc.).

Monitoring and evaluation of quality are provided by dedicated independent organizations, at national level, under the authority of a minister. Their mission is to guarantee maintenance of a satisfactory quality level for the services proposed, both at home and in institutions.

The countries studied place great importance on the use of sound data and **on the implementation of a scientific evaluation approach.** For these countries, this is a means to ensure and guarantee equity between regions.

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Key learnings from the benchmark (2/2)

The rating system for regions and their management of services and institutions attempts to transpose and integrate – as faithfully as possible – **the reality and characteristics of the regions**. Thus it is possible to include the diversity of areas in analyses, and make the comparisons more relevant.

The **indicators** used to monitor and evaluate services are **results-oriented**. They make it possible to measure the impact of support on health and on quality of life.

This strengthened evaluation practice **requires reinforcement of digital data collection** and **greater interconnection of information systems**. This should facilitate more frequent information transfers, enabling real-time exploitation of data to enhance steering and decision-making. **The three countries studied have made evaluation data a priority issue for the next few years.**

The countries studied make **measurement of the satisfaction of users and their families** central to the evaluation process.

Lastly, the three countries studied **cultivate transparency in the results** and in the analyses that complete evaluations, in the spirit of open government. Data is communicated to the public, which is useful both for users and for all players in autonomy policy, who can also depend on it.

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Where are we now? Digitisation and data in adult social care in England

Adult social care in England is delivered by about 18,000 organisations, with the vast majority being independent sector (private) providers. These organisations deliver care in about 40,000 sites, employing about 1.5m people.

Compared with England's National Health Service (NHS) adult social care providers lag behind in their levels of digitisation. This, in turn, impacts on the quality and availability of data about social care.

Starting point in England, c.2020/21

Only 40% of care providers using digital social care records

Poor cyber resilience, including low compliance with basic cyber security standards

~62% of care providers using internet connections inadequate for SMEs

Low confidence in adopting digital tools, and in staff digital skills

→

Lack of data availability

Duplication of data collection

Lack of standardisation

Data gaps

→

Hard to track and improve people's experience of care and their outcomes

Staff time is wasted

Data not available for planning, management and policy use cases

Challenging to integrate someone's care journey between clinical and community settings

Where are we now? Digitisation and data in adult social care in England

In 2021, the UK Government committed to invest at least £150m to digitise the adult social care sector, plus up to £50m to improve data collection, as part of a raft of measures designed to reform social care provision.

Digitisation

- Improve adoption of digital social care records (DSCRs) from 40% to 80% by March 2024
- Drive adoption of proven care technologies
- Improve the digital skills, connectivity and cyber resilience of care providers

Data

- Streamline and improve data collection
- Establish new data collections and bridge data gaps
- Improve access to data and produce better insights from this data

80%
Target for care providers using digital social care records (April 2024)

56%
Care providers using digital social care records (April 2023)

40%
Care providers using digital social care records (2021)

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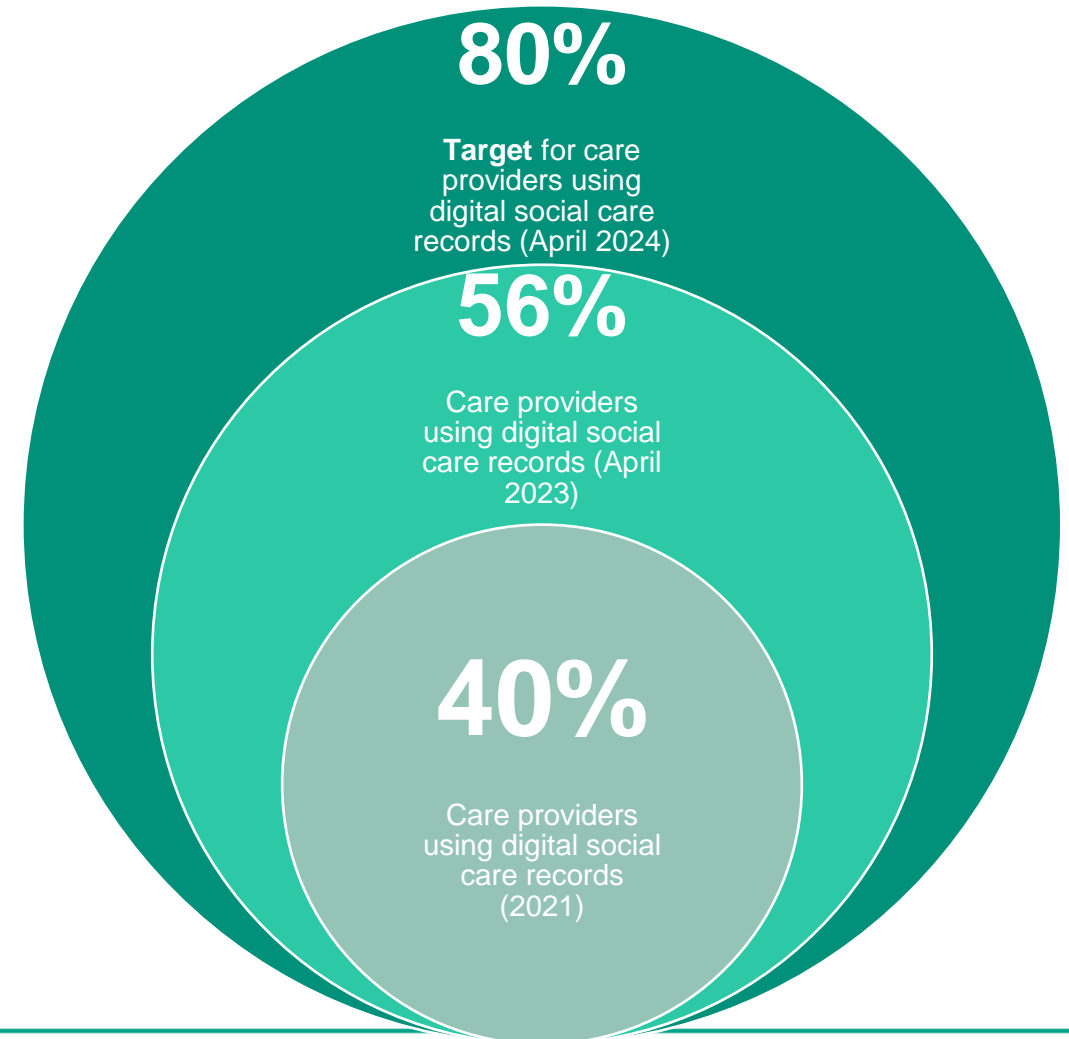
Open comparisons
National, Regional and Local

Sweden

Michaela Prochazka, onc RN, MPH, PhD

Programme Officer, Coordinator for elderly affairs

The open comparisons in elderly care contains 4 different parts

- Registries – mandatory and non-mandatory

- Survey to the municipalities

- Survey to the units who provides elderly care

- Survey to those who use elderly care

The survey to the elderly care units

- Annually since 2007

- Response rate around 85 percent

- Engages 290 municipalities and about 5 000 special housing and home care units

- Topics that cannot be found in other sources of data

- Both public and private (profit/not for profit)

Socialstyrelsen

Example of topics

- If the unit have a routine for staff to discover if the elderly persons has been subjected to violence or abuse by a relative

- Proportion of elderly persons (at the unit) with a plan that contains information about their wishes and needs in connection with the meal

- If the staff speak other languages than Swedish

Socialstyrelsen

Survey to older persons

- ≥65 years with homehelp services or living in special housing

- From 2013 yearly to all (except 2021)

- Results presented as:
  - Excel to be used by persons in leading position
  - Written report to the government

2022			
Ca 210 000	Homehelp services 140 000	→	Response rate 59%
	Special housing 70 000	→	Response rate 43%
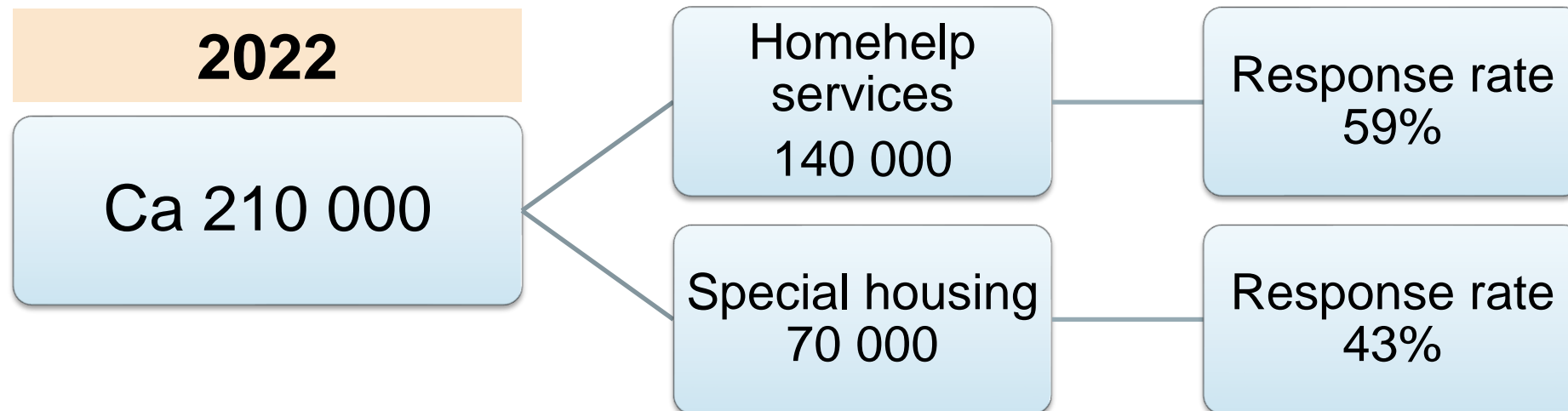
The Elderly Guide

- to provide overall information and a possibility of comparing municipalities and units of special housing.

To obtain in-depth information about services and care, one is recommended to contact the municipality or unit in question.

Effective Long-Term Care underpinned by Data and IT Germany: Quality Assurance visible for all

New indicators and publication framework

Irmelind Kirchner
Malmö, 16.06.2023

AOK. Die Gesundheitskasse.

Four elements of quality management

The legal framework for a comprehensive quality assurance system of LTC connects four elements:

1. **Internal Quality Assurance System** is a task for each care provider

2. **External quality evaluation** conducted by independent inspection organisations (person-centred, sample)

3. **Dialogue on quality** between inspectors and providers as part of advisory character/learning system

4. **Publishing data on quality** as consumer-oriented information

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Internal quality management: quality indicators

Quality indicators area 1: Maintenance and support of autonomy

1. Maintain and support mobility

2. Maintain/support autonomy with regard to everyday routine tasks (self-care)

3. Maintain autonomy concerning day-to-day activities

Quality indicators area 2: Protection against factors that are detrimental to health

4. Incidence of pressure sores
5. Falls with wide-ranging health consequences
6. Unintentional weight loss

Quality indicators area 3: Support for individual needs

7. Conducting integration conversations (after moving to the facility)

8. Use of restraints

9. Use of bed side panels

10. Up-to-date pain assessment

Data on these indicators are transferred to a neutral collection point (twice a year)
Plausibility check
Reports sent to: providers, regional associations of the care insurers, external inspection bodies

External quality inspections: quality indicators

- Once every year (announced)

- Results of internal quality management (report) is taken as basis

- Aspects relating to professional care management within the facility such as management of risk factors and hygiene management are taken into consideration

- <u>Important</u>: dialogue on quality, advice for improvement through external inspectors

In addition, each inspection looks at a sample of up to nine care home residents, evaluating the quality of care for each individual. Inspection focuses on aspects of care closely aligned to the individiual care grade assessment (*decides the care grade for each individual with care needs: six areas covering mobility, communication and coginitive abilities, daily life competence, ability to cope with and manage burdens related to illness, organising daily life and participation in social life*).

The results of these person-centred care inspections fall into four categories:
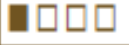
a) No deficiencies or particular points of concern

b) Points of concern without risks or negative outcomes for resident

c) Deficiencies which carry a risk of negative outcomes for resident

d) Deficiencies resulting in negative outcome for resident

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Publication of results online for each provider

Results for Internal quality indicators are published for the 10 indicators in 5 grades:

External inspection results are published for different aspects of individual care; 4 grades:

Results quality well above average: ●●●●●

Results quality slightly above average: ●●●●○

Results quality near average: ●●●○○

Results quality slightly below average: ●●○○○

Results quality well below average: ●○○○○

No or slight quality deficiencies
Moderate quality deficiencies
Significant quality deficiencies
Severe quality deficiencies
Not applicable for residents included in sample

Best results achieved by providers:
Worst results achieved by providers:

Results will be comparable across providers.
No overall scores but detailed information – differentiation from previous system.

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Thank you.

Irmelind Kirchner

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Thematic panel discussion Long-term care undepinned by data and IT

The building up of data policy in France

MALMÖ – JUNE 16 2023

ANDASS
pour un développement
social et citoyen

2000-2014

Laissez Faire

Each administration decides to develop its own system or to buy it on the market (100 county councils, 100 strategies)
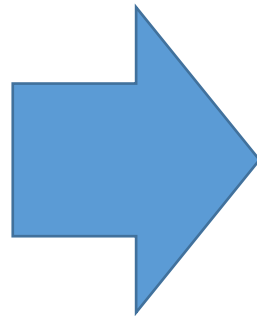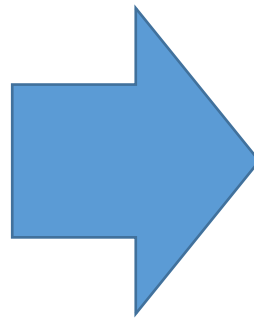

No data policy

No common definitions

No communication between systems

« Manual » data collection reported to the central administration

2014-2020 : convergence

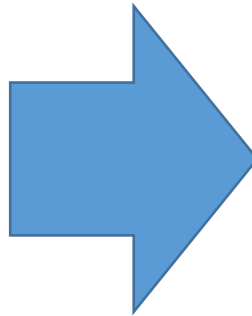**Counties councils are gradually obliged to use labelized softwares**

→

Common definitions

Automatic collection of data by central administrations

Impact on work organization

Implementation issues

2014-2020 : unification

Counties are obliged to use a unique « in-house » system

Building block approach

(first block 80 M€)

Common definitions

Automatic collection of data by central administrations

Limited cost for local authorities

Risk of failure

Reduction of local decision-making powers

Assesment of work organization impact

Conclusion

What are we still missing ?

Pairing with other databases (e.g health, school, employment data, care providers systems)

Governance

Legal clearance

Labelisation

Were other strategies possible ?

Data exchange standards API

Where we are

How we will get there

- Limited digitisation
- Lack of data availability
- Duplication of data collection
- Lack of standardisation
- Data gaps

Building our understanding of the data we all need through engagement and our online survey

Working through local health and care commissioners to embed change in their area

Building capacity within local authorities and care providers to deliver digitisation in their own organisations

Using commercial levers to proactively shape the technology supplier market to achieve our vision for improved care outcomes

Streamlined and improved existing data collections

Client level data collected from local authorities

Provider level data collection and national minimum dataset

Fit for purpose **ASC survey and Survey of Adult Carers**

New data collections only to bridge data gaps, including for workforce and unpaid carers

Improved access to the data and better insights

New national digital product to **improve access to social care data**

Strengthened **Adult Social Care Outcomes Framework** metrics

Sector digitisation

Improve adoption of **digital social care records, 80% by March '24**

Deliver a **comprehensive learning offer** to improve staff digital skills

Improve the **cyber resilience** of care providers, inc. use of secure email

Support providers to improve their connectivity, including for mobile care

Drive **adoption of care technologies** that support independence

Improve the confidence and capability of buyers, inc. market management

Department of Health & Social Care

Annex | 10 principles for moving forward and transforming adult social care data in England

1. **Data will be collected once and made available to those who need it**, to avoid national and local government collecting the same data separately from care providers, unpaid carers and those who access care and support

2. **Data will routinely be shared back with data suppliers wherever possible**, in an accessible manner appropriate to the needs of different data users for additional insights and benchmarking purposes

3. The **option for automated data collection methods as an alternative to manual collection will be available wherever possible**, to minimise the data collection burdens on data suppliers

4. **Frequency of data collection will be the minimum needed** to meet data needs

5. **Data collections will be based on data already held by a data supplier, wherever possible,** and where new or amended data is required, it will be kept to a minimum

6. **Feedback will be sought from relevant stakeholders wherever possible**, prior to finalising the details of new or amending existing collections

7. **The collection of very granular data will be kept to a minimum** where such data is not held in digital format and therefore would present a significant burden on providers to submit manually. If individual level data is being collected, **providers will not be expected to bear the burden of anonymising or pseudo-anonymising such data,** rather this will be considered when identifying an appropriate data collection mechanism

8. **Information will be processed and made available safely and securely,** and only processed in accordance with the legal framework, including data protection legislation, with respect for people's privacy and with due regard to their consent. Reasons for providing access to data will be transparent, open, and understood

9. **Access to data for research and analysis will be made available through SDEs**, which will ensure that the highest standards of security, privacy and transparency are upheld

10. **Changes to new and existing data collections will be reviewed and approved by the relevant governance structures**, to ensure changes are appropriate and proportionate

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