Quality improvement in German and UK care homes

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Introduction – wider policy and practice issues

Care homes for older people provide care and support which can range from that traditionally classified as health care to that designated in many welfare systems as "social care". The boundaries between these forms of care, which have been the subject of long-standing dispute (Twigg, 2000), are likely to continue to shift as definitions of health care broaden. What is clear, however, is that the care home provides a different form of health care from that offered by the acute care sector – residents make a home in the facility, and so their stay is usually long-term, and their care is necessarily broad and addresses wider issues of quality of life than specific health problems, for which there are correspondingly specific treatment guidelines and protocols (Henwood, 1992).

There has been little universal agreement within countries and across Europe about the standards of care in care home settings, other than medical and nursing care. This is slowly changing. For example, recent legislative changes in the UK in the form of the Care Standards Act (Department of Health, 2000) brought about the establishment of the National Care Standards Commission in the UK, in April 2002, which has powers to regulate and inspect care to national standards as defined in the Care Homes Regulations (Department of Health, 2001a) and National Minimum Standards (Department of Health, 2001b). There are, however, concerns that quality of services varies unacceptably across the EU resulting in inequalities of provision (Wolfe *et al.*, 2002). The International Society for Developing Social Minimum Standards provides a forum for those managing and working in care homes to discuss their different models of practice and to share their ideas about standards of care. Harmonisation of standards is discussed and advocated yet it has not been achieved.

The situation is made more complex by the changing structures in which care homes operate. Welfare systems across Europe are undergoing a period of change in response to a range of economic, political and demographic pressures, including the issues raised by an ageing population and the implications this may have for the funding and form of services. In this complex environment the provision of services is increasingly moving from existing models to meet the needs of a changing population in different ways. Hugman (1996) has argued that forms of welfare development are becoming increasingly blurred as "mixed economies" of welfare provision emerge. Hence, a pluralistic approach, in which state, private (for-profit), voluntary (not-for-profit), and informal sectors provide services, is becoming more common. The developing pluralism of care home provision in the UK and Germany has stimulated debates about how this sector should be managed, which has prompted the development of health and social care policy and the growth of quality management (Evers and Harding, 1997).

The complexity of services provided by care homes and the difficulties associated with defining standards of practice present particular issues for quality management systems and processes of regulation of the care home sector. Clearly approaches to quality management need to be holistic and comprehensive, and to support an ongoing and responsive process of quality improvement for the individuals and the community living in the care home. Øvretveit (2000) has pointed to similar drivers across other areas of health care, and identified a number of initiatives that were made in response, including standard

setting, self-regulation systems, and government regulatory mechanisms.

Regulation, consumerism and quality management

Among the arguments for harmonisation of quality standards in care homes across the EU is the realisation that consumerism in older people is not necessarily developed in such a way that market forces can be left to effect change – the consumers are vulnerable and their choice of home is more serious and complex than choosing many other consumer goods. Recognition of this has resulted in legislation in both countries to provide something other than consumer power as a vehicle for maintaining quality care beyond minimal standards. In 1999 in the UK a consultation paper *Fit for the Future* (Department of Health, 1999) was circulated as part of the move towards placing responsibility on local authorities to address quality issues in care homes. This trend is also evident in Germany where care insurance has been obligatory since the mid-1990s, which obliges care homes to have quality assurance procedures in place. While these legislative moves indicate that the problem of quality is recognised, in themselves they do not address the problems of operationalising these ideas.

These debates and tensions have been played out differently in the UK and in Germany, in line with the different cultural, structural and political drivers at work in these two settings. One of the most critical issues is that of regulation and inspection, which have taken different forms in the two countries. In Germany, where provision is mainly by the voluntary sector, for example, church groups, inspection is relatively infrequent and, as Klein (1997) describes, focuses on custodial aspects and standards of accommodation (*ordnungpolitisches Modell*). The model of regulation here seemed to be consensual, in other words based on assumptions of shared values between regulator and regulated, which reduces the need for inspection. However, the current situation in Germany is characterized by legal changes. From January 2002 inspection units are obliged to do at least one inspection per home per year. Also the Medical Services of the Health Insurance has to do a sample of 5 per cent of all homes per year and inspect care standards. The new care quality assurance law (*Pflegequalitätssicherungsgesetz*) requires the implementation of independent experts or quality boards (*Prüfstellen*) who give proof of the quality of services in care homes and the domiciliary sector (*ambulante Dienste*). They are now the third body inspecting homes for quality.

In the UK where the private sector has a stronger presence than Germany, inspection is more frequent and more clearly formulated to police care (Burgner, 1996). The UK and Germany, therefore, can be argued to represent different stages in the development of this form of provision, and are facing problems particular to these stages, with the UK more accustomed to private sector provision than Germany. The current UK approach, however, presents future resource and management problems – the cost implications of increasing private sector provision and the resultant need for increased inspection are potentially huge.

The development of Qual A Sess

It was against this policy background that the *Concepts of Quality* study took place funded by the EU Human Capital and Mobility Programme (Klein and Cook, 1998). In response to the findings of this study, a self-regulation system, Qual A Sess in the UK and "*Selbstbewertungssystem für stationäre Einrichtungen der Altenhilfe*" in Germany, was designed by different institutions in Germany and the UK under the project management of the Fraunhofer Institut für Arbeitswirtschaft und Organisation (IAO).

The system incorporated strategies for continuous quality improvement within a care home and an approach to assess the home's performance against accepted standards found in the literature, for example, the Department of Health in the UK, Homes are for Living in and the European Quality Award. The Qual A Sess system creates a process that involves residents, relatives and staff in the assessment of the home's current performance and in the development of action plans to promote improvements in the quality of care and service provision.

The system consists of two inter-related parts: the work package and the self-assessment process. The work package includes a description of the system, guidelines for implementation of the system in the home and recording materials.

Within the package there is a standards matrix, which is the framework that is used to assess the home's performance. The standards matrix includes ten elements in the UK version and 12 elements in the German in line with the findings of the original research and development work (see list below). Each of the elements is subdivided into ten questions and corresponding standards:

Three elements that focus on the essentials of running a good home:

- Policy and strategy (how the home formulates, communicates, reviews and turns its policy and strategy into actions).
- People management (the management of people to achieve the aims and objectives of the home and a quality service).
- Processes (how the home identifies, manages, reviews and improves its processes and procedures).

2 *Six elements that focus on services for residents which are essential to their quality of life and quality of care:*

- Information (the quality of information made available to residents).
- Assessment and planning (the assessment, planning and review of residents' needs).
- Direct care and health services (the quality of direct care and health services available to residents).
- Physical environment (the physical comfort of residents and general upkeep and maintenance of the home).
- Catering services (the planning of menus, the quality and presentation of meals and resident satisfaction with the food provided).
- Interests and activities (the interests and activities available to residents).

3 *One essential outcome for everyone connected with the home:*

- Customer Satisfaction (what the home is achieving in relation to the expectations of residents and other customers).

In Germany Qual A Sess identified two more elements:

1 *One service element*: therapeutic services (assessment, planning, access and review of therapeutic services). This element reflects the differing service structures in Germany, where therapeutic services such as occupational therapy are managed within care homes due to their average size or, if not, to how far structures contribute access to such services, (rather than by statutory hospital services, as often happens in the UK?).
2 *One outcome element*: employees' satisfaction (what the home is achieving in relation to the expectations of staff members). This element reflects the greater concern towards employees in Germany. Good management practice views staff performance and staff motivation as key factors in enhancing quality and recruiting staff.

The standards differ in the UK and German versions of the system to reflect the cultural and structural situations in the respective countries. For example, under the element "Interests and activities" the UK standard stipulates that "residents can attend local libraries, or the mobile library visits: newspapers and journals are available." In Germany, this standard does not appear. Similarly, in Germany one standard states that "If needed, residents are supplied with a shopping service", which is a service that is familiar to German people, but not to those living in the UK. Therefore, this standard does not appear in the UK Qual A Sess system. There are, of course, arguments for making standards uniform across the two countries, in order to challenge norms and expectations of services, but this strategy would run the risk of discouraging homes from using a framework which did not fit well with the wider service and cultural practices in existence.

The self-assessment process includes selection and recruitment of the self-assessment team, group discussion, development of the action plans, negotiation of the action plans with the home manager and review following implementation of those plans. In this process the self-assessment team, which compriss residents, relatives and staff members of different functions, assesses the home's performance in each of the elements. This happens through discussion and examination of evidence such as issues presented in suggestion boxes, complaints, inspection reports and personal experience. This process takes place in a structured group discussion where all of the participants are encouraged to state their evaluation of the element and standards under scrutiny and then discuss the reasons for their judgements. The discussion moves onto reaching a group consensus about the home's performance against each of the standards and the development of a quality improvement plan. These plans are then recorded and the person with responsibility for co-ordinating the system negotiates the implementation of the plans with the home manager. During subsequent meetings of the self-assessment group the progress of implementing the action plans is reviewed. Hence, the process ensures that the experience of those who use and provide the service is central to the examination of existing services provided by the home, and the improvements that are suggested in situations where performance is shown to be deficient.

These quality improvement plans provide a vehicle either for the improvement of the quality of services provided by the home or tailoring of services already provided by the home to the preferences of those using the service. The assessment of the home and development of quality improvement plans are carried out collectively by those providing and using the service. Thus, another aim of the self-assessment process is met, which is to locate the control of the assessment of the home and subsequent changes with those living in the home and with the individuals who will work alongside the home management structure.

The studies

Method

The evaluation studies were a collaborative venture between partners in the UK (at the Centre for Care of Older People at the University of Northumbria) and Germany (at the Fraunhofer IAO, Stuttgart). The studies aimed to explore the potential of the Qual A Sess system to become a tool for continuous quality improvement and to promote service user involvement in quality development in both countries. The studies were designed within different funding and resource constraints and with different funder requirements and research questions. Therefore, the studies varied in some respects, as it was not possible to design them to exactly mirror each other. Another aim of the collaboration, however, was to map out differences and similarities between the German and UK situations, and therefore the basic research framework and design had to allow this. Standard comparative designs were unlikely to capture this complexity in a way that would enable a clear understanding of process issues in the two different countries to be achieved. For this reason the studies used case study design (Yin, 1984) in order to explore the processes of self-regulation and the interplay between these processes, structural factors and outcomes. This also allowed some development to take place – the UK data were collected before the German study, and the study design allowed case-by-case analysis to inform the German study, particularly in the way that Qual A Sess was introduced into the care homes.

In the UK, Qual A Sess was introduced by a commercial organisation (Bettal Quality Consultancy) which was developing Qual A Sess as a commercial product, and data were also collected from the facilitator who managed this process, through a diary which was kept of the process, and a formal interview at the end of the process. In addition, the facilitator gave the research team verbal progress reports throughout the process.

In Germany, the research team developed a training method for introducing Qual A Sess, in the light of early UK findings. Three different kinds of training were provided: general introduction training, training for group co-ordinators and moderators, and quality plan training.

Sample

The selection of cases was purposive and concerned with seeking rich sources of data to address the research questions (Woods, 1997). A total of 11 care homes in the UK and ten care homes in Germany participated in the studies. The UK homes were all part of one care home company – Ashbourne Homes – which had expressed interest and support for the project. The UK homes varied in terms of the following characteristics:

- size (42-93 residents);
- registration category (residential, EMI, nursing); and
- location (rural and inner city).

Using one organisation was advantageous to the project in the UK as it simplified negotiation and communication with individual homes, and it established a level of organisational and managerial support across the sample. In terms of organisational structure, using one company ensured a degree of consistency and standardisation, which would not have been possible otherwise. The care home sector is, however, a diverse sector, and it is recognised that the homogeneity of the sample may have limited the types of homes included in the UK study, and consequently reduced the applicability of the findings to other types of homes. Despite this assumed organisational homogeneity, however, the participating care homes demonstrated contrasting outcomes with six of the 11 homes completing the self-assessment process, two completing most but not all of the elements, and three not proceeding beyond the first element.

In Germany the Social Ministry of Baden-Württemberg funded the study. An objective was to cover a wide range of homes with different background structures. The sample consisted of homes from different organisations (voluntary, private, public sector), within the state of Baden-Württemberg (rural and city areas) selected through inviting homes with which the Fraunhofer Institut had already been in contact through various training

programmes to express interest in participating in the research. The German homes had an average of 155 residents, varying from 80 to 307 residents, covering all care levels. On average 118 staff members were employed, varying from 55 to 183 employees. From the ten homes initially expressing interest, eight agreed to participate in the study. In contrast with the UK care home where one self-assessment team was established, the German homes had between one and 12 assessment teams (usually between two and three) working on selected elements. For example, one home had eight assessment teams and each of them dealt with four elements, thus evaluating each element between two and four times.

Data collection

Each care home was treated as a case and multiple sources of data were used for each case. These data included the information that is collected as a result of the Qual A Sess process itself, such as records of attendance at self-assessment groups, scores and action plans. This information allows research conclusions to be drawn about the process of participation and quality development, but also allows external bodies, such as inspection and commissioning units, to audit the process for their purposes. In addition the UK research team carried out individual and group interviews with self-assessment team members (that is residents, relatives and staff), Qual A Sess co-ordinators and home managers in each home which completed the process and also elicited views from care home inspectors where they were available for interview. As the care homes were all part of a company that had a regional structure, the regional manager and quality manager were interviewed. Also the managers of those homes that did not complete the self-assessment process were invited to take part in telephone interviews .

The German data collection differed slightly from that of the UK, as the greater geographical distances between homes made individual interviews unfeasible. The data included:

- A total of 180 questionnaires for buyers of Qual A Sess were mailed in order to find out whether they apply the system and what kind of experience they have with it. A total of 40 buyers answered the questionnaire, the response rate being 22.2 per cent.
- Diaries for managers, co-ordinators and moderators throughout the implementation process in order to get their personal impressions on the implementation process. Return rate of the diaries was 38 per cent home managers, 100 per cent co-ordinators and 84 per cent moderators.
- A total of 14 observations during the self-assessments in order to find out whether the process of self-assessment works and how the self-assessment team members discuss and achieve their results.
- Questionnaires for managers, co-ordinators, moderators and staff members, residents and relatives after having established the quality plan in order to obtain judgements on the practice and the outcomes of Qual A Sess (see Table I).

Data analysis

The study produced numerical descriptive data on home scores, levels of participation, and number of action plans developed. These data were incorporated into the case study data as descriptors of care homes and Qual A Sess activity.

The study also produced qualitative data, through the interviews. The qualitative data were analysed using a qualitative data analysis computer software program, QSR NUDIST (Richards *et al.*, 1992). This programme allows the attaching of codes to data text for future retrieval and sorting. Text can be multiple-coded, allowing reports to be generated which retrieve text coded with selected codes, but which also shows relationships with other codes.

Initially a list of codes was developed reflecting the research questions and propositions of the study. For example, the codes related to structural issues (what needs to be in place to successfully implement the Qual A Sess system), process issues (e.g. processes of identification of standards in the home which required change and the process of negotiating stakeholder involvement in the self-assessment process) and outcome issues (e.g. development of action plans and changes to the home). Gradually, as new data was collected and analysis proceeded, these codes were extended or new codes were generated to denote the themes and issues emerging in the data.

Findings

Although the analysis generated findings relating to the processes of implementing a quality management system, Qual A Sess, in care homes and facilitating the meaningful involvement of residents, relatives and staff in assessment of care and service delivery, the focus of the findings reported in this paper will be on the action plans that were generated from the Qual A Sess process.

Action plans – UK

Although the UK homes had met the regulatory requirements and five of the six UK homes that completed the assessment had been accredited with ISO 9002, between 14 and 42 action plans for suggested improvements to the home were made during the Qual A Sess process. It is important to emphasise that Qual A Sess actively incorporates an assessment of strengths as well as of areas for suggested improvement; therefore Table I also indicates by default the self-assessment of level of strength of each home.

The nature of the plans varied from home to home, although there were some elements that were of concern across the sample. The elements which attracted the highest level of suggestions in the UK were (see Table II): catering (26), assessment and planning (22), closely followed by customer satisfaction (21), whilst the lowest scoring elements were policy and strategy (ten) and direct care and health services (11).

The action plans and subsequent changes in care can be broadly divided into two categories. The first is material improvements, in other words changes in the fabric of the home and the provision within it. These included changes such as garden furniture purchased, provision of lockable drawers in residents' rooms, and cruets provided on every dining-table. In one home the residents voiced their desire to decorate their rooms according to their preferences, rather than those of the company.

The second group of plans were about relationship and communication. In a number of groups plans had been developed which involved issues of participation in care. For example, groups suggested the implementation or resumption of residents' meetings, the development of an information/newsletter and the identification of a named person to contact for enquiries. Other suggestions included developing a database of residents who do not receive visitors to support a befriending scheme and increasing community involvement in home activities.

Action plans – Germany

In comparison with the UK homes the number of suggestions for improvement are far higher in the German homes. An average of 110 suggestions of improvement per home were made, ranging from 57 up to 196 suggestions (see Table III). Key areas were employee satisfaction (this element was not available in the UK), information policy and customer satisfaction, whilst the least action plans were suggested for the following elements: assessment and planning, physical environment and policy and strategy. In some cases the implementation of the suggested action plans resulted in several activities; therefore, the scope of change cannot be equated with the documented action plans if they were fully implemented. The following are selected examples of suggestions for improvement to the care and services provided by the home for the elements information and communication technology and needs of the resident:

1 *Information and communication technology* (this was an issue in all of the participating homes):
   - circulation of protocols about important issues requiring signing to ensure that staff were aware of them;

Table I
Questionnaire response rate in the German data collection set

Questionnaire	Response	Response rate (per cent)
Home managers	7	87.5
Co-ordinators and moderators	27	61.7
Team members	89	41.0
Total	123	45.7

Table II
Action plans in the UK

	Suggestions for improvement per home							
Element	1	2	3	4	5	6	Average	Total
People management	2	3	1	4	6	2	2.6	18
Direct care and health service	1	2	3	2	1	2	1.8	11
Customer satisfaction	2	0	7	6	4	2	3.5	21
Policy and strategy	0	0	0	4	3	3	1.6	10
Processes	0	1	1	4	5	3	2.3	14
Information	0	1	3	7	3	3	2.8	17
Assessment and planning	3	3	2	5	3	5	3.5	21
Physical environment	3	2	2	2	2	5	4.3	26
Interests and activities	4	0	1	2	4	5	2.6	16
Catering services	3	2	5	6	4	6	4.3	26
Total	18	14	25	42	35	36	37.8	227

- news items to be placed in the journal of the home; and
- information written on the blackboard for public consumption.

2 *Needs of the resident* (this included suggestions to improve the wellbeing of the resident):
- ascertaining a biography of the resident to identify their preferences and habits;
- analysing the need for leisure activities; and
- identification of key workers.

The responses to the final questionnaire distributed in the German homes showed that 77 per cent of respondents agreed that the implementation of the suggestions for improvement noticeably increased the quality of care in the home. Motivation increased and 94 per cent agreed that Qual A Sess was very helpful in introducing a quality process. In the interviews with staff in the UK, comments were also supportive of the process.

Differences within and between countries

The differences between the two countries are striking, in that the UK homes identified fewer possible improvements than the German homes. This could be read as suggesting that the UK homes were "better" than the German homes, and did not need to improve or, conversely, that the German homes were simply more able to respond to the Qual A Sess framework. An alternative explanation, and one that relies less on speculation, is that the drivers for completion were different in the two countries, with German care homes, subject to legislation which made the use of a quality assurance system mandatory, whereas the UK homes did not have such pressures. This factor may also have influenced the successful implementation of the Qual A Sess process in all of the homes in Germany in contrast with the outcome observed in the UK homes.

It is also interesting to note that both in Germany and in the UK there is a huge diversity between care homes, in terms of the areas that have been identified in the action plans. For each element the homes produced widely differing numbers for suggestions for improvement. In the UK, for example, the number of suggestions for the element "customer satisfaction" varied from 0 in one home to seven in another. In Germany the number of suggestions for this element varied from three in one home to 23 in another. Similarly there were differences in the number of suggestions for different elements within homes – Home 3 in the UK, for example, had no suggestions for policy and management and seven for customer satisfaction. Home 1 in Germany made seven suggestions for improving the physical environment and 24 for increasing employee satisfaction. While it must be stressed that there is no necessary connection between number of suggestions in a particular element and performance, as the number of suggestions may simply be a result of a team's ability to reflect on problems or potential developments, rather than an indication of quality in itself, the differences do suggest an area for further investigation. The differences in suggestions indicate that homes have distinct configurations of issues which are unique to them, and the precise configuration is important to know – for example, if a home makes few suggestions about improving the physical environment but many about improving employee

Table III
Action plans in Germany

	Suggestions for improvement per home									
Element	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Average**	**Total**
Policy and strategy	13	17	6	5	7	5	5	4	7.8	62
People management	18	13	13	10	1	5	3	8	8.9	71
Processes	17	20	11	4	5	5	3	3	8.5	68
Assessment and planning	14	11	8	5	4	6	3	4	6.9	55
Physical environment	7	14	7	6	6	6	6	6	7.3	58
Information policy	23	19	13	12	6	6	10	3	11.5	92
Direct care and health service	19	13	11	5	9	5	6	4	9.0	72
Therapeutic services	15	16	16	10	4	5	3	7	9.5	76
Interests and activities	18	11	22	10	9	6	1	1	9.8	78
Catering and domestic services	12	10	8	15	9	7	7	7	9.4	75
Employee satisfaction	24	15	21	7	6	6	6	7	11.5	92
Customer satisfaction	16	11	23	5	9	7	8	3	10.3	82
Average	16	14	13	7.8	6.3	5.8	5.1	4.8	9.2	
Total	196	170	159	94	75	69	61	57	110.1	881

satisfaction, as did Home 1 in Germany, this suggests a particular set of concerns with very different aims and goals from other homes with very different suggestion profiles. The suggestion profiles, therefore, indicate unique patterns of action in each home, which any regulatory framework needs to acknowledge.

Discussion

The data presented in this paper are primarily those collected via the process of Qual A Sess itself, and the strengths and limitations of these data are important factors in determining the utility of Qual A Sess as a method of continuous quality improvement within the regulatory frameworks of Germany and the UK. The internal recording system provides a mechanism to track the assessment of the elements and the respective standards, and the generation and implementation of action plans. However, some inaccuracies in data recording were identified during the evaluation. For example, records of participants in Qual A Sess groups were not available or complete. While the researchers were able, in interviews with UK staff, to confirm participation of residents and relatives, this was done soon after the meetings, and any further lapse in time may have made this impossible. This raises questions about transparency of the process. For Qual A Sess to be a reliable tool, record-keeping has to be adhered to by staff, and possible mechanisms for verification need to be explored. However, the process in Germany might be a possible way. Here the moderator of the self-assessment team is responsible for the documentation of the results of the team and also records the participants. All participating homes in the study were informed about the process and made action plans public.

It is also important to point out that as a tool for quality improvement Qual A Sess would appear to have utility in the identification of standards and areas for improvement in a way which reflects the particular environment of the care home – hence the differences in action plans between care homes. To this extent, Qual A Sess appears to facilitate quality improvement, in that it enables care homes to evaluate care and service provision in a systematic way, and develop action plans for the future, which can then be reviewed. It therefore makes the process of quality improvement more transparent and accessible to monitoring to check whether the changes to the home resulting from the generation of action plans are sustained.

Although the homes participating in this study had met the regulatory requirements, suggestions for improvement were identified through this system. This highlights the gap that exists between procedural control and quality of life as experienced by those who use and provide care home services. The trend towards seeking registration with ISO 9002 (British Standards Institute, 1994) in the UK and legislative requirements for quality assurance procedures to be in place in care homes in Germany also suggests that there is growing awareness that this gap exists and new approaches need to be developed to reduce it. Porter and Tanner (1996) suggest that caution in these developments is necessary as external quality audits can degenerate into bureaucratic procedures that limit themselves to assessing control of procedures with little attempt to explore quality improvement opportunities. Hence, alongside the regulatory structures that ensure that the appropriate environment is in place, processes for continuous quality improvement internal to care homes offer an approach to move standards beyond the bare minimum, whilst tailoring the environment to the needs and preferences of those living in it.

Although the focus of this paper has been on selected outcomes from the introduction of Qual A Sess in care homes, the main strengths of this system rests with its emphasis on processes and participation and its responsiveness to local issues and concerns. The system contributed to quality of structures and results mainly through the outcomes of the action plans. The data from this study suggest that attempts to develop international standards or to harmonise standards across countries may run the risk of imposing frameworks which do not reflect the concerns and priorities of care homes and the residents who live in them or the cultural and social variations in national contexts. However, the developing approach in a UK and German team considered these differences in formulating the questions and standards. The process of the system showed that it worked in both countries. Qual A Sess is a very flexible instrument and can be adapted to different local, regional and national requirements. It shows a pan-European potential and would be worthwhile considering in the context of the discussion of social minimum standards in care.

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