European Centre for the Development
of Vocational Training

RESEARCH PAPER

No 7

Quality assurance in the social care sector

The role of training

Luxembourg:
Publications Office of the European Union, 2010

CEDEFOP

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Cataloguing data can be found at the end of this publication.

Luxembourg: Publications Office of the European Union, 2010

ISBN 978-92-896-0665-3
ISSN 1831-5860
doi:10.2801/33560

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Cedefop was established in 1975 by Council Regulation (EEC) No 337/75.

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Foreword

Invest in people! Never before has this been so pertinent as nowadays.

In present times of rising unemployment and economic slowdown, investing in people's educational, health and social wellbeing, presupposes strong commitment to people as Europe's most valuable asset in the 21st century. This commitment over time should secure full participation in society for vulnerable groups.

The year 2010 was declared 'European year for combating poverty and social exclusion' to raise awareness of and remedy the weaknesses of our social systems in which between 83 and 84 million Europeans face the risk of poverty, representing 16.5% of the population ([1]). 'Combating poverty' figures among the 'five measurable EU targets for 2020' proposed in the communication from the Commission *Europe 2020. A European strategy for smart, sustainable and inclusive growth* of March 2010 (European Commission, 2010) and further consolidated by the Council conclusions on the social dimensions of education and training of 11 May 2010 (Council of the European Union, 2010).

With the above two initiatives, the European Union wishes to reaffirm the importance of collective responsibility for combating poverty and social exclusion and in reducing substantially the number of Europeans living in poverty. There are particular vulnerable groups more exposed to poverty and social exclusion than others, often with health problems too.

To give one example, in 2002 people with a disability' represented 16.2% of the EU population aged 16 to 64. People with disability showed employment rates (50%) significantly lower than people without disability (68%). In particular, employment rates were very low for people with severe (41%) and very severe disability (19%) ([2]).

In 2008, according to Eurostat ([3]), some 17% of people aged 15+ in the EU reported health-related limitations in performing daily activities (limitations of at least six months). People with health-related limitations are overrepresented in the poorest groups of the population (21% of the population with an income below 20% of the median income and 21% of the population with an income between 20% and 40% of the median income).

([1]) *Source:* data for 2008, Cedefop's calculation based on Eurostat, survey on income and living conditions [cited 22.7.2010].

([2]) *Source:* Eurostat, labour force survey, 2002 ad hoc module on employment of disabled persons [cited 22.7.2010].

([3]) *Source:* survey on income and living conditions [cited 22.7.2010].

Despite our social protection and security schemes, too many people fall under the category of 'vulnerable groups' since new groups such as the elderly, single-parent families, people with mental health problems or the homeless have joined the list of people with a disability, migrants and asylum-seekers or the long-term unemployed. At the same time, fundamental societal changes such as ageing of the population, globalisation and growing cultural diversity increase the need for social services for almost all categories of the population.

They all need targeted action plans and programmes, specialised services and support schemes, if they are to (re)-integrate into society and employment. The social care sector is called upon to provide them. As it is related to public health, national health care systems and to social protection, it should not be reduced to a mere economic activity given its importance for both human wellbeing and social cohesion. Ultimately, what differentiates it from the other sectors is it refers to people servicing other people in need. Therefore human rights, empowerment, codes of ethics and practice standards enter into play and have to be observed seriously.

However, it is widely agreed that current financial turmoil is putting funding of social services under extreme pressure. It is therefore very important to deliver services most effectively and efficiently or, in other words, provide good services at the right time and at a good price.

In parallel, the sector is expanding into one of the largest and a very important job providers. According to Eurostat ([4]), in EU-27, 21.5 million persons are employed in the health and social sector. Employment in this sector registered a rise of 24% since 2000 and represented in 2009 around 10% of total employment. This figure refers to a larger population of professionals in which social care is included. According to EASPD, the European Association of Service Providers for Persons with Disabilities, there are currently eight million formal carers to which an estimated equal number of informal carers should be added. Due to often poor working conditions the sector is not sufficiently attractive to young people. Resulting labour shortages are met by importing workers from 'newer' Member States or from non-EU countries.

As reported by research partners, in Denmark for instance, half a million people from eastern European countries work in the sector. The migrant labour force often has important language problems and no – or at least difficult to assess – qualifications and diplomas. Besides, it is less if at all, exposed to modern technology, which is an important part of caring. All these issues require major

([4]) *Source:* 2009 labour force survey [cited 22.7.2010].

focus on workforce development, training and retraining with particular attention on women, who constitute the vast majority of the labour force ([5]).

In addition, the current movement for deinstitutionalising care represents a major cultural change on how society and the sector understand disability, care delivery, recovery and patient autonomy. Care services need to be delivered in the community instead of institutions and new soft skills and competences are expected from professionals besides their specialised knowledge.

Against this complex and competitive background, and in conformity with Article 2 of the Treaty establishing the European Community – which lays down the tasks of promoting, inter alia, a high level of employment and social protection, raising the standard of living and quality of life and economic and social cohesion and solidarity throughout the Community, that Cedefop decided to analyse the skill needs and quality of service provision in the social and health care sectors.

The present study focuses on the competence needs of two groups of professionals, front-line workers and service managers/leaders in community-based services. Both groups' performances impact on the quality of care provided. Cedefop decided to focus on the professionals working with three most vulnerable and disadvantaged groups all with multiple, complex and long lasting needs in different key life domains: the elderly, the homeless and persons with disabilities.

Six generic competences for front-line staff, middle management and management were identified and further verified in discussions of focus groups set up in five European Member States representing different European social models and traditions: Scandinavian, continental, central-eastern, Mediterranean and Anglo-Saxon.

The six generic competences were further studied by analysing 18 innovative training and lifelong learning practices, selected in the above-mentioned Member States. Particular attention was also paid to the quality and transferability elements inherent in them.

The work produced a scenario on future skill demands based on a strategic vision of VET and lifelong learning in the social care sector. The scenario was validated by key European service organisations, as well as by the Disability Unit of DG Employment, Eurofound and DG EAC.

Finally, the study proposes a series of recommendations for policy-makers at European level, service-providers and VET providers to develop further the sector's human potential and increase its employability by alleviating handicaps for better socioprofessional inclusion of those in need.

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([5]) According to 2009 Eurostat labour force survey data, 78.5%, [cited 22.7.2010].

Acknowledgements

This report is a team effort, reflecting the work of Tina Bertzeletou, Cedefop's senior expert in charge of the project, and a research consortium led by both Professor Dr Chantal Van Audenhove, Director of LUCAS (Centre for Research and Consultancy in Care, KUL-Leuven) and Mr Luk Zelderloo, Secretary-General of EASPD (European Association of Service Providers for Persons with Disabilities) and composed of AWO (Arbeiterwohlfahrt), EPR (European Platform for Rehabilitation), FEANTSA (the European Federation of National Organisations Working with the Homeless), and Workability International – the European section ([6]).

Cedefop thanks project partners in the five Member States (Germany, Poland, Portugal, Sweden and the UK), who organised national focus groups to discuss research hypotheses, provide information on the care needs of the three target groups (the elderly, the homeless and persons with disabilities), define and compare the competences of innovative front-line workers and service managers and analyse three cases per country. The full list of consortium members can be found in Annex 1.

Cedefop also expresses its gratitude to those working in the sector who agreed to participate in the focus groups.

Cedefop would like to thank those who participated in the validation process, namely: the Disability Unit of DG Employment; the ACV-CSC Trade Union representative in Cedefop's Governing Board; DG EAC; Eurodiaconia; Eurofound; Fontys OSO; St Mungo's; Learning and Development Unit, UK; Hogeschool Universiteit Brussel; University College Arteveldehogeschool; and Vlaams Ministerie van Onderwijs en Vorming.

Finally, thanks are due to Cedefop colleagues, in particular Marco Serafini and Vladimir Kvetan for providing updated statistical data and forecasts and to Christine Nychas, Annette Cloake and Alessia De Martino for their technical support.

([6]) The work was carried out under Cedefop's service contract No 2008-0175/AO/ECVL/TB/Quality-in-VET/021/08 Lot 1.

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Executive summary

Health and social services are one of the largest growing economic sectors. The European Union (EU) uses a very broad definition of social services. They can be grouped into two broad types: statutory and complementary social security schemes and other services provided directly to a person. The latter play a preventive and socially cohesive role, such as social assistance services, employment and training services, childcare or long-term care services for the elderly and disability services. This study focuses on this second type. These sectors are challenged by fundamental societal changes (such as the ageing population, globalisation, growing cultural diversity) and new policy trends such as deinstitutionalisation of social care, new public management and evidence-based practices. These fundamental changes demand new skills and competences of front-line workers and managers in the social and health services. They also challenge current vocational education and training (VET) programmes to adapt to these changes.

This study has three goals:

- identification of the main societal and policy changes and their consequences for the social care sector;
- identification of generic competences of front-line workers and management;
- gathering and analysis of good practices of VET in the social care sector.

Societal and policy changes

The EU is experiencing significant ageing of the population. As a result, less active people will be available on the labour market. These demographic changes also lead to growing and changing demands for care and for care workers (OECD, 2005b). On the labour market, there are fewer low-skilled jobs available so unemployment is more strongly related to educational status. Delaying marriage and births is an expression of citizens' new life priorities as well as constraints since families hesitate to have children because of the difficulties of combining a job with raising children. Family breakdown is a relatively new social risk, since single-parent families face a significantly higher poverty risk. Individualisation refers to the process where individuals have to shape their own life courses and make choices continuously. In other words, the life course is less programmed by gender, social class, religion or

neighbourhood. More people find it difficult to create their own place in society. Europe has also become more culturally diverse because of migration. Cohabitation of people of different cultural backgrounds is one of the most compelling challenges for the EU. It is estimated that if our approach to climate and environmental protection does not change profoundly, by 2050 there may be 200 million 'climate migrants' in the world (Brown, 2008). Scientific evidence also shows the negative impact of social inequality in health, psychosocial problems, crime and less social cohesion. One of the new vulnerable groups are those with mental health problems. Mental disorders constitute a major part of the European burden of disease (European Commission, 2008c). In any given year, a quarter of Europeans are likely to be affected by mental disorders, while less than half will have contact with health services. In addition, projections show growing psychic vulnerability. In 2020, depression, alcohol abuse, dementia and self-inflicted harm will be among the 10 leading causes of disability-adjusted life years and will contribute to more than one quarter of the total disability burden in developed countries. Minorities, migrants and asylum-seekers are also relatively new vulnerable groups (Huber et al., 2006).

Policies towards social and health services are characterised by new public management, the growing importance of the European method of coordination, deinstitutionalisation of social care, the breakthrough of evidence-based practice and new, more emancipatory approaches based on human rights, empowerment and inclusion. Deinstitutionalisation of social care deserves special attention. It refers to replacing residential institutions with community-based services to enable people to become fully participating members of the community. This causes a paradigmatic change in social care: instead of bringing the users to the institutions, services have to be brought to users. Social services also have to function more and more in a market-driven environment.

At the same time, large differences exist between health care and social care services across Member States. Social care models in the EU can be summed up in four categories:

- residual model;
- Scandinavian model;
- corporatist model;
- family care model (Eurofound, 2006).

The residual model relies on means-tested services and benefits and is most prevalent in the UK. The corporatist welfare State follows the Bismarck model and is linked to Belgium, Germany, France, the Netherlands and Austria . Labour market participation is the central guarantee for being entitled to social protection. For social services, subsidiarity is the core value. Non-profit services are

subsidised by the government to provide social care. In the family care model (Spain, Greece, Italy, Portugal), the family is the main provider of social care and the State only provides very modest services. This causes a heavy burden on informal care and drives families to the grey economy. Most central eastern countries can also be allocated to this model. In the Scandinavian model, a broad range of high-standard care is provided by the State and local authorities.

These differences in welfare State regimes also influence social and health services. In general, employment in these services is growing strongly. From 2000 to 2009, about 4.2 million new jobs were created in EU-27 (+24%). This represents around a fifth of growth of the whole services sector ([7]). Employment in the health and social care sector continued to grow (+0.6 million jobs, +2.6%) even between 2008 and 2009, despite the crisis, which provoked at the same time a drop of -1.8% in total occupation and a stagnation in employment in services. However, the share of employment in health and social services in total employment is very different throughout the EU. It is relatively small in southern, central and eastern countries, but is high in some northern and western European countries.

Due to these societal and policy changes, the need for social services will increase, while social services are confronted with a growing shortage of care workers. The public image of social care is also less valued and working conditions are not sufficient to attract enough new workers. In other words, societal and policy changes increase pressure on social care workers while these social services have to convince new workers to work in their sector. In particular, mobility of care workers from new Member States or even from outside the EU is believed to be a solution for these shortages. However, they often have language problems and no specific training. It is an enormous challenge to train these new workers and guarantee the current quality of social care.

Generic competences in the social care sector

In this study, competences are defined as the ability to use and integrate knowledge, skills and attitudes to realise specific goals. By using the term attitude, it is made explicit that care work has an important ethical component. Generic competences can be defined as shared knowledge, skills and attitudes of different occupational groups of social care staff.

([7]) Cedefop's calculation based on Eurostat, labour force survey [cited 15.7.2010].

Nowadays, specialised education and competences are highly valued. Social care workers are under pressure to specialise in specific target groups and/or specific methods. However, these specialist competences can possibly lead to neglect of generic competences, which aid cooperation between different professional groups, since they provide a common language. In addition, research shows that these generic competences increase the effectiveness of social care interventions (Wampold et al., 1997). Although the study focuses on generic competences, it recognises the importance of specialist competences to work with specific target groups or in specific social services. However, specialist competences seem already better covered in existing VET standards and in regulating the professions.

The study focuses on generic competences needed to support care providers working with difficult target groups. Their problems are related to physical, psychological or mental health, vulnerability to stress, lack of basic coping skills, limited transfer of learning experiences, addiction problems and behavioural difficulties. It concerns persons with ongoing (or even lifelong) needs for support in different key domains of life or long-term care. The OECD (2005a) has defined long-term support as a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living over an extended period of time. Elements of long-term support include, medical treatment for long-term conditions, home nursing, social support, housing, employment and services such as transport or meals. Different professional groups are responsible for these various social and health interventions.

This study focuses on front-line social care workers and managers. Since front-line workers have face-to-face contact with the target group, they have an essential function in delivery of social services. Managers were selected, since they are responsible to adapt social and health services to the challenges caused by social and policy changes.

The literature review led to five generic competences of front-line workers to:

- coordinate services in different life domains;
- create an inclusive community and fight stigma and discrimination;
- empower service users based on a human rights perspective and encourage their participation;
- build a relationship of trust with service users characterised by ‘low expressed emotion’ and a recovery-oriented approach;
- build partnerships with informal support providers.

At organisational level, innovative team models were identified. In transdisciplinary teams, the aim was to pool and integrate the expertise of

different team members to develop more effective assessments and interventions. For social care leaders, the literature review pointed to the following competences: be able to centralise by mission and decentralise by operations; create an organisational culture that identifies and tries to live by key values; create an organisational structure and culture that empowers their employees and themselves and ensure that staff are trained in human technology.

Focus groups consisting of social care workers, managers, VET providers and service users were organised in five countries. Based on the rich data of the focus groups, six groups of generic competences were defined. The first are personal characteristics and attitudes, such as assertiveness, empathy, patience. Second, because the quality of the relationship between the care worker and the client strongly influences the effectiveness of social care interventions, front-line workers need to have the ability to build relationships based on trust and communicate effectively with service users. The third group of skills relates to being able to transfer knowledge into practice. Fourth, empowerment is strongly stressed in all focus groups. Fifth, brokerage skills refer to skills to assist service users to benefit from the services they need. The last category of generic competence relates to teamwork: front-line workers have to be able to work in teams consisting of different care workers in various disciplines.

Results of the literature review and the focus groups were compared and discussed with various stakeholders during a hearing. The discussion resulted in a list of six generic competences:

(a) **empowerment:**
- recognise and respect individual rights and human dignity;
- view people as subjects and as holders of rights and not as objects;
- focus on strengths instead of problems;
- improve and stimulate self-realisation, self-determination and personal mastery over one's own life;
- ensure equal enjoyment of all human rights without discrimination;
- involve service users in decision-making;

(b) **brokerage skills:**
- assist service users to identify, access and benefit from relevant community services in different life domains (social security, employment, housing, leisure activities, health services, etc.);
- assist service users to develop a natural support system consisting of friends and family;
- work with local communities to create an inclusive and accepting environment in which everyone can participate;

(c) **multicultural diversity:**
- respect different cultures and be sensitive to cultural differences;
- adapt interventions to different cultures and search for ethno-sensitive interventions;

(d) **transdisciplinary teamwork:**
- share roles systematically with team members across discipline boundaries;
- pool and integrate the expertise of team members to provide more efficient and comprehensive assessment and intervention services;
- communicate with all members in a regular, planned and continuous give-and-take way;
- teach, learn, and work together with professionals from different disciplines, to accomplish a common set of intervention goals;
- differentiate between disciplines based on the situation rather than on discipline-specific characteristics;
- carry out assessment, intervention, and evaluation jointly with team members;

(e) **knowledge management skills:**
- transfer theoretical knowledge into practice;
- transfer knowledge to other social services and social care sectors;
- integrate new technological developments into social services;

(f) **leadership:**
- create an organisational culture based on a central vision and key values;
- entrepreneurship;
- manage change.

This study identifies three essential generic competences of innovative leadership. The first relates to the way social service leaders communicate, support and reinforce an organisational vision. Leaders ensure the vision is a shared vision and identify its relevance to service users. Leaders use central values as anchors and guidelines for decisions. The second competence is entrepreneurship. Due to new public management and new steering instruments such as tendering procedures and introduction of quasi-markets, social service leaders need more entrepreneurial skills to obtain public means and show the results of their actions. The third competence is managing change. Since society is changing very fast, social services are constantly challenged to analyse their functioning and to search for other and better answers to evolving needs of changing vulnerable groups. Consequently, social service leaders ease, monitor and evaluate organisational change.

Innovative vocational education and training

Based on Cedefop's definition (2008c), VET comprises all more or less organised or structured activities – whether or not they lead to a recognised qualification – which aim to provide people with knowledge, skills and competences necessary and sufficient to perform a job or a set of jobs. Trainees in initial or continuing training thus undertake work preparation or adapt their skills to changing requirements. VET is independent of its venue, age or other characteristics of participants, and of their previous level of qualification. VET content could be job-specific, directed at a broader range of jobs or occupations, or a mixture of both; VET may also include general education elements. However, the definition of VET and continuing training (CVT) in individual countries varies considerably.

In the five selected Member States, good cases of VET programmes on generic competences were collected and analysed. Based on this material, five recent trends can be highlighted as innovative characteristics. They refer to:

- participation in VET of service users themselves;
- VET being organised at European level in the two cases initiated and reported by the European Platform for Rehabilitation;
- cooperation with knowledge-producing centres such as universities or colleges for sustainable updating of teaching content;
- importance of combining theoretical knowledge and practical experience;
- systematic promotion of innovative use of European Funds.

Involving social care workers and employers helps to customise training, while involving trainees provides valuable feedback for further development and improvement of training offered. Assessing students/trainees should form an integral part of curricula. Most of the 18 cases of good practice included in the present study have feedback mechanisms based on evaluation by students/trainees. Significantly, another group of stakeholders, namely service users, are progressively becoming interested in planning, implementing or evaluating VET, claiming an active role in this.

Policy recommendations

On the one hand, societal and policy changes increase demand for social care services. On the other, these services are confronted with growing shortages of social care workers. These fundamental changes demand new skills and competences of front-line workers and managers in social and health services as well as innovative VET programmes. VET has to play an essential role to help

these sectors face current challenges. To realise their potential, investments are needed in VET.

Generic competences are less valued, but are needed to make the social care sector more demand-oriented and effective. They apply to all professional groups operating at the front-line of social care organisations. These generic competences need more attention from policy-makers, social care workers, managers and VET providers.

Based on the good practices analysed, this study highlights six policy recommendations to make VET programmes more effective and innovative:

- involvement of service users in VET;
- VET programmes organised at the European level;
- strengthening of the cooperation with research institutions (universities, university colleges);
- European grants as drivers for change;
- combination of different learning methods;
- transdisciplinary learning between different professional groups.

To guarantee the quality of VET, this study shows at least five quality assurance measures:

- involvement of stakeholders in the different phases of the quality circle;
- flexible programmes which make a more tailor-made approach possible;
- assessment of the effects of VET on trainees, the organisation and on the quality of care (goal attainment);
- cooperation with universities or other knowledge centres to link VET to research and development;
- assess trainees' satisfaction, learning processes and (objective) learning outcomes.

One of the greatest challenges is to assess the impact of VET on social care workers and their organisations. To improve sustainability of VET programmes, more research into the effects of such programmes is needed. More cooperation between researchers and VET programmes is necessary to assess these effects more validly.

1. Introduction and methodology

This first chapter introduces into the aims of the study, its methodology and describes the content of the chapters of this report.

1.1. The goals of this study

This study has three main goals. The first is to identify current societal changes, policy trends and challenges facing health and social services. The second is to identify generic competences of front-line workers and leaders. The third is to gather and analyse innovative VET programmes in the social care sector.

First, social and health services are one of the largest growing economic sectors. The EU uses a very broad definition of social services. They can be regrouped into two broad types of services, the functions and organisation of which can vary a great deal across the EU: on the one hand, statutory and complementary social security schemes and on the other, other services provided directly to the individual that play a preventive and socially cohesive role, such as social assistance services, employment and training services, childcare or long-term care services for the elderly, disabled, or mentally ill. This study focuses on the second type of services. These sectors are challenged by fundamental social changes, such as ageing population, globalisation and growing cultural diversity. The social care sector is also steered by new policy mechanisms such as new public management and evidence-based practice. At the same time, large residential institutions are being replaced by community-based services. This deinstitutionalisation of care refers to a fundamental shift: instead of delivering social care in institutions, services have to be brought to service users in their natural environment. In other words, the social care sector is undergoing fundamental changes. These changes demand new skills and competences of front-line workers and managers in social and health services. They also challenge current VET programmes to adapt to these changes.

Second, this study focuses on generic competences which can be defined as shared knowledge, skills and attitudes of different occupational groups of social care workers. Social care workers are under pressure to specialise in specific target groups and/or specific methods. However, these specialist competences can possibly lead to neglect of generic competences, which are necessary for cooperation between different professional groups and which make social care

interventions more effective. Although the study focuses on generic competences, it recognises the importance of specialist competences to work with specific target groups or in specific social services. However, specialist competences seem already better covered in existing VET standards and in regulating the professions. Focus is on the generic competences needed to support care providers working with difficult target groups with ongoing needs for support in different key domains of life.

This study is limited to front-line social care workers and managers. Since front-line workers have face-to-face contacts with the target groups, they have an essential function in delivery of services. Managers were selected as they are responsible for adapting social and health services to the challenges caused by social and policy changes.

Innovative VET programmes which focus on identified generic competences were gathered and analysed. Special attention was paid to quality assurance through involvement of stakeholders and evaluation methods.

1.2. Methodology

Identification of current societal and policy changes was based on a literature review of evidence from scientific journals, studies commissioned by the EU, European policy documents and data from Eurostat and OECD.

Generic competences were identified by two methods: literature review and focus groups in the five participating countries (Germany, Poland, Portugal, Sweden and United Kingdom). They represent different social care models in the EU. Composition of the focus groups was characterised by large diversity which reflects the broad spectrum of the social care sector itself. Participants in focus groups work in social services and institutions for the elderly, disabled or homeless. Their diverse professional backgrounds enrich the present study. National partners took care of practical aspects, such as inviting candidates and setting up meetings. National partners received a manual on practical organisation, methodological rules and content for focus groups' work. Three topics were covered by focus groups. The first were the main societal and policy challenges and their effects on the social care sector in the countries under investigation. The second concerned the needed generic competences for front-line staff. In particular, they were asked to describe the ideal front-line worker. The third concerned the qualities and competences characterising good leadership in community-based services.

To validate the results of both the literature review on societal changes and on generic competences, a hearing group was organised composed of representatives of a broad range of non-governmental organisations (NGOs).This broadened the view on both topics and brought in new perspectives. Hearing group participants were also asked to comment on the material gathered in the focus groups.

On the third aim, national partners selected good VET practices, based on a semi-standardised questionnaire in which, a broad definition of VET was used. Thus, VET comprises all more or less organised or structured activities – whether or not leading to a recognised qualification – which aims to provide people with knowledge, skills and competences necessary and sufficient to perform a job or a set of activities. The first part of the questionnaire dealt with content of the VET programme:

- what are the main objectives of VET;
- describe how these goals are linked toone of the generic competences of this study;
- what is the target group of this VET;
- what is the main content of this VET course (different modules or topics);
- who organises the programme: a social service provider or a training institute;
- how is the VET financed;
- to what extent have learners to pay for the VET programme? Do people have to pay themselves or will employers/authorities pay;
- didactical approach: what learning methods are used to support participants to acquire new competences?

The second part of the questionnaire focused on quality assurance and was mainly based on the European quality assurance reference framework for VET (EQARF). National partners were asked to document the following six topics related to quality assurance:

- is there permanent evaluation and corrective coordination during training to fine-tune the VET process to participants' needs;
- how is the VET programme evaluated at the end;
- how do different forms of evaluation lead to quality improvement of VET training;
- how are the main stakeholders involved and consulted to identify training needs;
- certification;
- accreditation of VET?

To validate the conclusions of this study, a new hearing group was organised. They had the opportunity to discuss the main results and enrich them. In addition, they were asked to comment on the policy recommendations.

1.3. Structure of the report

The report is composed of five chapters. Chapter 2 identifies current societal changes, policy trends and challenges of the health and social services as an economic sector. These social and policy trends are illustrated with relevant research evidence from scientific journals and studies commissioned by the EU and with comparative data from Eurostat and OECD.

Chapter 3 identifies the generic competences needed in long-term care for vulnerable persons with often complex and multiple problems. It is based on literature review of scientific evidence on generic competences. The first part defines generic competences. Then an overview of recent research evidence of generic competences for front-line workers is presented. The third part focuses on the characteristics of good leadership in social care services. The fourth part summarises the main conclusions and redefines the evidence into categories of generic competences.

Chapter 4 reports on the material from the five national focus groups, which were organised in five Member States: Germany, Poland, Portugal, Sweden and the UK, because of their different cultural, social and welfare State regimes. First, the characteristics of participants inthe focus groups are described. Second, a brief overview of the challenges each country is facing is provided. Then, a comparison between countries is made to develop the main differences and similarities. Third, this information is compared with the literature review on generic competences. This comparison leads to a list of six generic competences. This chapter ends with a report on the first hearing group organised to validate the results of the literature review and the main conclusions of the focus groups.

Chapter 5 describes the gathering and analysis of innovative VET practices which are linked to the six generic competences. These VET programmes were selected in the five different Member States and analysed under a quality assurance perspective to underline their potential for implementation in other countries with different sector contexts.

Chapter 6 formulates the policy recommendations of this study. These results were validated by a broad group of representatives from European organisations.