Ajuntament de Barcelona

# New municipal management model of Home Care Service in Barcelona

## Proximity teams for home social care (HSC)

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# INDEX


1 Changing the managing model
- Home Care Service in Barcelona (SAD)
- Initial diagnosis – Strategic objectives

2 Solution: New SAD model of proximity for superblocks
- Innovation
- New possibilities : Project Proximity teams and Health Care

3 Results
- Main challenges

# Home Social Care / SAD

**Definition:** Home care is the social care provided to a person in the place where they live, at any stage of their life, with the aim of maintaining them in their usual environment and thus achieving the highest level of quality of life, well-being and autonomy.

## Target persons:

**84% People in a situation of recognized dependency and with an Individual Care Plan (PIA):**

**16% lindividuals and families in a situation of vulnerability or social risk (due to lack of parental skills or abilities, or a situation of homelessness or abuse):**

## Data:

| SAD | 2023 |
|---|---|
| **People** | **21.397** |
| **Women** | *77%* |
| **> 65 years** | *86%* |
| **No. of SAD hours provided** | 3.926.036 |

# HSC challenge: initial diagnosis

**Complex service - diversity**
- Diversity of users
- Diversity of tasks
- Diversity of households

**The "classic" service**
- Prescription of closed schedules
- Commitment : "a professional referent" / "substitutions".
- Quality "attendance and punctuality".
- High satisfaction, but…

**Concentration of service hours**


**Labor tensions / precariousness (?):**
- partiality
- Temporariness / rotation
- physical and psychological burdens,
- substitutions / bag of hours
- travel times
- absenteeism …

**Work organization:**
- Hierarchical
- Individual
- Fordist/ task-based

**Cost structure / productivity**

# HSC challenge: objectives

## Strategic objectives

**Improve the quality of the SAD,** adjusting the services to the needs of the users, guaranteeing an active listening to the people served, ensuring a personalized and close treatment to the user

**Generate stable employment** that respects the rights of workers.

To **guarantee the social and economic sustainability** of the SAD

## Objectives of the future SAD

To improve **user satisfaction.**

To improve the **working conditions** of **professional caregivers**: *reduce* ***precariousness****, extend* ***working hours****, reduce* ***travel****, provide* ***support in teams****, reduce the undesired effects of the* ***rotation of professionals****.*

To make the **teams** of professionals visible in the community and facilitate **synergies** with the rest of the community agents, especially in health.

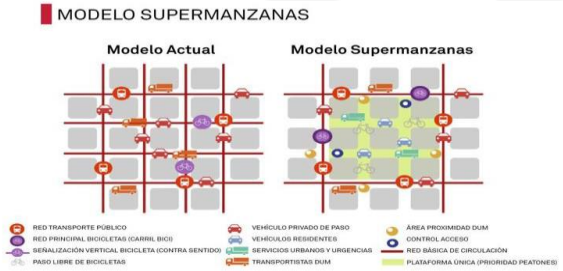
To increase **social recognition** of care and for citizens to have an inclusive vision.

Increase the number of **actors involved** in care.

# Solution: New SAD model of proximity for superblocks

The new model is based on the creation of **teams** of professionals who **attend to a group of users who live in a superblock** SAD of proximity.

An **urban superblock** is a territory of proximity, physically defined by a set of blocks of the urban fabric with a population between 5,000 and 8,000 inhabitants. The **social superblocks** pursue the idea of "distributed or virtual residence": **The neighborhood provides all the common services** that are provided in a residential area, within a radius of 300 meters.




**Characteristics** SAD of proximity, and adaption of the Buurzog model used in Netherlaands

- Flexible territorial unit
- Between 5,000 and 8,000 inhabitants
- Between 40 and 90 SAD users /HCS users
- Between 250-350 hours of service per week
- In the action area of the same Social Services Center and, whenever possible, within the same care area of a Basic Health Area
- Physical space to hold team meetings and work space during service outages and to make changes (WC + Office)

# New SAD model of proximity for superblocks

## Start-up of a new team of superblock:

**Selection of territory** → **Quantitative and qualitative study of users and services** → **Team building: Superblock start-up (Critical phase)** → **Team operation**

- Identification of the **physical space** where to locate the team.
- **Communication** to the professionals of the **team**.
- **Communication** to the referring professionals of the **CSS**.
- **Training** to share the vision of the model.
- **Start-up of the superblock**.
- After 3 months the **meetings** change from bimonthly to **monthly**, the superblocks and the teams are stabilized.
- **Communication** to **users** and **families**.
- **Re-planning** of services and incidents.
- Sharing **complex cases** and working to **improve services**.

# SAD of proximity: Innovations

1. The person is cared by their family worker and by the rest of the professionals of the **team**, whom they **know/identify** from the beginning.

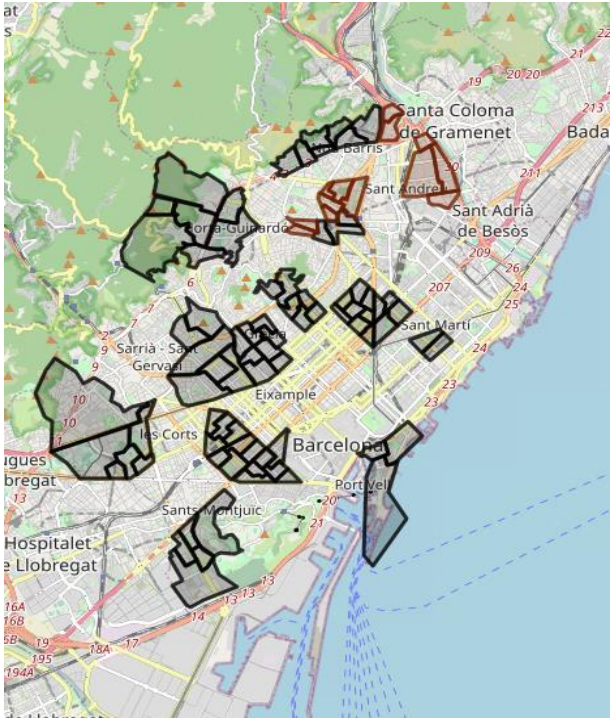
2. The person is informed in advance of the **flexibility of the service** and the **communication** channels with the team.

3. The teams are made up of **10 to 15** direct care workers and **a technical coordination person**.

4. The team as a whole is oriented towards **self-organization** and this implies the need for all team members to participate in all assigned tasks, and requires greater coordination. It also implies the follow-up of the users and the contact with the Basic Social Attention Team to transfer information.

5. The team acts as a **cushion for the workload** that some services entail and the contractor assumes the commitment to increase the number of full-time employees.

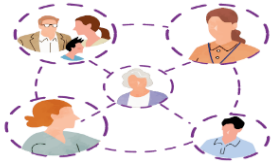
# Solution: New SAD model of proximity for superblocks




| | 2024 | Rest of territory | Result |
|---|---|---|---|
| Proximty Superblocks | 92 | 0 | 92 |
| SAD users | 6.311 | 11.786 | 18.097 |
| % Proximity Superblock | 35% | 65% | 100% |


# SAD of proximity: new possibilities

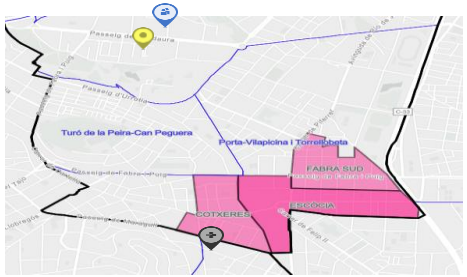
## New experience Proximity teams and Health Care



It is a new way of working for social and health teams to improve care for citizens. In short, it is the care in which professionals from different professionals from different services, who have the same objectives and incorporate, in shared decision-making, the person and their care environment.

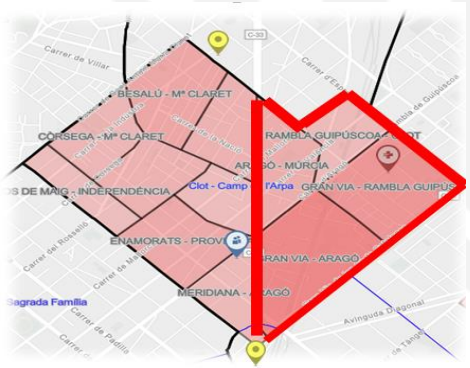
CIS Cotxeres : 3 Superblocks , 200 citizens (2018)

- Final phase 2




CAP Clot: 4 superblocks, 250 citizens (2024)

- Beginning phase 2



# SAD of proximity: new possibilities

Phase 1

a) Establishment of the collaboration framework with the agents involved to
b) Identification of the users who will be the object of our intervention and exchange of basic data.
c) Collection of the user's acceptance to be included in the programe

Phase 2

a) Presentation of the teams and training.
b) Map of assets: Identification of community resources
c) Analysis of the people assisted
d) Planning of joint meetings between the health referents and the SAD team on each island.
e) Establishment of communication channels and joint registration systems

Phase 3

a) Comprehensive assessment of people and their environment
b) Integrated social and health information and communication system to update the registrations and de-registrations of the people cared for on each island pending the availability of an integrated information system.

Phase 4: Shared work plan in those complex cases that have been considered.

Phase 5: Planning of individual, group or community actions that can reinforce the objectives of integrated care:

Phase 6

a) Evaluation of the experience and the care provided to the user assisted in this service.
b) Evaluation of the experience of the direct care professionals who have intervened in the programme

# SAD of proximity: Results

## MANAGEMENT RESULTS

### Human resources management

- **Direct attention.** Reduction of part-time. Training in teamwork. Increase of permanent contracts and working days of more than 30 hours.
- **Technical coordination:** Improved follow-up of users. Training in accompaniment.

### Service management

- **Continuity, personalization, follow-up and communication** with the user.
- Time spent working on tasks with better results, productivity and reduction of travel time.

### Other supports

- **Information systems** that support management: control panels, establishments and computer equipment.

## RESULTS FOR USERS

### Referent

The reference of the service becomes the superblock's **team.** Emphasis on the communication of the change.

### Communication of incidents

There is a **contact telephone number** for the team to whom the user can call in case of incidents.

### Programming

The service schedule (days and hours) can be changed **at the request of the user or the team.**

# What is needed for this model to work?
# Main challenges:

1. How to regulate the dynamics of **incoming and outgoing services within a superblock** and dimension the proxi teams.
2. Integrate into the model the **accompanying services outside the superblocks**.
3. **Management** of an important volume of **services with timetables** that are limited to certain coinciding time slots.
4. Integration of the **prescribed services in weekends**.
5. Adequate treatment of **socio-educational and highly complex services**.
6. Manage the perception of the **increase of fatigue in family workers** resulting from the decrease in travel between services.
7. Ensure the **digital disconnection of family workers Territories with low density** or complicated holography.
8. **Homogenization of the model** among the different providers.
9. **Coexistence of the two models** in the same territory.
10. Availability and/or **adequacy of establishments** to be made available to the company in sufficient time.
11. **Knowledge of the model by the community network** and the CSS.
12. Financing of meeting hours, coordination, etc., towards a **mixed financing** (effective hours provided + quality results obtained).

# What elements of the model do we value most?

- Teamwork of professionals
- Direct communication between user and team
- Matching of social and healthcare teams

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# Thank you!

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