National Health Plan 2012 – 2016

3.3. Strategic Axis - Quality in Health

(January 2012)

National Health Plan
2012–2016

3.3. QUALITY IN HEALTH

Quality of care - doing the right things right, at the first time to the right people, at the right time in the right place, at the lower cost (The New NHS: UK, 1997).

3.3.1. CONCEPTS

WHAT IS UNDERSTOOD BY QUALITY IN HEALTH?

.1. **Quality in Health** (QeS) can be defined as the provision of affordable and equitable healthcare, with an excellent professional level, taking into account the available resources, while achieving the citizen's adhesion and satisfaction (Saturno P *et al.*, 1990). It also implies the adequacy of healthcare to the needs and expectations of citizens and the best possible performance.

REFER TO THE GLOSSARY:
Self-management of disease, Healthcare technologies assessment, Healthcare impact assessment, Healthcare value chain, Chronic disease management, Governance, Clinical governance, Health literacy, Evidence-based medicine, Monitoring, Clinical orientation guidelines (NOCs), Accreditation processes, Disease management programmes, Health outcomes, Value in health

- Access to quality health care, at all times and all levels, is a **fundamental right** of the citizen, to whom all legitimacy to demand quality in the care provided to him/her is recognised.
- The degree of QeS may be **conditioned** by multiple factors: i) extraordinary social, political, environmental, scientific and technological evolution; ii) uncertainty and unpredictability of events such as epidemics and disasters, climate change and terrorism; iii) characteristics of the Health System; iv) determinants of the demand for care (e.g. ageing, chronic disease, more information, expectation and stringency) and responsiveness (e.g. human resources, increasing specialisation, multidisciplinary and inter-sectorial work); v) new concepts of health outcomes and quality of life (Campos L, Carneiro AV, 2010).
- QeS has different **dimensions**, such as the appropriateness, effectiveness, efficiency, access, safety of patients, professionals and other stakeholders, equity, timeliness, patient-centred care, continuity and integration of care throughout the process, mutual respect and non-discrimination, sustainability, opportunity in the provision of care, communication and participation (Campos L, Carneiro AV, 2010; Norway And it's going to get better, 2005) and different **perspectives**: that of the health services user, the professional and the manager, i.e.,

the effective and efficient use of resources in the response to the user's needs (Lopes M *et al*., 2010).

- QeS depends on the action aimed at: i) care provision **structures**, such as physical and human resources, facilities and organisation; ii) **processes** resulting from the provision of care itself, i.e., the technical quality of care, the appropriateness and validity of the information produced, the integration and continuity of care; iii) **outcomes**, which include the rehabilitation/recovery of the patient (UK Integrated Governance Handbook, 2006), control of the chronic disease, empowerment, education and health literacy, changes in behaviours and satisfaction with care (Donabedian A , 1997).

WHAT ARE THE PERSPECTIVES FOR THE PROMOTION OF QUALITY IN HEALTH?

.2. The Basic Law on Health (Law No. 48/90, as amended by Law No. 27/2002) grants special importance to the adequacy of resources and the performance of the Health System, aimed at the promotion of health and prevention of diseases. Such fact implies a holistic conception of health and imposes on healthcare providers the challenge of incorporating, within a framework of continuous quality improvement, the actions of health promotion and disease prevention the same way that they incorporate the provision of curative, rehabilitative or palliative care.

BOX 3.3.1 - THE PROMOTION OF QUALITY IN HEALTH INVOLVES:

- Promotion of the healthcare value chain;
- Cycles of continuous quality improvement and professional and institutional development;
- Monitoring, benchmarking and evaluation (internal and external).

.3. From the external evaluation of the NHP 2004-2010, one may infer the need to close important loopholes in policies, particularly in healthcare quality and patient safety, in a more integrated approach.

.4. Fostering a culture of continuous quality improvement implies equating prospects for its further development and implementation.

.5. The prospects for the promotion of QeS involve:

- **Promotion of the healthcare value chain (BOX 3.3.1),** understood as the processes that lead to greater gains considering the investment made (Porter M, Teisberg EO, 2006).
  - *It considers how the chain of care uses available resources (organisational, human, financial, knowledge, technology, etc.) in order to achieve the best result. It includes the processes of healthcare value creation in each health service, but also:*
    - *i) The transfer of value between services and institutions (access and referral processes, information sharing, integrated management, therapy conciliation, etc.).*
    - *ii) The empowerment of the citizen to make the decision which may represent more value, grounded on information, communication and transparency (PL Yong et al., 2009).*
  - *It considers costs that can be direct, indirect and intangible. The direct costs are related to the resources used in the programme (medication, transportation, compensation of technicians and caregivers); indirect costs are associated with the reduced productivity of citizens (time spent participating in the health programme); intangible costs (for example, the suffering associated with the treatment) are difficult to measure, but should be considered, given their relevance to health.*
  - *It fosters research and innovation that may reduce the required organisational and financial effort (costs of non-quality and loss of opportunity), while maintaining or increasing the gains*

obtained, and freeing up resources for other needs.

- **Cycles of continuous quality improvement** through the systematic identification of problems and opportunities with the aim of solving or improving them, setting desirable and realistic standards, identifying and acting on critical points, planning and implementing changes, monitoring and assessing. These processes should be multidisciplinary, non-punitive, of the professionals' own initiative and associated with professional and institutional development plans.

- **Monitoring, benchmarking and evaluation (internal and external),** including processes of accreditation, evaluation and identification of best practices, among others. These should occur at the levels of the professional, work team, service, institution and political decision-making, transparently, while promoting social responsibility towards the citizen. Goals, indicators and targets should be explicit; models of organisation and provision, allowing comparability and identification of best practices, and standards of structure, process and outcome.

STRATEGIES AND RESOURCES FOR THE ENHANCEMENT OF QUALITY IN HEALTH

.6. QeS depends on programmed intervention in certain key areas (BOX 3.3.2):

- The **Integrated Governance** encompasses clinical, corporate, financial, informational governance and risk management (UK NHS in East Essex, 2010).
  - ***Clinical Governance*** *(Portuguese Observatory on Health Systems, Glossary) constitutes a reference to areas such as professional performance and technical competence, the efficient use of resources, risk management and patient satisfaction (UK Integrated Governance Handbook, 2006):*
    - *i) It is based on: 1) care based on an ongoing relationship between physician and patient; 2) personalised care, anticipating the needs of the patient; 3) sharing of information and knowledge; 4) evidence-based decisions; 5) safety; 6) transparency; 7) waste reduction (Campos L, Carneiro AV, 2010).*
    - *ii) It is associated a no blame, questioning and learning culture, professional development and partnership with the patient (Halligan A, Donaldson L, 2001).*
    - *iii) It provides for the incentive to participation and research; a clear definition of responsibility and accountability; dissemination of evidence-based clinical practice; multidisciplinary teamwork and leadership, while valuing autonomy and every professional's ability to manage care provision (MS Governance of Hospitals, 2010;*

BOX 3.3.2. - QES CAN BE PROMOTED THROUGH:

- Reinforcement of an integrated governance:
  - Clinical
  - Corporate
  - Financial
  - Informational
  - Risk management
- Influence mechanisms:
  - Clinical Orientation Guidelines (NOCs)
  - Environment and architecture
  - Funding models
  - Human resources planning
  - Culture of quality assessment and development
    - Technology and impact assessment
    - Monitoring and benchmarking
    - Assessment and accreditation of health units.
    - Development of Reference Centres
    - Research, development and innovation
- Integrated care processes
- Participation and empowerment of patients

Som CV 2004).

iv) It requires instruments such as, among others, standards and clinical guidelines, integrated care processes, professional development, and information systems.

- ***Corporate Governance*** *applied to healthcare is understood as a set of systems and processes by which health services lead, manage and control their functions in order to meet their organisational goals and through which they relate to their partners and the community (UK Corporate Governance Framework Manual for Strategic Health Authorities, 2003).*
- ***Information systems*** *are a quality improvement and cost reduction tool, in that:*

i) They enable clinical knowledge sharing, support to decision-making, collection and reporting of clinical and epidemiological information, the use of warning systems, as well as the monitoring and subsequent assessment of indicators.

ii) They influence the provision of care, through mechanisms such as computerised reminders, computerised prescription, computerised systems supporting clinical decision-making, or still computerised clinical education.

iii) They allow the reduction of medication errors, the recovery and availability of information in real time, in a legible and coded manner.

iv) They promote comparability between practices and services, and research.

- ***Safety*** *is a major dimension of Quality, and* ***Risk Management*** *represents a tool for its assurance:*

i) The complexity of treatments and technologies, the interdependence of tasks and infections are factors that make care provision an activity of high complexity and risk, uncertainty and insecurity which favours the occurrence of adverse events and errors, with the possibility of damage (Fragata J, Martins L, 2004).

ii) The source of the error is often multi-factorial, stemming from factors associated with healthcare practice, involving professionals and the organisation, and with the complexity of the patient, or still all of the above put together. The occurrence of errors and adverse events represents an opportunity for learning and improvement (Campos L, Carneiro AV, 2010).

iii) The instruments of risk management and error prevention are: notification systems, warning systems, audits, protocols, multidisciplinary team decision, redundant verification systems, mortality and morbidity meetings, discussions on unexpected clinical progresses, continuous training.

- **Influence mechanisms**:
  - ***Clinical and Organisational Orientation Guidelines (NOCs) -*** *enable an informed and evidence-based decision, both in clinical practice and in management and policy decision-making. The decision is simplified, the uncertainty, risk and variability are reduced and the quality of care improves (Portuguese Observatory on Health Systems, Glossary). The development of clinical guidelines, their publication, dissemination and implementation, as well as their monitoring/follow-up regarding outcomes are a key element in ensuring the sustainability of the Health System. The standards and clinical and organisational guidelines can be developed by experts, national bodies, national or international scientific societies, universities or institutions providing care, and the declarations of interests of its scientific authors should be known as to comply with the principle of ethical transparency. NOCs allow:*

i) Professionals to have access to a summary of the relevant clinical information, with recommendations, and provide a benchmark for best practices (Campos L, Carneiro AV, 2010).

ii) To provide patients with reliable sources of information on clinical practice, risk and prognosis.

iii) To reduce the variability of clinical practice and medication errors, thereby improving patient safety and optimising care.

iv) To harmonise and integrate practices, including multidisciplinary and multi-institutional ones, from the standpoint of the patient, of the disease and of the processes, thus improving the continuity of care.

v) To optimise resources, preventing unnecessary repetition of procedures (Sakellarides C, 2009), to reduce costs of waste resulting from the duplication of actions and complementary diagnosis tests and therapies, to contribute for the generalisation of practices and interventions which prove to be more cost-effective.

vi) To disseminate innovation and better expertise, to help health professionals to achieve a practice based on evidence and on recent national and international scientific consensus.

vii) To stand as a reference for the organisation and forecasting of care, management and communication of risk, forecasting and management of resources, indicators of structure, process, outcomes and impacts, and quality assessment.

viii) These may be developed or adapted by national agencies (e.g. NICE in the UK), by national and international scientific societies, by universities or institutions providing care, desirably in a transparent, reasoned, systematic and collaborative manner.

- ***Structural aspects, such as architecture and environment**. The spaces, accesses (including for people with mobility impairments), signage, decor, lighting, colours, sounds, smells and privacy contribute towards a provision of care with higher quality and positively influence the recovery process by optimising the satisfaction of patients and professionals (Altimier LB, 2004; Ulrich RS, 2001).*
- ***Funding models and care payment system:** the combined systems of prospective nature (incentives for compliance and penalties for non-compliance), based on contracts and agreements on goals and targets seem to be the most advantageous, accountability-inducing, autonomy promoters for those involved and promote motivation among professionals although they lack impact studies on clinical outcomes.*
- ***Human Resources Planning**, involving:*

  *i) **Professional development**, including pre- and post-graduate education, continuous training, development of skills for multidisciplinary teamwork, communication, management and research.*

  *ii) **Institutional management:** organisations must recruit professionals adequate to the specificities of healthcare provision, through proper planning, guidance and integration, having in mind the needs of citizens. They should, simultaneously, provide professionals with the means for their updating, adaptation and adjustment to technological change, functional reorganisation or evolution of knowledge in accordance with the principles of Ethics and Deontology.*
- *Processes leading to a **culture of quality assessment and development** at the different levels of the system.*

  *i) **The Impact Assessment** of the changes that occur in the system can increase the degree of evidence in decision-making processes, provide models and best practices, and support the investment in some areas and the disinvestment in others.*

ii) ***Monitoring*** *allows benchmarking with other centres or with pre-established standards, identifying problem areas to correct and areas of excellence, as an example of best practices, and documenting the result of the changes introduced.*

iii) ***The Accreditation processes*** *of the services, driven by quality criteria and with the goal of accrediting, boosting the continuous improvement of management and quality, enhancing their performance and strengthening professional and public trust in the institutions providing healthcare. They set standards, defining and promoting best practices, based on quality criteria, on the recommendations for an evidence-based clinical practice and on the assessment of health technologies. It is possible to state that the national accreditation model is self-sustaining, due to the promotion of a rational and safe use of medicines and health technologies and the continuous monitoring of performance in relation to economic and health outcomes.*

iv) The ***development of Reference Centres****: reference centres are organisational structures that allow preventing, diagnosing and treating people with specific diseases, informing and supporting their families and operate as liaison elements with other healthcare and social professionals. As a result of the concentration of cases, technologies and skills, they promote the economy of scale and raise the level of quality, and should guarantee an offer of high quality, effective and safe healthcare, exploring the potential of European cooperation in the field of highly specialised healthcare and taking advantage of healthcare innovation. These structures should be actively involved in teaching, research and recording of the diseases, maximising the potential for innovation of medical science and healthcare technologies, through a necessary and inherent knowledge sharing and training of health professionals, with their high differentiation recognised, nationally and internationally, by healthcare professionals and also by patients and their associations.*

v) ***Healthcare Research, Development and Innovation*** (R&D&i) are, par excellence, continuous improvement processes crucial for the competitiveness and sustainability of the health system. They consider bio-based processes, translational, epidemiological, clinical, and public health research in health, technology assessment and impact assessment services and policies. Research also supports and fosters development and innovation as cross-sectional processes with organisational, social, political and cultural vectors of change in the way society organises its responses to health challenges, including the fight against health inequalities and the increase in the healthcare value chain. It promotes confidence and investment in the health system and its economic and social value.

- **Integrated Care Processes**
  - *Integrated care processes place citizens, with their needs and expectations, in the centre of the system and encompass, within a logic of continuous process, all actions of health professionals across the care provision network, throughout the entire patient circuit (with a given disease or health problem), at any point of contact and level of care within the health system. An organisational change is then triggered, based on the knowledge and engagement of all professionals involved in providing care, driven by their ability and willingness to continuously improve quality and to focus their efforts on people.*
  - *The approach by integrated care processes allows ordering and optimising the different workflows, thus integrating the different components involved in providing care,*

homogenising performances and putting the emphasis on outcomes in order to meet the expectations of both citizens and professionals.

- *The development and implementation of integrated care processes, which include clinical and organisational standards with functional flowcharts, clinical pathways, quality standards and well-defined performance indicators, aims to ensure that:*

  i) The performances of the professionals are defined and parameterised with the responsibilities of the different stakeholders clearly identified.

  ii) Those performances are carried out so that the needs, rights and expectations of the patient may be met.

  iii) Health education and therapeutic education, including safety education, occur in a continuous and constant manner.

  iv) The participation of the patient in decisions on the care provided to him/her is a reality, holding co-accountable all professionals, patients and their caregivers.

  v) The organisation of services enables the best use of available resources, integrating and harmonising them on a case-by-case basis, while continuity of care is ensured without discontinuities.

  vi) The services evolve bearing innovation, organisational modernisation, development of specific skills, patient safety and knowledge sharing in mind.

  vii) Care is based on the principle of rationality, avoiding duplication of tests and the variability based on non-validated and costly practices, due to the containment of non-quality costs.

  viii) The integration of quality standards throughout the entire patient circuit and the clear allocation of responsibilities, known by all stakeholders, allow achieving the best health outcomes for the person receiving care.

- The **participation and empowerment of patients**, their family and informal caregivers, including aspects of **chronic disease management, are quality in health goals** that lead to the promotion of self-management and self-care, changes in lifestyles and risk behaviours and appropriate access to resources (*Canada British Columbia Chronic Disease Management*). The disease management programmes, specifically by supporting the self-management of chronic diseases, motivational counselling and access to information, support groups and self-help, as well as the involvement in the decision and in the organisation of services, result in better therapeutic compliance and alliance, higher quality of life of patients and health gains.

BOX 3.3.3. DEVELOPMENT OPPORTUNITIES OF QUALITY IN HEALTH:

FOR CITIZENS:

i) Greater participation in decision-making, better use of care, and integrated management of their disease;

ii) Empowerment to deal with the disease, self-care and support to family and informal caregivers;

iii) More realistic expectations on getting health outcomes, greater safety and protection from marketing and advertising campaigns which create unfounded expectations;

FOR HEALTHCARE PROFESSIONALS:

iv) Increased safety in relation to clinical uncertainty, clear benchmarks for the assessment of their work and appreciation of merit, and continued development, with greater satisfaction;

v) Fostering multidisciplinary work, focused on achieving results, and raising standards related to safety and excellence in care;

vi) Encouraging clinical research and improved ability to incorporate evidence and innovation into clinical practice, and greater ease in guiding postgraduate training to increase the quality of clinical practice;

FOR HEALTHCARE INSTITUTIONS:

vii) Recognition of the quality and effectiveness of care, and respective enhancement;

viii) Professionals and patients geared towards continuous improvement, in a culture of assessment and development;

ix) Greater social confidence due to the transparency in performance information and safety;

x) Investment protection and resource development, by acknowledging the impact on results as regards quality, safety, and health gains;

FOR POLICY-MAKERS:

xi) Added value in health - public investment translates into increased quality of care and a clearer vision, in the long-term, of the possible care with the available resources;

xii) Benchmarking between units regarding performance from common policy frameworks;

xiii) The Health System is recognised as a social engine for the promotion of involvement and excellence.

BOX 3.3.4. THREATS TO THE DEVELOPMENT OF QUALITY IN HEALTH:

FOR CITIZENS:

i) Inadequate pressure from interest groups, through biased processes of communication and use of evidence;

ii) Decontextualised information is used to promote the demand for services, without assessing both risk and gain;

FOR HEALTHCARE PROFESSIONALS:

iii) Processes of continuous quality improvement excessively demanding in terms of time and bureaucracy, ill-adapted to priorities and work context and with no return with regard to clear incentives and resources for an effective and sustained improvement;

iv) Insufficient involvement in the chain of patient care and poor adherence to action protocols;

v) Lack of alignment between goals and priorities of the top management, professionals and citizens, thus resulting in fragmented perspectives of quality;

FOR HEALTHCARE INSTITUTIONS:

vi) Profile of population, with unclear and heterogeneous levels of access and services provided, hampering comparability with institutions of similar responsibilities;

vii) Lack of sensitivity towards the processes of continuous quality improvement, which require the involvement of top management, professionals, patients/citizens, the coordination of information systems, service organisation and synergy with research and training activities;

AT THE LEVEL OF POLITICAL DECISION-MAKING:

viii) Lack of critical structures to create, monitor and assess, in a systematic and extensive way, the guidelines and technical-scientific recommendations;

ix) Punitive vision of error and lack of quality, which is a disincentive to the professionals' initiatives;

x) Difficulty in freeing resources resulting from increased quality, not providing any evidence on the return attributable to the improvement and the value of investment;

xi) Lack of long-term vision and insufficient mandate duration (political cycle) to obtain efficiency gains attributable to policies;

xii) Lack of coordination between the policies related to information systems, contracting and incentives, investment in resources, integration and continuity of care, training and research, around the promotion of quality assurance.

3.3.2. FRAMEWORK

LEGAL, LEGISLATIVE, REGULATORY AND STRATEGIC FRAMEWORK

.7. The **National Strategy for Quality in Health (ENQS**) (Order No. 14223/2009) is the Ministry of Health's programme which prioritises the areas for action:

- *Clinical and organisational quality.*
- *Transparent information to citizens.*
- *Patient safety.*
- *Qualification and national accreditation of healthcare units.*
- *Integrated management of disease and innovation.*
- *Management of the international mobility of patients.*
- *Assessment of complaints and suggestions from the NHS users.*

- The Directorate-General of Health, through **Quality in Health Department**, created in 2009 (Ordinance No. 155/2009), has the authority to coordinate the National Strategy for Quality in Health, programmes and activities of continuous improvement of organisational and clinical quality, to ensure the qualification system for healthcare facilities and programmes for the promotion of patient safety, in addition to the surveillance of diseases covered by the system of integrated disease management, coordination of international mobility flows of patients, management of the monitoring and perception systems for quality in services by the patients and health professionals and healthcare innovation.
- The **National Council for Quality in Health,** in office since 2009 (Order No. 13793/2009), is the consultative body with jurisdiction to rule on issues related to the execution of the mission of the QeS Department, through the operationalisation of the ENQS.

.8. Other institutions also develop supplementary activities in the area of quality in health, under the Ministry of Health, such as:

- *The National Authority of Medicines and Health Products (INFARMED) (Decree-Law No. 46/2012) which ensures the quality and safety of medicines for humans and health products.*
- *The National Health Institute Doutor Ricardo Jorge (Decree-Law No. 27/2012) which ensures the external assessment of laboratory quality.*
- *The Portuguese Institute of Blood and Transplant, (Decree-Law No. 39/2012), which comprises: the former Authority for Blood and Transplant Services (Regulatory Decree No. 67/2007), with the mission of inspecting the quality and safety of the donation, harvesting, testing, processing, storage and distribution of blood components, organs, tissue and human cells; and the Portuguese Blood Institute (Decree-Law No. 270/2007), which regulates the activity of transfusion medicine and ensures the availability and accessibility of high quality, safe and effective blood and blood components.*

- For higher quality in the management and delivery of care, **Integrated Management Structures (IM)** have been created, for instance:
  - ***Horizontal**: **Hospital Centres** between Hospitals; **ACES** between Primary Care Centres; allow the economy of scale and increased market power.*
  - ***Vertical**: **Local Health Units** (Decree-Law No. 207/99) (ULS), including Primary and Hospital Care: Matosinhos (Decree-Law No. 207/99); Alto Minho, Baixo Alentejo and Guarda (Decree-Law No. 183/2008); North Alentejo (Decree-Law No. 50-B/2007); Castelo Branco (Decree-Law No. 318/2009) and Northeast (Decree-Law No. 67/2011).*

.9. Several strategies aimed at achieving greater competitiveness and development of the Health System have been identified, with influence on the quality issue: Europe 2020 Strategy (WHO-Euro), European Union Health Strategy "Together for Health", the OECD Innovation Strategy, the Lisbon Strategy, Technology Plan - Knowledge, Technology and Innovation, Programme for Competitiveness Factors of the National Strategic Reference Framework NSRF 2007-2013 and Digital Agenda 2015.

STUDIES AND SOURCES OF KNOWLEDGE ON QUALITY IN HEALTH

.10. Little is known about the assessment of quality of care in Portugal.

- The **Evaluation of the NHP 2004-10** as an instrument of QeS by WHO-Euro (WHO Evaluation of the NHP, WHO/ACS, 2010) identifies a number of areas where there is lower performance, namely healthy behaviours and inequalities in health. It also refers that key areas such as the sustainability of the Health System, human resources, and quality and safety of care were not focused by that NHP. It also highlights the excessive number of programmes and the lack of focus on priority goals, mobilising and understandable, representative of problem areas with potential for improvement and impact on health.

.11. However, other indicators suggest some quality gaps at the level of the NHS:

- In the study **O Estado Da Saúde em Portugal,**on the state of health in Portugal (Villaverde Cabral M, Silva PA, 2009), it is stated that 95% of the Portuguese people advocate the need for changes in the NHS (67% point out major changes) namely the reduction of waiting times (43%), better organisation of the resources (33%), more investment (30%), better quality (24%);
- The analysis of **complaints through the Sim-Cidadão System** shows hospitals to be the institutions with the largest number of complaints, and the emergency room the major cause of dissatisfaction.

.12. **Citizen's Bureaus** (DGS, Normative Resolution No. 12/2009), redesigned in 2009, for the analysis and processing of suggestions and complaints on Primary Healthcare, response and corrective action.

PROCESSES AND TOOLS FOR PROMOTING QUALITY IN HEALTH

.13. **Computerisation of Health Services.** There is a wide variety of applications under development: electronic prescription, scheduling of medical appointments (CTH and e-agenda); management and disclosure of surgical waiting times (eSIGIC); dematerialisation of death certificates.

- *The **National Commission for the Electronic Health Record (CNRSE**) (Order No. 381/2011), created in 2011 with the mission of, pursuant to the Programme for the Electronic Health Record (RSE), coordinating and implementing the RSE by the end of 2012.*
- *Consequently, the Committee for Clinical Computerisation (CIC) was also created for the design and implementation of the **Health Data Platform** (PDS, PDSi.1) - successor to the Electronic Health Record. It is expected to be in operation in the 1st half of 2012. By using it, health professionals, in an initial stage, and patients, at a later stage, may have access to clinical information so far archived in healthcare institutions.*

.14. Accreditation of Healthcare Institutions

- Between 2001 and 2009, 13 of the 27 ***hospitals*** that had begun the process of accreditation by the KF/HQS, obtained the accreditation; of the 15 hospitals in the process of accreditation by JCI, only 2 were accredited (DGS, 2009). Accreditation targeted issues related to the organisation, infrastructure

or the individual certification of specific areas, but it lacked focus on the clinical component of the process of care and its outcomes.

- *At the level of the CSP, the **accreditation of the USF of Valongo (2010)** according to the model of the Health Quality Agency of Andalusia (ACSA), defined by the Ministry of Health as the official model for the NHS, within the ENQS.*

- **National Health Accreditation Programme**
  - *The ACSA accreditation model, approved as the Official and National Model for Health Accreditation by ministerial order (Order No. 69/2009), is based on the quality model, on the standards of the Standards Manual and on methodologies developed by ACSA, with which the Directorate-General of Health has signed a cooperation protocol.*
  - *Focused primarily on the accreditation of clinical management and its outcomes, which allows recognising the performance and quality of care, in addition to the support and structural aspects, the accreditation programme for healthcare facilities is a powerful tool to promote and support the implementation of the standards and clinical guidelines issued by the Quality in Health Department of the Directorate-General of Health. The same applies to integrated care processes that incorporate standards and guidelines of good clinical practice.*
  - *The standards manual of the ACSA accreditation model is developed around five areas:*
    - *ix) The citizen, centre of the system.*
    - *x) The organisation of user-centrered activity.*
    - *xi) Professional development.*
    - *xii) Support processes, and quality and information systems.*
    - *xiii) The results of key processes.*
  - *In addition to the accreditation of health facilities, the National Healthcare Accreditation Programme also involves the accreditation of professional skills (from a job post standpoint), the accreditation of continuous training and the accreditation of web pages.*

.15. **Assessment of complaints and suggestions from users of the National Health Service.** The development of the SIM-CIDADÃO System, which was redesigned in 2009, allows the systematic analysis and processing of the suggestions, complaints and comments submitted by citizens in health services. Thus, it provides for the recording, adequate and timely processing of the situations described by citizens and their qualitative analysis, constituting an important source of information for taking corrective action and for the continuous improvement of the Health System.

.16. The inclusion, by the ACSS, of quality goals of the programme contracts with hospitals and ACES, combined with incentives or penalties, is a strong accountability tool for QeS.

PROGRAMMES

.17. Other examples of plans/programmes under development:

- Of DGS's responsibility:
  - ***On Safety**: National Programme for the Prevention and Control of Healthcare-associated Infections (DGS, 2007); National Programme for Prevention of Antimicrobial Resistance (DGS, 2010); National Reporting System for Incidents and Adverse Events and Patient Safety Observatory (DGS, 2012); National Hand Hygiene Campaign (WHO World Alliance for Patient Safety. Clean Care is Safer Care); "e-Bug" Project, a platform of European initiative to raise students' awareness towards the prevention of communicable diseases and the prudent use of antibiotics (DGS, "e-Bug" Project); Healthcare Associated Infections in European Long Term Care Facilities Project (DGS, HALT Project);*

"Safe Surgery Saves Lives" Project (Normative Resolution No. 16/2010).

- ***On Integrated Disease Management*** *(DGS, Normative Resolution Nos. 2 and 13/2008**)** - Multiple Sclerosis, Chronic Kidney Disease, Morbid Obesity (DGS, Quality Dep, 2010) and Diabetes (DGS, Normative Resolution No. 23/2007).*

INTERNATIONAL NETWORKS PROMOTING QUALITY IN HEALTH

.18. There are several **International Health Promoting Networks**: i) for Accreditation, such as *King's Fund, Joint Commission,* ACSA; ii) for patient management and safety, such as *European Foundation for Quality Managemen*t (EFQM), EUNetPaS *(European Union Network for Patient Safety*); iii) hospital-specific, such as *Health Promoting Hospitals and Health Services* (WHO Integrating Health Promotion into Hospitals and Health Services), for cities, *European Healthy Cities Network* (WHO European Healthy Cities Network).

.19. And **Institutions and National Agencies** of Health Departments as the NICE (National Institute for Health and Clinical Excellence), the NPSA (National Patient Safety Agency) in the UK, the HAS (Haute Autorité de Santé) in France, or independent as the *German Agency for Quality in Medicine*.

.20. The OECD is developing, with its Member States, the project ***Health Care Quality Indicators*** - OECD (OECD Health Care Quality Indicators, 2010), a set of quality indicators for health systems that is intended to be a tool for *stakeholders* and to contribute for the promotion of transnational learning.

INNOVATION PROJECTS AND FUTURE PROSPECTS

.21. **Pilot-projects for funding schemes by risk-adjusted capitation** (e.g. Local Health Units). These allow institutions to benefit from their improved performance, nonetheless some problems remain such as the selection of patients/pathologies based on financial criteria (UK Corporate Governance Framework Manual for Strategic Health Authorities, 2003).

.22. **National Quality Indicators Panel,** under development by the DGS, shall allow addressing the lack of indicators to support the decision-making process and to monitor organisational performance and the quality of the NHS, in four key areas: health determinants; Health System; accessibility; quality and outcomes (DGS, Quality Department).

.23. In the Family Health Units, the **USF Performance Monitor** is a panel of Institutional Quality Indicators associated with information systems, allowing healthcare professionals to monitor continuously the contracted quality indicators and to convene automatically the patients with overdue screenings.

3.3.3. GUIDELINES AND EVIDENCE

AT THE POLITICAL LEVEL, ONE SHOULD:

.1. **Enhance responsibility for integrated governance**, including clinical governance at all levels and in all sectors of the Health System, in line with the ***National Strategy for Quality in Health***.

- The development of policies, design, articulation and integration of structures and networks according to the provision of quality care promote better outcomes, professional and citizen satisfaction, patient safety and combat waste. The governance of healthcare organisations should be part of the governance framework of the Health System.
- The assessment of the quality of care and services includes areas such as: i) information and involvement, which ensures the provision of information to citizens by providers, ii) personalised care and support, ensuring effectiveness and adequacy iii) equipment and facility safety; iv) ensuring the qualification and competence of professionals, v) risk management, safety standards, and reporting of deaths and other incidents within the organisation; vi) appropriate management of the organisation (UK Care Quality Commission, Focused on Better Care, 2009).
- Strategies that ensure better access to knowledge to professionals foster good clinical practices and better performance.
- Information systems play a key role in quality, at all levels of care and in the coordination between them.

.2. **Assess the quality policy**, by appointing external independent bodies, responsible for monitoring, preparing recommendations and regularly publicizing outcomes.

- Scotland, England and Australia are examples of countries with independent agencies with powers to coordinate the safety and quality of healthcare, identify issues and policies and recommend priorities for action; disseminate knowledge and report on compliance with national standards (*Australian Commission on Safety and Quality in Health Care*).

.3. **Develop standardisation tools** (*standards)* for the promotion of quality in clinical procedures, information, quality indicators, monitoring and assessment, training and management of services and institutions.

- The standards should specify the minimum and the desirable values of performance, compliance, results, among others, and allow understanding the evolution of the performance of each institution and benchmarking between institutions.

.4. **Promote the accreditation of the healthcare-providing services**.

.5. **Strengthen the responsibility of general medical specialties**, such as family and general medicine, internal medicine and paediatrics in the overall management of the event/person/family and in the responsibility for the clinical pathway.

.6. **Institutionalise the assessment of healthcare technologies** as a prerequisite for the paced and careful introduction of innovation, including medicines, medical devices, procedures, information and communication technology, and organisation of care.

- Technologies are a significant and growing cause of healthcare expenditure, and incorrect decisions have enormous impact.
- The evaluation of healthcare technologies is the set of processes that support the decision to

adopt new technology, based on evidence. It includes perspectives of cost-effectiveness, epidemiological relevance, expectations and preferences of citizens and professionals, social acceptability and ethics, among others.

- Several countries have agencies responsible for the assessment, which needs to be independent and adapted to the social context, the practices and the organisation of health care, and there are international networks of healthcare technology assessment.

.7. Promote the adoption of actions with better cost-effectiveness and avoiding waste.

.8. Develop mechanisms to promote benchmarking, the identification of best practices, the development of value chains, enabling the attainment of potential health gains resulting from the adoption of standards based on the best references, and guiding the inherent priority interventions.

AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:

.9. **Establish quality policies at an institutional level**, including strategies and processes to promote quality, monitoring, safety, identification and correction of errors.

- Every healthcare facility should have a structure for clinical governance, responsible for monitoring, evaluating and improving the quality of care, with its own financial and human resources, facilities and strategy. The strategy will be to obtain the commitment, effort and shared responsibility of healthcare professionals and managers for patient safety, quality and the fight against waste.
- Every institution is responsible for developing a safety and risk management strategy, through communication, standardisation and control of procedures, team management and a safety culture.
- The audits on all aspects associated with error, performance monitoring, the use of IT automated tools and uniform terminology, the standards and protocols, and the analysis and processing of complaints and claims are promoters of QeS.
- The recording of errors, accidents and incidents should also be promoted within a process of improvement, while considering the multiple factors involved, from the individual to the institution and within a no blame culture.
- Team work, training, leadership, supervision and division of tasks, the limitation of extended periods of work and the prevention of burn-out should be encouraged.
- The accreditation process to which institutions can adhere voluntarily is also promoter of QeS, so every institution should not only apply but also endeavour all efforts to be accredited.

.10. Establish quality policies at an institutional level to ensure the quality of care and safety of patients and professionals.

.11. Monitor the satisfaction levels of citizens and professionals.

.12. **Promote training sessions on Quality in Health in healthcare organisations,** focusing on the use of standards and guidelines according to the most recent scientific evidence.

- Knowledge and skills should be ensured to enhance the processes of continuous quality improvement, case management, risk management, reduction of variability in care, critique of the scientific evidence, a culture of assessment and scientific discussion.

.13. **Assess and disseminate the quality and cost-effectiveness of institutional practices**, rigorously and transparently, thus contributing towards a culture of

knowledge-building and best practices.

- The Health System is a complex adaptive system so its adaptability to the context, flexibility of response, management of available resources and the need to respond to individual expectations, discourage the application of strict recommendations (Campos L, Carneiro AV, 2010). However, it is desirable to apply principles of scientific practice, assessable and disseminable, which may contribute to the knowledge and improvement of the quality of care.
- The adherence and adoption of clinical guidelines, of cost-effective evidence for the adoption of new technologies, of initiatives of continuous quality improvement and of institutional research projects should be clarified and publicised (e.g. on the institution's *website*).

IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD

.14. **Professionals should ensure the demand for a QeS vision**, understanding the healthcare value chain in which their activity is integrated, the clinical pathway, the role of case management and risk management, while promoting and taking on practices and skills for a continuous improvement.

- Chronic disease is paradigmatic of the relevance of case management, and represents an important burden (Velasco-Garrido *et al*., 2003), with large individual and social impact, due to its costs and economic impact (indirect costs, such as hospital days, premature deaths, labour absenteeism, etc.).
- There is evidence of the effectiveness of the support provided to self-management, to the decision-making process and at the level of service organisation. Measures such as education, motivational counselling and distribution of informational materials have an impact on the patient's quality of life, health status, knowledge and compliance with therapy. The citizens' participation in the decision-making process is increasingly important, with evidence that their empowerment and contribution to the planning of services can significantly influence quality.
- The practice of working in multidisciplinary teams motivates professionals to follow the NOCs, and the same thing happens with the implementation of evidence-based guidelines or with the organisation of clinical discussion meetings (Busse R et al., 2010).

.15. In addition to the global aspects of quality, health professionals should have **a specific view on patient safety and risk management in the individual and personalised clinical act.**

.16. Strengthening **the accountability of health professionals in the promotion of health, prevention of disease** and, where appropriate, **management of the disease**, within their area of focus and expertise, with emphasis on a culture of multidisciplinarity and articulation.

AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

.17. **Contribute towards the quality improvement of the Health System**, by making appropriate use of its services, cooperating with standards and rules, supporting professionals in their mission, presenting complaints, criticisms, suggestions for improvement, and engaging in decisions at different levels.

.18. **Increase their knowledge and skills** associated with their individual responsibilities, as part of a family and community, and social responsibilities, becoming an active empowered partner and demanding a quality Health System.

3.3.4. VISION FOR 2016

Institutions compete to demonstrate the quality of their services and professionals. *Professionals and patients are proof of the progress in technical and human aspects of care, in the management and articulation between institutions driven by the* ***accreditation process***. *The* ***process for institutional monitoring of quality and access indicators*** *is consistent with the areas of epidemiological and clinical relevance, management, quality and patient safety, taking on a strategic character in the development of the institution and its professionals, while closely associated with training and research. Professionals feel rewarded for their commitment to continuous improvement, whether of a financial nature, or in the conditions for innovation and for developing their own projects, or in the recognition both by citizens and the institution. The* ***continuous improvement and compliance with standards of excellence and reference are part of the identity and mission of the institutions***.

"Institutions take on the continuous quality improvement as their culture"

Institutions and services/departments have a ***vision of development based on quality improvement and integrated into a network of responsibility sharing***, *with emphasis on the complementarity between proximity, versatility and specialised services. They consider the area of influence, the optimal relationship between concentration of resources (services, technology, specialised human resources) and accessibility (within a geographic network of resource allocation). Contractualisation reinforces this view, as well as the responsibility of each unit within the network in which it operates and the articulation with all others. And it is based on the negotiation of goals and responsibilities, in a logic of coherent and continuous development, which complies with the plans articulated at the different levels (national, regional, local, institutional), of various natures (type of services and distribution of technology, human resources, training, referral networks), and strengthening strategic development programmes (e.g. integrated management of disease, quality or research).*

"The development plans of the institutions/services are articulated and contracted"

There is a ***single electronic health record***, *with adequate access and security levels to ensure the privacy of data. It is shared by public and private care providers and provides information to citizens on their medical condition, including emergency episodes. The authorised health professional has access to medical history, diagnostic tests and therapies, for a well-informed clinical decision, lower risk, information sharing between providers and a better therapy balance. The electronic health record is also* ***associated with clinical guidance protocols, for prevention*** *(e.g. scheduling of vaccination and screenings) and* ***chronic disease surveillance***, *through notices, thus reducing missed opportunities in the contact with the different care providers. It also warns about drug interactions and predefined safety situations, while respecting the autonomy of healthcare professionals. This record features an interface with the citizen, thus being an* ***instrument of communication, literacy, and support to self-management and empowerment.*** *It also allows the creation of* ***statistical indicators of the quality of the clinical pathway, the integration of care and adherence to NOCs***. *The professionals feel the need to maintain their records properly documented and valid, as they are shared and informative for the citizens themselves, for adequacy and professional and institutional performance statistics, and support clinical research.*

"The Health Data Platform promotes quality and continuity of care"

Health professionals have access to updated ***Clinical Orientation Guidelines*** *that incorporate scientific evidence and respond to the most common and relevant situations. The NOCs adequately assume the context of the practice of care, multidisciplinary care, multiple pathologies, use of multiple medications, risk management and clinical pathway perspective, enabling case management and teamwork.* ***The NOCs promote the best service efficiency and establish comparative quality standards****, including indicators of access, adequacy and performance, with more cost-effective actions. Professionals adopt and implement the NOCs within their teams, disseminating the health institution to citizens/patients as a benchmark. Institutions have explicit policies for the adoption, implementation and assessment of compliance and impact of the NOCs and participate in their creation and review. The academies, scientific societies, patient organisations and industry (pharmaceuticals, medical devices and information technologies) are the driving force behind the creation of the NOCs, whose quality, certification, and assessment are conducted by an independent body.*

"There are national references on quality standards of care, supporting clinical decision, integration and coordination of care, and interdisciplinary work"

The ***training of professionals includes****: i) prospects and determinants of structure, process and outcome that influence the quality of the acts; ii) patient safety and risk management; iii) skills for continuous quality improvement; iv) aspects of multidisciplinary teamwork, communication and health education. It also includes skills for a critical approach to scientific evidence, for engagement and decision sharing with the patient, for auditing and preparing clinical essays/assessments, for participation in research. Professionals are assessed for suitability and performance of services, including knowledge, skills, clinical attitudes and management of their activity, teamwork and relationship with the citizens.*

"The training and assessment of professionals focus on continuous quality improvement"

The assessment of policies, institutions and professionals *is seen as an* ***essential step in the process of continuous improvement, credibility and valorisation*** *of all stakeholders as a learning process for organisations which is vital to their dynamics. The state takes on a positive regulatory role by ensuring high quality resources and tools for the systematic evaluation of policies, institutions and professionals. These resources include corporate governance, clinical governance, systems to support decision-making (at the political, managerial and clinical level), monitoring, identification of best practices and assessment. Institutions, services and departments promote* ***interim continuous quality improvement processes and accreditation processes****, and participate in* ***external evaluations*** *as highly enriching processes in which similar institutions within the public, private and social sectors, professional bodies and associations, scientific societies and patient associations are also involved.*

"Promoting an assessment culture, at all levels"