Quality

Quality Plans. The Report on the National Health System 2005 made it clear that most of the Autonomous Communities had been including the quality of their health care services as one of their strategic objectives for some time previously. The analysis of the information provided then allows us to deduce a great similarity in the approach of different communities to Quality Plans. The priorities in this subject usually coincide with those which are defined in the countries of the European Union. There are variations, however in the degree of development of some initiatives which could be the seed of new strategies (comprehensive care plans, evidence-based medicine projects, etc.).

The areas with the most information are patient-centred care and security.

The fact that ten communities have institutional surveys with wide coverage is remarkable. As regards security, it is certain that the Safety Strategy for the Patient of the Ministry of Health and Consumers' Affairs has had a decisive influence.

However, it must be asked why certain aspects which the professionals consider to be significant, such as clinic effectiveness, are not tackled more frequently. The inclusion of continuous care in only four of the community plans should also be cause for reflection. There are also a number of new projects and ideas that will have to be evaluated in the near future.

Most of the Autonomous Communities are working on a Quality Plan to cover several years as part of the strategic programme of their health policy. The twelve communities which informed of the existence of such a Pluriannual Quality Plan have now been joined by the Quality Plan of the Board of Health of Rioja, which was drawn up by their Agency of Health Evaluation and Quality, with an approach that is also based on the framework provided by the EFQM (European Foundation for Quality Management). The Quality Plan for the National Health System was put into action in 2006 to provide support and coverage for the initiatives which had been started at that time and those which were to follow in the future.

Accreditation. Most of the Autonomous Communities who reported accreditation initiatives have developed their own systems. The creation of accreditation initiatives has emerged as a significantly dynamic area in the communities and only a few of these initiatives are highlighted, as a sample that shows the diversity of strategies and the range covered by accreditation.

Andalusia has carried out extensive work in this terrain. The Andalusian Agency of Health Quality, which was created in 2002 as the certifying body responsible for the public health system in Andalusia, is responsible for implementing the different accreditation programmes (professional staff,

health units and centres, training and web pages of health information). 2006 saw the start of the programmes for the accreditation of professional responsibilities, pharmacy offices and haemodialysis units.

Taking "authorization" as its instrument of accreditation, the Canary Islands passed Decree 105/2006 which regulates the authorization of health centres, services and establishments, and develops the legal framework for health sector contracts, by establishing requirements for inpatient surgery and for medium-stay centres.

The same framework for approving services forms the background for the Orders of the Board of Health of Castile-La Mancha which are applied to the centres and services of the blood donation network, haemotherapy and haemovigilance, mental health care and chiropody.

Cantabria completed the validation of its bronze seals, which are awarded for excellence in all the health centres of the Cantabrian Health Service. Aragon is setting up accreditation systems based on the ISO (International Standards Organization) guidelines in three categories: clinical laboratories, sterilization centres and primary health care teams.

Castile and Leon has undertaken activities with the aim of creating the Quality and Standards Agency in the near future.

Catalonia has published the Decree in 2006 regulating the accreditation of acute hospital care centres of Catalonia, while Extremadura has approved the Order which establishes the standards of the quality model for health centres, services and establishments in the region.

Guidelines for clinical practice. A growing effort has been made to develop guides for clinical practice, and they have been included among the objectives of the "contracts" which some communities have signed with the health centres in their region. The public health system of Andalusia has been making a notable effort for several years in the management of health care processes, drawing up 61 processes and standardized care plans, and 5 support processes, and it is estimated that 15% of the population of Andalusia have benefited from the structured intervention and follow up in attending their health problems.

Patient satisfaction surveys. Practically all of the autonomous communities have developed initiatives around this instrument of quality measurement, as has been seen in previous years. There is a widespread tendency towards greater methodological rigour and an increase in the range of services analysed, as well as satisfaction surveys of "internal clients", such as the atmosphere in the workplace.

Introduction of objectives in contracts. From reading the reports, it can be seen that all the communities, are systematically including them, although there is not sufficient information to allow us to analyse the link between meeting

these objectives and the application of incentive schemes to professional staff or institutions, such as the one developed by the Board of Health of La Rioja in its contract with the Calahorra Hospital Foundation, in which quality categories are analysed, plotted and the budget allotted accordingly.

Patient Safety. Patient safety has become one of the priorities of health systems. The publication of the report *"To err is human: building a safer health system* by the Institute of Medicine gave epidemiological data, but above all else placed the issue in the political spotlight for full debate.

The WHO launched the World Alliance for Patient Safety in October 2004.

Other international institutions, such as the Health Committee of the European Council, and other international agencies and organizations have developed strategies, actions and legislation to monitor avoidable adverse effects in clinical practice.

The current practice places special emphasis on the fact that the adverse effects of medical interventions are more closely related to system organization than individual conduct.

Undesirable side effects of health care are a cause of serious illness and death in all the health systems of the developed world. To the personal consequences for patients' health must be added the high social and economic cost.

The reason why health care involves such risks can be explained by its growing complexity. Modern clinical practice involves an ever-increasing number of organizational, personal and clinical factors.

The development of a safety-first culture within an organization calls for firm leadership, good planning and careful monitoring. Experience of the professionals' point of view is the first step towards introducing the actions that will allow their practice to change. Research, information and training have to take priority in setting up a culture of patient security.

2005 saw the Ministry of Health and Consumers' Affairs give patient safety high priority among its activities.

In this sense, the first National Study of Adverse Effects (Eneas), created by the Ministry in 2005, has been an important step forward.

This study, which was the third of its kind to be carried out in Europe and the fifth most important in the world, shows that the occurrence of adverse effects in the hospitals of the National Health System (9.3%, of which 43% were avoidable) is at a comparable level with the other countries that have carried the study out, namely France, the United Kingdom, Canada and Australia. It also shows where the greatest opportunities for improvement lie: adverse reactions to medicines, hospital infections and effects related to anaesthesia and surgery.

As a consequence, the Quality Plan of the National Health System which the Ministry of Health and Consumers' Affairs unveiled in March 2006, includes patient safety among its twelve top-priority strategies. Besides other

initiatives, the Minister signed the agreement by which the Ministry of Health and Consumers' Affairs adheres to the WHO plan "Clean Care is Safe Care". A number of training activities have been developed for health professionals and managers, and there has been a drive which has led to 140 professional groups to sign a declaration committing them to take action in favour of patient safety.

The patient safety strategy of the Quality Agency included in the Quality Plan focuses on 5 fundamental points:

1. Safety should permeate the entire culture of health organizations as a strategy of continuous improvement.
2. The inclusion of patient safety among the priorities of the health services and its medical suppliers through the introduction of safe practices.
3. Strengthen awareness and analysis of adverse effects by systematic study, and create registers and information systems and preventative measures.
4. Reinforce the skills of professionals and the spread of safety information.
5. Promote research.

To reach this objective, the following activities are being developed to respond to the specific goals of the strategy: raise awareness and patient safety culture among the patients and professional staff of the National Health System, introduce safer clinical practices, design a system for informing and noting adverse effects for training purposes and encourage the involvement of patients and consumers in the patient safety strategies.

Strategies. Recent experience in other countries suggests that the best way to handle collective activities is by drawing up strategies for the most significant illnesses in order to achieve a shared focus across the whole of the National Health System.

These strategies must establish the standards and suggest procedural models based on the best practices available in the fields of promotion, prevention, clinical treatment, rehabilitation, social reinsertion, information systems and research. They must be created with input from a wide base of scientific bodies and social groups, and revised on a regular basis.

The strategies approved during 2006 by the Interterritorial Council of the National Health System (cancer, ischaemic heart disease, diabetes and mental health) comply with all these characteristics.

These strategies are based on three pillars: clear service standards, appropriate services and the monitoring of results. Their guiding principles are solidarity, equity and participation to achieve the reduction of inequalities and the promotion of quality in care and information.