Guaranteeing the quality of health care

Summary

Are management boards and supervisory boards equipped to ensure the quality and safety of care, both now and in the future?

Care institutions are currently facing turbulent times: many old certainties are disappearing, with a fight for survival looming on the horizon. Successfully navigating these developments will require effective brinkmanship. There is a very real danger that the focus on quality and safety could suffer as a result. This is all the more urgent in view of the growing external pressure to provide greater transparency and ensure the quality and safety of care.

In these uncertain times, the aspects of quality, safety and transparency are all the more crucial to stakeholders, helping patients to make informed decisions and regain trust in the system, enabling health insurers to purchase effectively, offering financiers certainty on their investments, helping political parties safeguard the public interest and allowing care providers to continue their services and regain trust.

These objectives cannot be achieved by simply applying more stringent requirements to management boards and internal supervision bodies.

So why is it so difficult to effectively manage quality and safety and to provide greater transparency on quality? Currently transparency as to the quality and safety of care is based on a long list of performance indicators and accreditation procedures, and offers a false representation of reality. While little is known about care institutions' organisational culture and behaviour, the aspect of culture is key to determining whether an organisation is actually learning from its mistakes and working towards continuous quality improvement. Furthermore, the hands-on experience of patients and clients is not being adequately applied to assess and improve the aspects of quality and safety. As regards the hospital sector, the current professional quality system - which has not been integrated into the hospital system - is simply inadequate.

The Council proposes another method of quality measurement and assurance that will allow both internal and external care institution stakeholders to assess whether a care provider can ensure safe, high-quality care. This will involve both 'hard' and 'soft' elements, such as organisational culture and hands-on expertise.

In essence, this will require a focus on:

- limiting the number of (externally imposed) performance indicators, which are to be replaced by indicators rooted in the healthcare practice;
- the integration of professional and institutional quality systems;
- a focus on adherence to formal and informal regulations in the area of continuous quality improvement;
- further bolstering of patients' governance, at both individual and collective level.

In order to achieve these objectives, the Council has issued the following recommendations:
Care institutions and care professionals should develop indicators relevant to the day-to-day care practice. These indicators should then come to replace the excessive amount of - often externally imposed - current indicators. The new indicators should be developed on the basis of the patient tracer system; a method whereby the quality of care is determined by tracing the patient's trajectory through the care process. Where possible, the institutions and professionals will formulate outcome indicators. The National Institute for the Quality of Healthcare Services will coordinate and facilitate this development and will determine which externally driven indicators are to be abolished in consultation with the parties involved.

Care professionals and their professional and scientific associations will apply these new indicators to develop a framework of standards for the measurement and monitoring of service quality and periodical reporting to the Management Board, the Supervisory Board and other stakeholders. The professional associations will ensure that participation in all aspects of the professional quality system (including the requirement to provide accountability) becomes mandatory for all individual medical specialists. Sectoral organisations will incorporate this framework of standards in the governance code for the entire care sector (in the form of an addendum).

Care providers actively involve patients in the monitoring and improvement of quality and safety, at both individual and collective level. This will involve the use of a patient tracer system, whereby the experiences of patients are used to assess the quality and safety of provided care.

Care institutions devote structural attention to the aspect of organisational culture. They work to develop a culture of patient safety by explicitly embedding the aspect of culture in their quality systems. They afford responsibility for compliance to the institution's staff members. This internal compliance monitoring will include systematic and integral risk analysis. The National Institute for the Quality of Healthcare Services will support institutions by developing a suitable care model on the basis of existing models.

Will these measures prove sufficient to resist external pressure and rebuild trust? The Council expects stakeholders to demand a greater say in matters, a claim to which care institutions will eventually have to respond.

It envisages a role for a 'Supervisory Board 2.0' in this process, an administrative body with the following social responsibilities:
- acting as a de-facto 'counterweight' to Management Boards and other internal bodies and
- bringing in the outside world: representing the interests and concerns of legitimate external stakeholders within the institution.

Internal supervisory bodies are currently not equipped for these tasks. The Ministry of Health, Welfare and Sport (VWS) and the Dutch Society for Board Trustees in Health and Social Care (NVTZ) must reach binding agreements on the desired development of supervisory boards; this will include a mandatory training component.

The challenges currently facing the care sector call for a different form of internal supervision:
- extroverted, and engaged in dialogue with the outside world;
- with an independent perspective on public interests, including collective healthcare costs;
- measured by the yardstick of regional institutions' social performance;
- and with the patient's perspective - including patient participation - serving as a guiding principle.

This new approach will ensure that care institutions' internal supervisory bodies are better equipped to play an active role in the safeguarding of public interests.