



National Health Services Quality Policy

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PREFACE

Quality is defined as a dynamic business management process that developed from quality assurance to continuous quality improvement, it involves a competitive edge as it endeavours to do the right thing right the first time, and every time. Quality is an achievable, measurable, profitable entity once there is commitment and understanding and one is prepared for hard work. Therefore everyone in the organization is responsible for quality as cost and performance outcomes are irrevocably linked.

The need to measure and improve the performance of health systems has been emphasized by international organizations, notably the World Health Assembly (WHA), World Health Organization (WHO) and Pan American Health Organization (PAHO). In an attempt to improve the quality of health care and the health status of the population of Anguilla, at the beginning of the 21st century, the Government of Anguilla embarked on a series of administrative, structural and technical reforms of the Health Sector that included the establishment of the Health Authority of Anguilla, and the development of the Strategic Plan for Health. The Ministry of Health and Social Development retained the responsibility not only for financing the Health Authority, but for policy formulation, health planning, monitoring, evaluation and regulation of health care. In addition it has assumed the role of purchaser of services provided by the Health Authority and the private sector.

Driving the effort to establish a National Health Services Quality Policy is the need for accountability, a complaints management system to address the complaints from the population concerning the quality of care and the low patient satisfaction levels. Also, a regional survey which has eleven Essential Public Health Functions conducted by PAHO in 2002 indicated that the ninth essential function which is **“ensuring the quality of personal and population based health services”** rated very low at 29%. This indicated that quality management in the health services needed to be addressed as a matter of urgency.

The establishment of this National Health Services Quality Policy ensures the institutionalization of the Quality Management System that will transform the culture of the health sector to accept and facilitate the required reforms. To achieve the necessary improvements, commitment is needed from all stakeholders beginning with leadership from the highest level of government, the public and private health sectors and health care professions.

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It is not enough to just do your best or work hard,

You must know what to work on.

(W. Edwards Deming)

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A special note of thanks is due to:

Mrs. Alma Hughes - Senior Health Services Quality Officer – Ministry of Health and Social Development

Mrs. Clavis Carter-Gumbs – Chief Operations Officer, Health Authority of Anguilla

Mrs. Alicia Haywood – Director of Nursing Services, Princess Alexandra Hospital

Ms Janice Hodge - Community Nurse Coordinator, Primary Health Care, Health Authority of Anguilla

Mrs. Diana Claxton-Carty – Infection Control Officer, Princess Alexandra Hospital

Ms. Coreen Hodge – Manager, Miriam Gumbs Senior Citizens Home

Ms Ingrid Queeley - Manager, Accident and Emergency Department, Princess Alexandra Hospital

Ms. Erdelle Flemming - Manager, Operating Theatre, Princess Alexandra Hospital

Mrs. Colvette Whyte –Colley – Centre Manager, Health Authority of Anguilla

Mrs. Twyla Richardson - Registered Nurse/Midwife, Princess Alexandra Hospital

Mr. Vincent Carty – Senior Environmental Health Officer, Department of Health Protection

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NATIONAL HEALTH SERVICES QUALITY POLICY

1. BACKGROUND

The growth of technology and information, the demands for transparency and public accountability, and the limits of financial and human resources oblige every member state to describe and reform its health system according to internationally recognized standards.

1.1 International Context

In 1997, The World Health Assembly launched the global targets of ‘Health for All’ by the year 2000 by adopting the declaration of the international conference on primary health care, held in Alma – Ata, 1978. In 1998, the Fifty-first World Health Assembly recognized the report “Health for All in the Twenty – First Century” and reaffirmed the commitment to the principle that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. They further committed their support for relevant regional and national policies and strategies and adopted **Health for all in the 21st Century and its 21 Health targets** as benchmarks against which to measure progress in protecting and improving health (see Appendix 1).

Target 16 of the 21 Health Targets “**Managing for Quality of Care**” ensures that clinical management of the health sector from population based health programmes to individual patient care at the clinical level is oriented towards health outcomes as the ultimate measure of quality. In particular:

16.1 The effectiveness of major public health strategies should be assessed in terms of health outcomes, and decisions regarding alternative strategies for dealing with individual health problems should increasingly be taken by comparing health outcomes and their cost effectiveness;

16.2 All countries should have a nationwide mechanism for continuous monitoring and development of the quality of care for at least ten major health conditions, including measurement of health impact, cost-effectiveness and patient satisfaction;

16.3 Health outcomes in at least five of the above health conditions should show a significant improvement, and surveys should show an increase in patients’ satisfaction with the quality of services received and heightened respect for their rights.

The Fifty-first World Health Assembly committed to strengthening, adopting and reforming, as appropriate health systems, including Essential Public Health Functions and services, in order to ensure universal access to health services that are based on scientific evidence, of good quality and within affordable limits, and that are sustainable for the future.

1.2 Regional Context

The Pan American Health Organization/World Health Organization (PAHO/WHO) through the Public Health in the Americas Initiative (1999) defined eleven (11) Public Health Functions to strengthen public health practice, and developed a methodology that allows countries to evaluate

their public health capacity, and urged member states to participate in the regional exercise to measure performance of the eleven Essential Public Health Functions (EPHFs) (see Appendix 2).

1.3 National Context

Between the periods 2001 – 2002 countries in the region participated in the regional assessment of the EPHFs. At the national level, the assessment revealed that EPHF 9 received the lowest score of the eleven EPHFs. The Ministry of Health in recognizing the low score impact of **EPHF 9 - “Quality Assurance in Personal and Population Based Health Services”**, and accepting **Target 16 of Health 21 – “Managing for Quality of Care”** embarked on the establishment of the Directorate of Health Services Quality Management (DHSQM), as the regulatory arm with oversight capacity that articulates national strategies for the health sectors with an explicit focus on improving the quality of care.

To address these issues, a Quality Management System (QMS) framework shall be instituted. To achieve necessary improvements, commitment is needed from all stakeholders beginning with leadership from the highest level of government, the public and private health sectors and health care professions.

2. INTRODUCTION

The Government of Anguilla (GoA) recognizes the Fifty-first World Health Assembly Report **“Health for All in the Twenty First Century”** as the support for the development of the quality policy and is obligated to provide basic health services for its population. It enunciates that a healthy population is necessary for the establishment of a dynamic, productive, and resilient society, and affirms its commitment to lead in the creation of a quality environment in the public and private health sector, that will promote wellness and high quality care for the people of Anguilla in a well regulated, accessible and equitable health care system.

3. VISION AND MISSION STATEMENTS

3.1. Vision Statement

The Ministry of Health is committed to ensuring that services provided for the population of Anguilla are of high quality, sensitive/appropriate to the customer’s needs and are delivered in a timely, safe, effective and efficient manner. This will be achieved through a continuous quality improvement system, which responds to changing user needs and preferences, as well as the changing epidemiological trends, technology and practices of the professions and other providers.

3.2 Mission Statement

The mission is to improve the quality of care and services delivered by public/private health facilities through the introduction of the quality management system that ensures access to a well regulated health care system that is client/customer focused and facilitates the health and well being of the population.

4. THE POLICY STATEMENT

The National Health Services Quality Policy is geared towards an outcome oriented health sector and provides a way to improve the quality of care in both the public and private sectors. The policy outlines the objectives, strategies and governance requirements that will provide the foundation for service planning, programmes, initiatives and activity aimed at ensuring the delivery of high quality care.

This quality policy addresses our entire quality management system and the applicable requirements, directives and associated standards. Therefore, institutions shall be accountable for continuously improving the quality of their services and the maintenance of standards and high levels of competence that allow excellence in clinical care to flourish.

Health professionals practicing within the system shall take responsibility for the standard of their own practice, and the maintenance of a system that provides safe care. Healthcare organisations shall identify and detail clear lines of responsibility and accountability for clinical care, and ensure that they are communicated throughout the organisation.

5. PRINCIPLES UNDERPINNING THE POLICY

The principles that underpin the policy focus on the internal and external customer and their expectations:

Principle 1: **Customer focus** – The Ministry of Health depends on its customers and should understand customer needs, meet the customer’s requirements and strive to exceed customer expectations.

Principle 2: **Leadership** – Leaders within the Health Service should establish unity of purpose and direction, and create and maintain the internal environment in which people can become fully involved in achieving the organization’s objectives.

Principle 3: **Involvement of People** - Staff at all levels are the essence of the Health Service and their full involvement enables their abilities to be used for the organization’s benefit.

Principle 4: **Process Approach** – This approach is built on the belief that a desired result is achieved more efficiently when activities and related resources are managed as a process. It is built on four concepts: inputs, outputs, verification, and validation. These four ideas form a cohesive structure to ensure that the desired outcome results are achieved.

Principle 5: **System Approach to Management** - Identifying, understanding and managing a system of interrelated process for given objective improves the Health Services effectiveness and efficiency.

Principle 6: **Continual Improvement** – Continual improvement should be a permanent objective of the Health Service.

Principle 7: **Factual Approach to Decision Making** – Effective decisions are based on the analysis of data and information.

Principle 8: **Mutually Beneficial Supplier Relationships** – The Health Service and its suppliers are interdependent, and a mutually beneficial relationship enhances the ability of both to create value.

6. GOALS AND OBJECTIVES

The ultimate goal of this National Health Services Quality Policy is to improve the delivery of safe, high quality health care that is comparable with international standards of best practice.

6.1 Goal # 1: To develop a framework for the improvement and maintenance of quality in the health services of Anguilla.

6.1.1 The Objectives are to:-

- i Establish a structure of Quality in the Health Sector.
- ii Establish clearly defined service standards which are measurable indicators of actual performance.
- iii Conduct strategic/operational research to inform the process of service development/improvement.
- iv Establish a Risk Management /Infection Control System.
- v Develop and ensure the implementation of a Customer Relationship/Complaints System.
- vi Institutionalize a system of monitoring and evaluation of health services.
- vii Develop an operational information system.
- ix Develop an adverse events (incidents) reporting system.
- x Promote public/private partnerships and the accountability of both sectors on quality improvement.
- xi Establish a National Health Sector Quality Council.

6.2 Goal # 2: To create a quality culture/environment throughout the Health Sector.

6.2.1 The Objectives are to:-

- i Conduct in-service training for Quality, and encourage participation in quality improvement projects.
- ii Promote Customer Service Excellence.

- iii Foster the team approach throughout the Health Service.
- iv Disseminate best practices in Quality.
- v Develop the National Charter of Patient's Rights and Obligations and ensure compliance of same.
- vi Institute a Continuous Quality Improvement (CQI) Programme.
- vii Develop continuing Professional Development Programmes and outcome review programmes to continually measure the competence of health professionals.
- viii Conduct national Patient/Customer Satisfaction Surveys, and develop Audit Tools/ Instruments.
- ix Establish a National Quality Award (NQA) System.

6.3 Goal # 3: To emphasize value for money as a quality principle for performance in all areas.

6.3.1 The Objectives are to:-

- i Build capacity for health care personnel and effectively redistribute human resources.
- ii Provide a strategic framework and guidelines for improving and maintaining an efficient referral/transfer (to include overseas transfers), and discharge planning system.
- iii Set norms and standards to address issues of equity as they ensure a basic minimum standard of care for all users of the health system.
- iv Develop a framework to increase access to information and services that will empower citizens to make informed decisions and create value for money.

7. PATIENT/ CLIENT /CUSTOMER SERVICE VALUES

This quality policy puts the patient/ client /customer and the community in the forefront and expects health care providers to uphold the following service values in the delivery of healthcare.

- i. **Timeliness** – the length of time a patient has to wait for service.
- ii. **Completeness** – the request of the patient is provided within reason.
- iii. **Courtesy** – the manner in which customers are treated by employees.
- iv. **Consistency** – the same level of service provided to each customer every time.
- v. **Accuracy** – The service is performed right every time
- vi. **Responsiveness** – how well do the organization react to unusual situations and the question/queries of the customer.

8. THE QUALITY MANAGEMENT SYSTEM (QMS) FRAMEWORK

8.1 Definition of Quality

The International Organization for Standardization (ISO) defines quality as: “**the totality of features and characteristics of an organization that bears on its ability to satisfy a patient/client/customer stated or implied needs**”... the first time and every time.

8.2 Definition of the QMS

The QMS is defined as the organizational structure which outlines responsibilities, procedures, processes and resources for implementing quality management (i.e., the coordinated activities that direct and control an organization with regard to quality) including all activities which contribute to quality, directly or indirectly (ISO).

8.3 The Framework

The Quality Management System (QMS) framework shall be instituted to govern the public and private health sectors. It is a practical approach that is designed to be a systematic process with identified leadership, accountability, and dedicated resources and uses data and measurable outcomes to determine progress toward relevant, evidence based benchmarks. Quality management should focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change.

The framework includes regulatory aspects relating to health professionals, service providers, quality standards, procedures and protocols of treatment, as well as the development of an effective health information system, and audit tools to monitor and evaluate the performance and effectiveness of health care. The framework facilitates the implementation of the Quality management System with emphasis on the client/patient/customer as the catalyst in the process.

8.4 Six Dimensions of Quality of Health Care

The six dimensions of quality and the quality of care indicators as well as the five cross dimensional issues shall measure, monitor and manage the performance of the health care system. They shall be addressed by all organizations that supply health services to the consumer and support the development of the quality system. These dimensions and indicators are as follows:

- i. **Safety** in health care is defined as “the extent to which potential risks are avoided and inadvertent harm is minimized in care delivery processes”. Everyone who works in the healthcare system has a professional duty to ensure the best possible quality of care and clinical outcome for their patients/clients.

Some examples of the quality of care indicators to measure **safety** are:

- Number of clients/patients and staff that report safety issues.
- Percentage of clients/patients experiencing falls in health care facilities;
- Percentage of clients/patients developing pressures sores;
- Percentage of clients/patients acquiring nosocomial infections

- Incident rate for amputations of Diabetic patients.
- ii. **Effectiveness** of health care: The effectiveness of health care services must be customer focused and outcome oriented as it relates to treatment, and intervention. Effectiveness embraces the concept of a continuum of care across primary and secondary services.

Some examples of the quality of care indicators to measure **effectiveness** are:

- The percentage of facilities using current Best Practice Guidelines.
 - Admission rates for asthma.
 - Screening rates for breast, cervical, prostate and colon cancer.
 - Mortality from hypertensive and cerebrovascular disease.
 - Number of clients/patients that receive care and treatment that is congruent with their diagnosis;
 - Call compliance and proficiency rate.
- iii. **Appropriateness** in health care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome. Patient/clients should be treated in the most appropriate setting relevant to their health needs. Services should be provided in an integrated way. Essentially, the appropriateness of health care is about using evidence to “do the right thing” to the right patient/client, in a timely fashion.

Some examples of the quality of care indicators to measure **appropriateness** are:

- Caesarian section rate;
 - Percentage of patients who have received a mental health assessment who present to primary care or the Emergency Department.
 - Number of patients with severe headache and Blood Pressure 210/110.
 - Rate of transfer to another service and/or overseas.
 - Health professional rates.
- iv. **Consumer Participation** in health care: Not only do consumers have a fundamental right to participate in health care delivery, but such input has considerable benefit. Opportunities must be provided for health consumers to participate collaboratively with health organizations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way. Consumer participation should enhance the level of **acceptability** of services which describes the degree to which a service meets or exceeds the expectations of informed consumers.

Some examples of the quality of care indicators to measure **Consumer Participation** are:

- Staff and patients/family satisfaction rates.
- Service utilization rate.

- Evidence of compliance with the complaints system.
 - Compliments rate.
- v. **Efficiency** of service provision: Health services must ensure that resources are utilized to achieve value for money. This can be achieved by focusing on minimizing the cost combination of resource inputs in the production of a particular service, as well as the allocation of resources to those services that provide the greatest benefit to consumers. All resources, human, material and financial shall be used in the most efficient manner to achieve stated objectives and quality standards.

Some examples of the quality of care indicators to measure **Efficiency** are:

- Cost per service output or cost per service completion for each client/patient in the clinic;
 - Number and rates of emergent calls.
 - Cost per call;
 - Average call handling time;
 - Average length of stay (ALOS);
- vi. **Access** to services: Health facilities should offer equitable access to health services on the basis of need. To facilitate access, information on the range and availability of services should be provided so that individuals can make informed choices about their care. An acceptable service will uphold in every case the patient/client's right to respect for their privacy, dignity, religious and cultural beliefs and the security of knowing that all patient information is confidential.

Some examples of the quality of care indicators to measure **access** are:

- Services are provided promptly – less waiting time.
- Waiting times for all services including (but not limited to):
 - elective surgery;
 - Managed care assessments;
 - Nursing home placements.
- Number of days between the date the patient called for an appointment and date of appointment.

8.5 Cross Dimensional Issues

The following cross dimensional issues have been identified as important components of performance and have an impact on the six dimensions of quality. Careful consideration must be given to all these factors when managing and organizing services.

i. **System Competence**

The system in which services are provided need to be competent to be able to provide excellent results. Competence must be seen as a major priority for review and action, by all health services.

There are three levels of competence namely:

- *Organisational competence* refers to the capability of a facility (or system) to assess its ability to perform particular functions or procedures or to supply a particular service. It focuses upon legislative and standards compliance, data and equipment quality and maintenance; service provider and facility accreditation, research and evaluation.
- *Multidisciplinary team competence* relates to the ability of the team to deliver optimum outcomes for the consumers.
- *Individual competence* is the level of competence which relates to the performance of individual employees and contractors. Competence relates to the skills, knowledge and attitude of the individual.

The assessment and management of “competence” is not to be restricted to clinical staff; there should be effective performance management systems in place to encourage and motivate all staff and to identify development needs and opportunities for all.

ii. Information Management

Information management is about improving the quality and availability of information to health staff (clinicians, management, researchers and other staff) as well as to the general public. Improvement in care is dependent in part upon the exchange of data about the quality of care provided. Health services need to give priority to the development of information systems and to promote and support appropriate use of information on health care quality. Health Services need also to implement skills development programmes for health professionals in research and data analysis.

iii. Continuity of Care

Continuity of care refers to the extent to which an individual episode of care is coordinated and integrated into overall care provision. Admission and discharge planning, communication and coordination between health care professionals, linking hospital and community care, is the basis of continuity.

iv. Education and Training for Quality

Successful implementation of the Quality Management System (QMS) Framework can be achieved through a quality management education programme for all stakeholders.

v. Accreditation

Accreditation provides a useful infrastructure for organisations to develop a “quality culture”. The structure and processes required to achieve accreditation provide a foundation to achieve outcomes of adequate quality from the services provided.

Accreditation requires organisations to demonstrate a commitment to quality and to continuous improvement.

9. NATIONAL ORGANISATION AND INSTITUTIONALIZATION OF QUALITY

The proposed Organisational Chart for Quality Management illustrates the management structure and governance framework for implementing the Quality Management System. The structure at the Ministry of Health includes the National Health Sector Quality Council, Complaints Authority, the Directorate of Health Services Quality Management, Accreditation Commission and a Quality System Data Base.

The support structure at the Health Authority of Anguilla includes the Complaints Review Panel, Quality/Risk Management Committee, a Quality Manager, Focal Points and Quality Improvement Teams in the primary and secondary health facilities.

Complaints of national importance emanating from the private health sector shall be addressed by the Complaints Authority in the Ministry of Health. The chair or the designate of the National Health Sector Quality Council shall appoint members from the National Health Sector Quality Council to act as the Complaints Authority in the Ministry of Health.

ORGANIZATIONAL CHART FOR QUALITY MANAGEMENT MINISTRY OF HEALTH/HAA

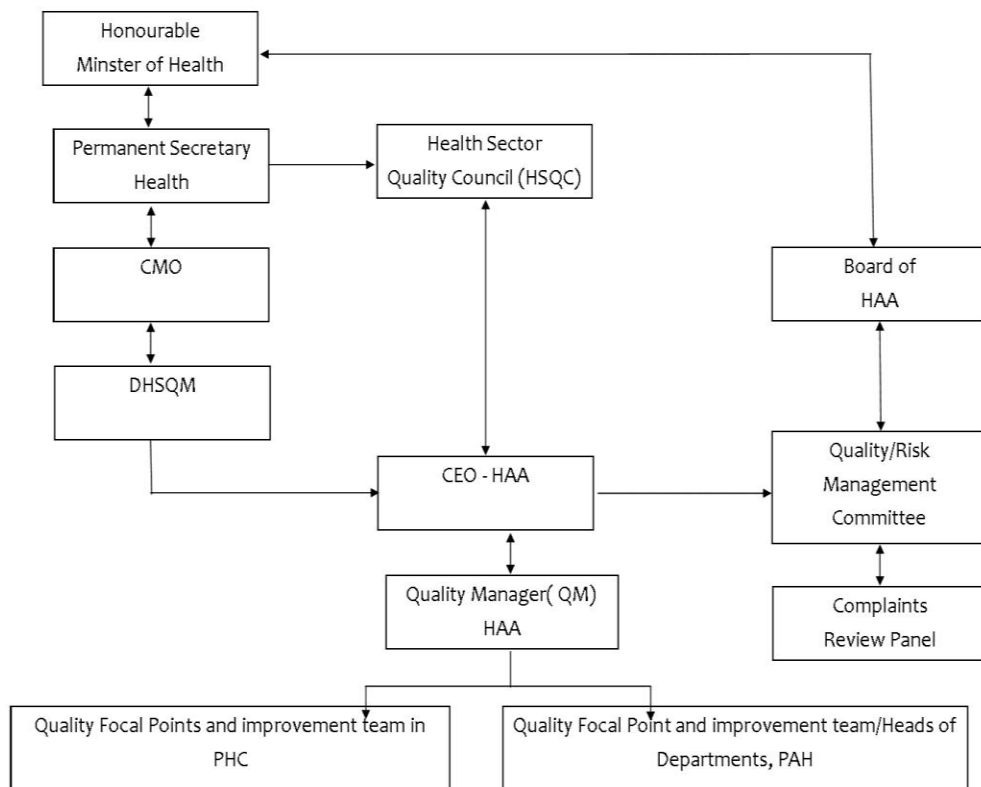


Figure 1: Proposed Organisational Chart for Quality Management.

9.1 The Ministry of Health shall:

- Establish the National Health Sector Quality Council;
- Review proposals and plans for Quality Improvement.
- Formulate a policy on complaints and develop the regulations for establishing a complaint authority and review panel;
- Monitor and regulate health quality;
- Provide resources (financial etc.);
- Initiate and support the process for developing health technology assessment.
- Develop national quality indicators.
- Design and ensure the implementation of an Accreditation System for the health sector.
- Develop quality specifications for inclusion in Annual Services Agreements;
- Review and revise national policies every five years;
- Establish and ensure the implementation of a National Quality Award System.

9.2 The Ministry shall establish the National Health Sector Quality Council to:

- Develop corporate strategy for implementing a Continuous Quality Improvement Programme for the Health Sector;
- Develop policy guidelines for monitoring the Quality Improvement System;
- Set national quality targets for the Health Sector;
- Recommend Quality Specifications for the Annual Services Agreements;
- Consider reports of the complaints review panel and make recommendations to the Minister of Health;
- Recommend criteria for the introduction of the National Quality Award;
- Review and make recommendations for revision of National Health Sector Quality Targets.
- Preparation and delivery of regular reports on the quality of health care being provided to the Minister of Health.
- Develop a research agenda for the advancement of quality improvement.

9.3 The Composition of the National Health Sector Quality Council

The Minister of Health shall establish the National Health Sector Quality Council which may include any of the following and any other person(s) possessing the required expertise.

- Permanent Secretary - Health
- Chief Medical Officer
- Director of Health Services Quality Management
- Representative from the Attorney General's Chambers
- Health Planner
- Chief Nursing Officer
- Director of Health Protection
- Chief Executive Officer in the Health Authority of Anguilla (HAA)
- Human Resource Manager – HAA
- Coordinator of the Health Information System - HAA
- Director of Statistics
- Doctor from the Private Sector

- Member of the community (consumer).

- 9.4** The Ministry shall mandate **the Directorate of Health Services Quality Management to:**
- Develop corporate strategies and plans to implement the Continuous Quality Improvement Programme throughout the Health Service;
 - Create a regulatory framework for Quality improvement;
 - Establish a system for developing and revising standards, protocols and procedures for care at health facilities;
 - Develop and implement a monitoring and audit system for the Health service;
 - Assess the impact of the application of technology on client outcomes;
 - Collaborate with other governmental agencies to develop standards for community care;
 - Facilitate the introduction of systems for increasing accountability and eliminating wastage;
 - Introduce a framework for developing a Quality Management System;
 - Develop a formal mechanism for effective networking with management units at the HAA;
 - Empower HAA managers and staff to implement and evaluate a Continuous Quality Improvement programme;
 - Develop national health service quality standards, procedures; and guidelines;
 - Establish and monitor a client feedback mechanism (Customer Complaints System) as a support system for the Risk Management System;
 - Collaborate with the Health Sectors in conducting operational research to inform service development/improvement;
 - Collaborate with the Attorney General's Chambers in developing quality health services legislation.

10. METHODS, TECHNIQUES AND TOOLS FOR THE DEVELOPMENT OF QUALITY.

- 10.1** The policy shall establish effective methods for Quality Improvement Mechanisms that are consistent with experience and scientific evidence.

10.1.1 The Ministry of Health shall:-

- Establish licensing, certification or registration requirements for Health Professions that are accessible to the public.
- Ensure that external assessment and Quality Improvement Programmes are recognized by and consistent with statutory investigation and inspection; and their standards, assessment processes, and operations, comply with international criteria.
- Establish formal mechanisms to provide and protect the rights of the patients and their families to Health Services.
- Ensure that quality programmes are systematically planned, coordinated and implemented to meet national priorities; and ensure that standards, measures and improvement techniques are explicit and effective.

11 RESOURCES FOR QUALITY IMPROVEMENT

11.1 The National Quality Improvement Programme shall identify responsibility for funding the basic knowledge, skills and information required for quality improvement.

11.1.1 The Ministry of Health shall ensure that:

- All personnel are trained to evaluate and improve the performance their own work and of their health care organization.
- Appropriate training is provided to in-service and professional coordinators in the Health services, and that they are supported, developed and retained.
- Personnel have allocated time to participate in formal, systematic quality improvement programmes.
- Health facilities provide staff with accurate, complete and timely data for analysis and dissemination in order to measure clinical and organizational performance.
- Information on theory and practice of standards and measurements and improvement are accessible to all health care personnel.
- The direct financial costs of the quality programme are realistically identified in advance and in accordance with agreed budgets, especially for training, research and information.

12. DELIVERING QUALITY CARE

Health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Thus, successful implementation of clinical governance requires the development of strong and effective partnerships between clinicians, nurses, managers, providers, and purchasers of healthcare in partnership with individual patients, their carers and the whole community. Consequently, health care organisations will need to identify and detail clear lines of responsibility and accountability for clinical care and ensure that they are communicated throughout the organisation. The need for action demands that competent health professionals are available to assure quality in health care and to continuously improve the care that is provided.

13. THE ROLE OF THE PUBLIC AND PRIVATE HEALTH FACILITIES

The Public and Private Health Facilities shall ensure that the following quality initiatives are implemented and integrated.

- Appoint a Quality Manager;
- Deliver quality health care;

- Develop and implement operational policies for quality;
- Institute systems for monitoring and evaluation;
- Conduct Quality audits and performance reviews;
- Establish systems for customer protection;
- Capacity building for quality improvement;
- Establish systems for infection prevention and control;
- Establish health risk management systems including a Quality/Risk Management Committee and adverse events surveillance;
- Implement the complaints system including a Complaints Review Panel for complaints resolution;
- Ensure the provision of resources;
- Ensure that national quality improvement targets are achieved;
- Comply with the MoH recognition criteria for the National Health Services Quality Awards.

13.1 The **Quality Manager** shall:

- Prepare operational policies in support of the Quality Improvement System for the approval Board;
- Develop and implement the Quality Improvement Plan;
- Establish systems for achieving Quality Improvement Targets;
- Provide quality improvement education;
- Establish structures for implementing quality improvement activities, defining relationships and reporting lines.
- Develop and implement systems for verifying the effectiveness of corrective actions;
- Ensure that systems and processes for achieving accreditation are implemented and maintained;
- Establish systems for developing and updating clinical practice guidelines;
- Establish a system for monitoring adverse events (sentinel surveillance) and timely intervention;
- Develop a system for quality monitoring and audit;
- Source the necessary information technology/infrastructure to support the quality management information system;
- Ensure quality controls systems for radiology, laboratory, and public health;
- Introduce Quality Improvement projects to improvement projects to improve the quality of care delivered to patients/clients;
- Convene meetings with clinical and non – clinical heads to discuss Quality Improvement Reports;
- Collaborate with Human. Resource to ensure systems for monitoring the credentials of health professionals are implemented and maintained;
- Maintain surveillance on bio-medical, utility and inventory management systems;
- Ensure that infection control systems are implemented and maintained;
- Implement systems for complaints resolution;
- Prepare monthly reports to the Chief Executive Officer on implementation of the Quality Improvement Programme;

- Prepare quarterly Quality Improvement reports for submission to the board of the Health Authority of Anguilla;
- Organize and implement a Customer Appreciation Day.

The quality manager shall be responsible for ensuring and improving quality, and for resolving quality problems including a focus on customer needs. The term customer refers in this case to both the external and internal customer.

The external customer is the beneficiary of the health services, and the internal customer includes front-line health professionals, supervisors, and other health team members within the organization who rely on fellow workers for products and services that help them to fulfill their part in providing quality care to the external customer. The quality manager shall also focus on systems and processes, data-based decisions, participation and teamwork, and leadership.

14. REPORTING

The way in which performance data are reported and disseminated plays a major role in the way in which the information is used (or not used) to effect change.

- A consistent approach to reporting is required of all service providers;
- Reports should be clear, accurate, succinct and useful;
- Reports should include an action plan for the improvement of results contained within the report;
- Measurements should have intrinsic value to the collectors to ensure accurate collection and subsequent use for quality improvement;
- Measures should first be reviewed by the collectors to ensure their accuracy and to minimize misinterpretation;
- Measures should be regularly reviewed and information made available to those to whom it relates and those who want it;
- Reports from the public and private health sector should be forwarded to the National Health Sector Quality Council in the Ministry of Health on an annual, quarterly and on an as needs basis.
- An annual report from the National Health Sector Quality Council shall be made available to the public and private health sector. This report should record the aggregated data provided to the National Health Sector Quality Council during the year. The report will be accompanied by an analysis of the trends and explanation of the results, so that the report accurately informs the health sector of the quality of health care being delivered and the actions that are being taken to improve it.

15. CONCLUSION

This framework shall ensure the emergence of a new quality culture which would involve all operational areas of the health sector through the use of continuous quality improvement. Commitment to continual improvement that is pervasive in the day to day functions of the health sectors will produce the kind of health system that the public deserves; one that has the consumer as the primary focus and the providers of health concentrating on interventions that are safe,

effective and appropriate. The quality of care indicators will over time measure the performance of the six dimensions of quality, and the five cross dimensional issues which represent the basic tenets of continuous quality improvement used to drive the national thrust for excellence in quality in the health sector.

APPENDIX 1

WHO HEALTH 21 TARGETS

TARGET 1 – SOLIDARITY FOR HEALTH IN THE EUROPEAN REGION BY THE YEAR 2020, THE PRESENT GAP IN HEALTH STATUS BETWEEN MEMBER STATES OF THE EUROPEAN REGION SHOULD BE REDUCED BY AT LEAST ONE THIRD.

In particular:

- 1.1 The gap in life expectancy between the third of European countries with the highest and the third of countries with the lowest life expectancy levels should be reduced by at least 30%;
- 1.2 The range of values for major indicators of morbidity, disability and mortality among groups of countries should be reduced through accelerated improvement of the situation in those that are disadvantaged.

TARGET 2 – EQUITY IN HEALTH BY THE YEAR 2020, THE HEALTH GAP BETWEEN SOCIOECONOMIC GROUPS WITHIN COUNTRIES SHOULD BE REDUCED BY AT LEAST ONE FOURTH IN ALL MEMBER STATES, BY SUBSTANTIALLY IMPROVING THE LEVEL OF HEALTH OF DISADVANTAGED GROUPS.

In particular:

- 2.1 The gap in life expectancy between socioeconomic groups should be reduced by at least 25%;
- 2.2 The values for major indicators of morbidity, disability and mortality in groups across the socioeconomic gradient should be more equitably distributed;
- 2.3 Socioeconomic conditions that produce adverse health effects, notably differences in income, educational achievement and access to the labour market, should be substantially improved;
- 2.4 The proportion of the population living in poverty should be greatly reduced;
- 2.5 People having special needs as a result of their health, social or economic circumstances should be protected from exclusion and given easy access to appropriate care.

TARGET 3 – HEALTHY START IN LIFE BY THE YEAR 2020, ALL NEWBORN BABIES, INFANTS AND PRE-SCHOOL CHILDREN IN THE REGION SHOULD HAVE BETTER HEALTH, ENSURING A HEALTHY START IN LIFE.

In particular:

- 3.1 All Member States should ensure improvements in access to appropriate reproductive health, antenatal, perinatal and child health services;

- 3.2 The infant mortality rate should not exceed 20 per 1000 live births in any country; countries with rates currently below 20 per 1000 should strive to reach 10 or below;
- 3.3 countries with rates currently below 10 per 1000 should increase the proportion of newborn babies free from congenital disease or disability;
- 3.4 Mortality and disability from accidents and violence in under 5-year-olds should be reduced by at least 50%;
- 3.5 The proportion of children born weighing less than 2500 g should be reduced by at least 20%, and the differences between countries should be significantly reduced.

TARGET 4 – HEALTH OF YOUNG PEOPLE BY THE YEAR 2020, YOUNG PEOPLE IN THE REGION SHOULD BE HEALTHIER AND BETTER ABLE TO FULFIL THEIR ROLES IN SOCIETY.

In particular:

- 4.1 Children and adolescents should have better life skills and the capacity to make healthy choices;
- 4.2 Mortality and disability from violence and accidents⁷ involving young people should be reduced by at least 50%;
- 4.3 The proportion of young people engaging in harmful forms of behaviour⁸ such as drug, tobacco, and alcohol consumption should be substantially reduced;
- 4.4 The incidence of teenage pregnancies should be reduced by at least one third.

TARGET 5 – HEALTHY AGING BY THE YEAR 2020, PEOPLE OVER 65 SHOULD HAVE THE OPPORTUNITY OF ENJOYING THEIR FULL HEALTH POTENTIAL AND PLAYING AN ACTIVE SOCIAL ROLE.

In particular:

- 5.1 There should be an increase of at least 20% in life expectancy and in disability-free life expectancy at age 65 years;
- 5.2 There should be an increase of at least 50% in the proportion of people at age 80 years enjoying a level of health in a home environment that permits them to maintain autonomy, self-esteem and their place in society.

TARGET 6 – IMPROVING MENTAL HEALTH BY THE YEAR 2020, PEOPLE'S PSYCHOSOCIAL WELLBEING SHOULD BE IMPROVED AND BETTER COMPREHENSIVE SERVICES SHOULD BE AVAILABLE TO AND ACCESSIBLE BY PEOPLE WITH MENTAL HEALTH PROBLEMS.

In particular:



- 6.1 The prevalence and adverse health impact of mental health problems should be Substantially reduced and people should have an increased ability to cope with stressful life events;
- 6.2 Suicide rates should be reduced by at least one third, with the most significant reductions achieved in countries and population groups with currently high rates.

TARGET 7 – REDUCING COMMUNICABLE DISEASES BY THE YEAR 2020, THE ADVERSE HEALTH EFFECTS OF COMMUNICABLE DISEASES SHOULD BE SUBSTANTIALLY DIMINISHED THROUGH SYSTEMATICALLY APPLIED PROGRAMMES TO ERADICATE, ELIMINATE OR CONTROL INFECTIOUS DISEASES OF PUBLIC HEALTH IMPORTANCE.

In particular:

Elimination of disease

- 7.1 By 2000 or earlier, poliomyelitis transmission in the Region should stop, and by 2003 or earlier this should be certified in every country;
- 7.2 By 2005 or earlier, neonatal tetanus should be eliminated from the Region;
- 7.3 By 2007 or earlier, indigenous measles should be eliminated from the Region, and by 2010 the elimination should be certified in every country;
- 7.4 By 2010 or earlier, all countries should have:
- an incidence level for diphtheria of below 0.1 per 100 000 population;
 - New hepatitis B virus carrier incidence reduced by at least 80% through integration of hepatitis B vaccine in the child immunization programme;
 - An incidence level of below 1 per 100 000 population for mumps, pertussis and invasive disease caused by *Haemophilus influenzae* type b;
 - An incidence level for congenital syphilis of below 0.01 per 1000 live births;
 - An incidence level for congenital rubella of below 0.01 per 1000 live births;
- 7.5 By 2015 or earlier:
- Malaria should in any country be reduced to an incidence level of below 5 per 100 000 population, and there should be no deaths from indigenously-acquired malaria in the Region;
 - Every country should show a sustained and continuing reduction in the incidence, mortality and adverse consequences of HIV infection and AIDS, other sexually transmitted diseases, tuberculosis, and acute respiratory and diarrhoeal diseases in children.

TARGET 8 – REDUCING NONCOMMUNICABLE DISEASES BY THE YEAR 2020, MORBIDITY, DISABILITY AND PREMATURE MORTALITY DUE TO MAJOR CHRONIC DISEASES SHOULD BE REDUCED TO THE LOWEST FEASIBLE LEVELS THROUGHOUT THE REGION.

In particular:

- 8.1 Mortality due to cardiovascular diseases in people under 65 years should be reduced on average by at least 40%, particularly in countries with currently high mortality;
- 8.2 Mortality due to cancers of all sites in people under 65 years should be reduced on average by at least 15%, with mortality due to lung cancer reduced by 25%;
- 8.3 The incidence of diabetes-related amputations, blindness, kidney failure, pregnancy complications and other serious health effects should be reduced by one third;
- 8.4 There should be a sustained and continuing reduction in morbidity, disability and mortality due to chronic respiratory diseases, musculoskeletal disorders and other prevalent chronic conditions;
- 8.5 At least 80% of children aged 6 years should be free of caries, and 12-year-old children should have on average no more than 1.5 decayed, missing or filled teeth.

TARGET 9 – REDUCING INJURY FROM VIOLENCE AND ACCIDENTS BY THE YEAR 2020, THERE SHOULD BE A SIGNIFICANT AND SUSTAINABLE DECREASE IN INJURIES, DISABILITY AND DEATH ARISING FROM ACCIDENTS AND VIOLENCE IN THE REGION.

In particular:

- 9.1 Mortality and disability from road traffic accidents should be reduced by at least 30%;
- 9.2 Mortality and disability from all work, domestic and leisure accidents should be reduced by at least 50%, with the largest reductions in countries with current high levels of mortality from accidents;
- 9.3 The incidence of and mortality from domestic, gender-related and organized violence and its health consequences should be reduced by at least 25%.

**TARGET 10 – A HEALTHY AND SAFE PHYSICAL ENVIRONMENT
BY THE YEAR 2015, PEOPLE IN THE REGION SHOULD LIVE IN A SAFER PHYSICAL ENVIRONMENT, WITH EXPOSURE TO CONTAMINANTS HAZARDOUS TO HEALTH AT LEVELS NOT EXCEEDING INTERNATIONALLY AGREED STANDARDS.**

In particular:



- 10.1 Population exposure to physical, microbial and chemical contaminants in water, air, waste and soil that are hazardous to health should be substantially reduced, according to the timetable and reduction rates stated in national environment and health action plans;
- 10.2 People should have universal access to sufficient quantities of drinking-water of a satisfactory quality.

TARGET 11 – HEALTHIER LIVING BY THE YEAR 2015, PEOPLE ACROSS SOCIETY SHOULD HAVE ADOPTED HEALTHIER PATTERNS OF LIVING.

In particular:

- 11.1 Healthier behaviour in such fields as nutrition, physical activity and sexuality should be substantially increased;
- 11.2 There should be a substantial increase in the availability, affordability and accessibility of safe and healthy food.

TARGET 12 – REDUCING HARM FROM ALCOHOL, DRUGS AND TOBACCO BY THE YEAR 2015, THE ADVERSE HEALTH EFFECTS FROM THE CONSUMPTION OF ADDICTIVE SUBSTANCES SUCH AS TOBACCO, ALCOHOL AND PSYCHOACTIVE DRUGS SHOULD HAVE BEEN SIGNIFICANTLY REDUCED IN ALL MEMBER STATES.

In particular:

- 12.1 In all countries, the proportion of nonsmokers should be at least 80% in over 15-year-olds and close to 100% in under 15-year-olds;
- 12.2 In all countries, per capita alcohol consumption should not increase or exceed 6 litres per annum, and should be close to zero in under 15-year-olds;
- 12.3 In all countries, the prevalence of illicit psychoactive drug use should be reduced by at least 25% and mortality by at least 50%.

TARGET 13 – SETTINGS FOR HEALTH BY THE YEAR 2015, PEOPLE IN THE REGION SHOULD HAVE GREATER OPPORTUNITIES TO LIVE IN HEALTHY PHYSICAL AND SOCIAL ENVIRONMENTS AT HOME, AT SCHOOL, AT THE WORKPLACE AND IN THE LOCAL COMMUNITY.

In particular:

- 13.1 The safety and quality of the home environment should be improved, through increased personal and family skills for health promotion and protection, and the health risks from the physical home environment should be reduced;

- 13.2 People with disabilities should have substantially improved opportunities for health and access to home, work, public and social life in accordance with the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- 13.3 Home and work accidents should be reduced as specified in target 10;
- 13.4 At least 50% of children should have the opportunity of being educated in a health-promoting kindergarten, and 95% in a health-promoting school;
- 13.5 At least 50% of cities, urban areas and communities should be active members of a healthy city or healthy community network;
- 13.6 At least 10% of medium- and large- sized companies should commit themselves to practicing healthy company/enterprise principles.

TARGET 14 – MULTISECTORAL RESPONSIBILITY FOR HEALTH BY THE YEAR 2020, ALL SECTORS SHOULD HAVE RECOGNIZED AND ACCEPTED THEIR RESPONSIBILITY FOR HEALTH.

In particular:

- 14.1 Decision-makers in all sectors should take into consideration the benefits to be gained from investing for health in their particular sector and orient policies and actions accordingly;
- 14.2 Member States should have established mechanisms for health impact assessment and ensured that all sectors become accountable for the effects of their policies and actions on health.

TARGET 15 – AN INTEGRATED HEALTH SECTOR BY THE YEAR 2010, PEOPLE IN THE REGION SHOULD HAVE MUCH BETTER ACCESS TO FAMILY- AND COMMUNITY-ORIENTED PRIMARY HEALTH CARE, SUPPORTED BY A FLEXIBLE AND RESPONSIVE HOSPITAL SYSTEM.

In particular:

- 15.1 At least 90% of countries should have comprehensive primary health care services, ensuring continuity of care through efficient and cost-effective systems of referral to, and feedback from, secondary and tertiary hospital services;
- 15.2 At least 90% of countries should have family health physicians and nurses working at the core of this integrated primary health care service, using multiprofessional teams from the health, social and other sectors and involving local communities;
- 15.3 At least 90% of countries should have health services that ensure individuals' participation and recognizes and supports people as producers of health care.

TARGET 16 – MANAGING FOR QUALITY OF CARE BY THE YEAR 2010, MEMBER STATES SHOULD ENSURE THAT THE MANAGEMENT OF THE HEALTH SECTOR, FROM POPULATION-BASED HEALTH PROGRAMMES TO INDIVIDUAL PATIENT CARE AT THE CLINICAL LEVEL, IS ORIENTED TOWARDS HEALTH OUTCOMES.

In particular:

- 16.1** The effectiveness of major public health strategies should be assessed in terms of health outcomes, and decisions regarding alternative strategies for dealing with individual health problems should increasingly be taken by comparing health outcomes and their cost-effectiveness;
- 16.2** All countries should have a nationwide mechanism for continuous monitoring and development of the quality of care for at least ten major health conditions, including measurement of health impact, cost-effectiveness and patient satisfaction;
- 16.3** Health outcomes in at least five of the above health conditions should show a significant improvement, and surveys should show an increase in patient's satisfaction with the quality

TARGET 17 – FUNDING HEALTH SERVICES AND ALLOCATING RESOURCES BY THE YEAR 2010, MEMBER STATES SHOULD HAVE SUSTAINABLE FINANCING AND RESOURCE ALLOCATION MECHANISMS FOR HEALTH CARE SYSTEMS BASED ON THE PRINCIPLES OF EQUAL ACCESS, COST-EFFECTIVENESS, SOLIDARITY, AND OPTIMUM QUALITY.

In particular:

- 17.1** Spending on health services should be adequate, while corresponding to the health needs of the population;
- 17.2** Resources should be allocated between health promotion and protection, treatment and care, taking account of health impact, cost-effectiveness and the available scientific evidence;
- 17.3** Funding systems for health care guarantee universal coverage, solidarity and sustainability;

TARGET 18 – DEVELOPING HUMAN RESOURCES FOR HEALTH BY THE YEAR 2010, ALL MEMBER STATES SHOULD HAVE ENSURED THAT HEALTH PROFESSIONALS AND PROFESSIONALS IN OTHER SECTORS HAVE ACQUIRED APPROPRIATE KNOWLEDGE, ATTITUDES AND SKILLS TO PROTECT AND PROMOTE HEALTH.

In particular:

- 18.1 The education of health professionals should be based on the principles of the HFA policy, preparing them to provide promotive, preventive, curative and rehabilitative services of good quality and helping to bridge clinical and public health practice;
- 18.2 Planning systems should be in place to ensure that the number and mix of health professionals trained meet current and future health needs;
- 18.3 All Member States should have adequate capacity for specialized training in public health leadership, management and practice;
- 18.4 The education of professionals in other sectors should include the basic principles of the HFA policy and, specifically, knowledge of how their work can influence the determinants of health.

TARGET 19 – RESEARCH AND KNOWLEDGE FOR HEALTH BY THE YEAR 2005, ALL MEMBER STATES SHOULD HAVE HEALTH RESEARCH, INFORMATION AND COMMUNICATION SYSTEMS THAT BETTER SUPPORT THE ACQUISITION, EFFECTIVE UTILIZATION, AND DISSEMINATION OF KNOWLEDGE TO SUPPORT HEALTH FOR ALL.

In particular:

- 19.1 all countries should have research policies oriented towards the priorities of their long-term policies for health for all;
- 19.2 All countries should have mechanisms that enable health services delivery and development to be based on scientific evidence;
- 19.3 Health information should be useful to and easily accessible by politicians, managers, health and other professionals, as well as the general public;
- 19.4 All countries should have established health communication policies and programmes which support the agenda of health for all and facilitate access to such information.

TARGET 20 – MOBILIZING PARTNERS FOR HEALTH BY THE YEAR 2005, IMPLEMENTATION OF POLICIES FOR HEALTH FOR ALL SHOULD ENGAGE INDIVIDUALS, GROUPS AND ORGANIZATIONS THROUGHOUT THE PUBLIC AND PRIVATE SECTORS, AND CIVIL SOCIETY, IN ALLIANCES AND PARTNERSHIPS FOR HEALTH.

In particular:

- 20.1 The health sector should engage in active promotion and advocacy for health, encouraging other sectors to join in multisectoral activities and share goals and resources;

- 20.2** Structures and processes should exist at international, country, regional and local levels to facilitate harmonized collaboration of all actors and sectors in health development.

TARGET 21 – POLICIES AND STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2010, ALL MEMBER STATES SHOULD HAVE AND BE IMPLEMENTING POLICIES FOR HEALTH FOR ALL AT COUNTRY, REGIONAL AND LOCAL LEVELS, SUPPORTED BY APPROPRIATE INSTITUTIONAL INFRASTRUCTURES, MANAGERIAL PROCESSES AND INNOVATIVE LEADERSHIP.

In particular:

- 21.1** Policies for health for all at country level should provide motivation and an inspirational, forward-looking framework for policies and action in regions, cities, and local communities and in settings such as schools, workplaces and homes;
- 21.2** Structures and processes should be in place for health policy development at country and other levels that bring together a broad range of key partners – public and private – with agreed mandates for policy formulation, implementation, monitoring and evaluation;
- 21.3** Short-, medium-, and longer-term policy objectives, targets, indicators and priorities should be formulated, as well as the strategies to achieve them, based on the values of health for all, and progress towards their achievement should be regularly monitored and evaluated

APPENDIX 2

ELEVEN ESSENTIAL PUBLIC HEALTH FUNCTIONS PAHO/WHO

- EPHF 1. Monitoring, evaluation and analysis of health status.
- EPHF 2. Surveillance, research, and control of the risks and threats to public health.
- EPHF 3. Health Promotion.
- EPHF 4. Social participation in health.
- EPHF 5. Development of policies and institutional capacity for public health planning and management.
- EPHF 6. Strengthening of public health regulation and enforcement capacity.
- EPHF 7. Evaluation and promotion of equitable access to necessary health services.
- EPHF 8. Human resources development and training in public health.
- EPHF 9. **Quality Assurance in personal and population based health services.**
- EPHF 10. Research in public health.
- EPHF 11. Reduction of the impact of emergencies and disasters on health.

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