Development Strategy for the National Palliative Care Program

National Network for Continuous Care
2011 – 2013

National Health Service
Portugal

Mission Unit for Integrated Continuing Care

Lisbon, June 2011
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<tr>
<td>ACES</td>
<td>Agrupamento de Centros de Saúde</td>
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<tr>
<td>CSS</td>
<td>Cuidados de Saúde Secundários</td>
</tr>
<tr>
<td>CCOMS</td>
<td>Centro Colaborador da Organização Mundial de Saúde</td>
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<td>CP</td>
<td>Cuidados Paliativos</td>
</tr>
<tr>
<td>CSP</td>
<td>Cuidados de Saúde Primários</td>
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<td>EAPC</td>
<td>European Association for Palliative Care</td>
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<td>ECL</td>
<td>Equipa de Coordenação Local</td>
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<td>ECR</td>
<td>Equipa de Coordenação Regional</td>
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<td>Equipas de Cuidados Continuados Integrados</td>
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<td>Equipa Comunitária de Suporte em Cuidados Paliativos</td>
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<td>EIHSCP</td>
<td>Equipa Intra-Hospitalares de Suporte em Cuidados Paliativos</td>
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<td>EU</td>
<td>European Union</td>
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<td>Grupo de Trabalho</td>
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<td>Instituto Nacional de Estatística</td>
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<td>IPOFG</td>
<td>Instituto Português de Oncologia Francisco Gentil</td>
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<td>IPSS</td>
<td>Instituições Privadas de Solidariedade Social</td>
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<td>LI</td>
<td>Lugares de internamento</td>
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<td>MS</td>
<td>Ministério da Saúde</td>
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<td>MFAP</td>
<td>Ministério das Finanças e da Administração Pública</td>
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<td>OMS</td>
<td>Organização Mundial de Saúde</td>
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<tr>
<td>PII</td>
<td>Plano Individual de Intervenção</td>
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<td>Programa Nacional do Controlo de Dor</td>
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<td>PNS</td>
<td>Plano Nacional de Saúde</td>
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<td>RNCCI</td>
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<td>Unidade de Internamento</td>
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<tr>
<td>ULDM</td>
<td>Unidade de Longa Duração e Manutenção</td>
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<tr>
<td>UMCCI</td>
<td>Unidade Missão para os Cuidados Continuados Integrados</td>
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1. INTRODUCTION
This strategic document, addresses the starting point for Palliative Care in Portugal, makes a review of its current status and considers, particularly, the conclusions of the meeting “Benchmarking National Palliative Care”, carried out on December 14, 2010 in the Hospital Magalhães Lemos Auditorium in Porto. Establishing goals and recommendations, identifying the responsibilities for all involved in Palliative Care, according to the priorities defined in the strategy. Then, are presented the targets by 2013 of the National Palliative Care and the "strategy" for its development, based on indicators that could be determined, in which the geographical unit can be both national and regional. The subsequent action plan identifies areas of intervention and action in each of the different levels of palliative care provision.

We hope that, the **Strategy for the Development of the National Palliative Care 2011-2013**, fulfills the important role that all (Ministry of Health Mission Unit of Continuous Care, Providers, Professionals, Patients and Families) assign to it, unifying ideas in debate and (re) guiding, of what currently seems more important to fully implement in the National Palliative Care in 2010, for the Improvement of Health and Welfare of the Portuguese.

The Coordinator of UMCCI
2. GENERAL ASPECTS
2.1 JUSTIFICATION

The 2010’s National Palliative Care (PNCP 2010) is characterized by a systematic set of measures that aims improving care for patients with problems resulting from an incurable and/or severe disease and with limited prognosis, through prevention and relief of suffering, of preparing and managing the end of life and support in the mourning, using the rigorous identification and treatment of problems not only physical but also psychosocial and spiritual, in order to improve the patients and their families quality of life (OMS).

The care provision is developed in a population context, at local, regional or national level and based on the patient identified needs and not just in diagnosis or prognosis, so that may be structurally introduced in the early stages of disease (whatever it is), even when other therapies, whose goal is to prolong life, are being administered.

The 2010’s PNCP is led by the Public Administration/Ministry of Health (MOH) and coordinated by the Office of Mission Units for Continuous Care (UMCCCI) and aims to cover the entire population, while respecting the principles of equity, accessibility, quality of care, efficiency, appropriateness and acceptability. For this to materialize, UMCCI continues to carry out continuous monitoring, through registration of a minimum data set in digital form and semi-annual evaluation results, which are available for public consulting in www.umcci.min-saude.pt.

Of the monitoring undertaken by OMS in the PNCP revision, resulted a letter of recognition, where one can read:

"The World Health Organization Collaborating Center for Public Policy for Palliative Care (CCOMS), had participated in the Mission Unit for Continuous Care in drafting the document mentioned above, by Dr. Xavier Gomez-Batiste, hereby express their agreement and ratify the contents of the Proposed Revision of the National Palliative Care."

The planning process of the palliative care needs takes into attention geo-demographic, social, epidemiological principles and mortality rates from the major diseases, for the organization of the health system and implementation of appropriate resources. These characteristics converge to a concerted action, ensuring a response or additional health and social and sustainability of the National Health Service (NHS).

With the progressive increase in the number of elderly population highlights that about 60% to 75% of the population will die after a period of a progressive chronic illness, which may include a situation of advanced illness or terminal. Under this scenario and in order to respond and safeguard the current and future health care
needs of the Portuguese population, the coordination of UMCCI, empowered by the Health Ministry developed the "Development Strategy of the National Palliative Care 2011 - 2013" which is based on four priority axes:

1. Policies for attracting human and structural resources and determining their and organizational models
2. Ensuring quality of care provided;
3. Formation and research;
4. Continuous monitoring and evaluation of the provision of health care.

The implementation of this strategy as well as the axes that support it, are intended for cancer patients and patients with chronic non-cancer evolution, at any age, who require palliative care.

2.2 VISION, MISSION, VALUES AND PRINCIPLES

Vision

Palliative care consists in providing care that meets the needs of people with advanced illness or terminal, as well as their families / caregivers, consisting therefore in an ethical imperative that all are entitled.

Mission

Develop, promote and ensure the provision of palliative care through a network provider of integrated continuous care at different levels of care from the NHS and with the participation of social solidarity institutions and the private sector.
Values

i. The right to the relief of suffering;
ii. Respect for individuality;
iii. Quality of life as set by the patient;
iv. Compassion toward the suffering
v. Consider the expectations of patients and families in RNCCI.

Principles

i. Continuity of care at different levels of CNS;
ii. Coordination at national and regional levels;
iii. Monitoring and evaluation of health care provided at different levels;
iv. Provision of care based on needs and involvement of the patient and family;
v. Provision of care based multidisciplinary / Individual intervention plan (IIP)
vi. Professional Competence in Palliative Care and stimulating continued formation;
vii. Integration of psychological and spiritual aspects of patient care.

2.3 STATUS OF PALLIATIVE CARE IN PORTUGAL

2.3.1 Starting situation

The National Health Plan 2004 - 2010 has identified palliative care as a priority area, focusing on intervention, organization and training in palliative care

In 2005, the study “Palliative Care Facts in Europe” showed that existing resources in Portugal were limited in Portugal and without one organizational model for homogeneous or standardized tools in its management.

The readiness for the provision of Palliative Care at that time in Portugal was 4 Inpatient Units (in-hospital + IPSS), 3 Home care teams and 2 in-hospital teams, which gave response almost exclusive to the users from the services of the hospital itself and which were distributed as follows:

- 4 in-hospital units (in IPOFG Porto, Coimbra and IPOFG Fundão Hospital, Irmãs Hospitaleiras - Belas);
- 1 unit in IPSS (SCM - Amadora);
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- 4 Home care teams (Health Centre of Odivelas, SCM of Azeitão and IPOFG of Porto and IPOLFG of Lisbon).

The inhabitants of the regions of Alentejo and Algarve had no palliative care service. Comparing with regions where resources for palliative care were installed had a low rate of coverage as shown in the table 1. However it is noteworthy that in parallel to providing palliative care, in accordance with the Monitoring Committee of the National Plan Against Pain, where operating Pain Units of three types, set in a hospital and that complemented the palliative care units. Table 2 shows the distribution and number of these Pain Units in 2005 where it appears that the percentage of hospitals with activity in chronic pain in 2005 was about 42%, which shows the existing gap in the organization of specific resources as response to chronic pain.

Table 1. Number of Units of internment units and places of Palliative Care, Portugal Mainland (2005)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of internment units</th>
<th>Number of internment places</th>
<th>Number of inhabitants Portugal Mainland (INE 2005)</th>
<th>Territorial coverage (beds/100.000 hab.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>1</td>
<td>20</td>
<td>3.737.791</td>
<td>0,54</td>
</tr>
<tr>
<td>Center</td>
<td>2</td>
<td>25</td>
<td>2.382.448</td>
<td>1,05</td>
</tr>
<tr>
<td>LVT</td>
<td>1</td>
<td>8</td>
<td>2.779.097</td>
<td>0,29</td>
</tr>
<tr>
<td>Alentejo</td>
<td>0</td>
<td>0</td>
<td>765.971</td>
<td>0</td>
</tr>
<tr>
<td>Algarve</td>
<td>0</td>
<td>0</td>
<td>416.847</td>
<td>0</td>
</tr>
<tr>
<td>Total (Mainland)</td>
<td>4</td>
<td>53</td>
<td>10.082.154</td>
<td>0,53</td>
</tr>
</tbody>
</table>

Fonte: Palliative Care Facts in Europe for 2005; INE - Estimativas da População
Table 2. Distribution by region of UDC, 2005

<table>
<thead>
<tr>
<th>Region</th>
<th>Hospitals with Activity in Chronic Pain in 2005</th>
<th>Number of Units by type of Chronic Pain (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N.º</td>
<td>%</td>
</tr>
<tr>
<td>North</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Center</td>
<td>18</td>
<td>50%</td>
</tr>
<tr>
<td>LVT</td>
<td>15</td>
<td>36%</td>
</tr>
<tr>
<td>Alentejo</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Algarve</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>42%</td>
</tr>
</tbody>
</table>

Fonte: Comissão de Acompanhamento do Plano Nacional de Luta Contra a Dor, 2005

In the evaluation in 2008, the study Palliative Care in the European Union showed that despite the late start of the organization of Palliative Care in Portugal, compared to other European countries, showed an accelerated development and an homogeneous organizational model for implementation due to well formed human resources and favorable legislation and financial model.

In the numbers published in 2008 in the European Parliament document - Palliative Care In The European Union-related to the resources available at the different countries, Portugal has developed substantially in the existing solutions since then, as recognized by the OMS. In the Chart 1, referring to the number of beds per million inhabitants, Portugal has developed from 5.05 to 20 in just three years corresponding to an increase of 296%
In terms of ECSCP and ECCI which provide palliative care, the developments are presented in Chart 2.
2.3.2 Normative mark

✓ Integrated with the NHS and with the offer in coordination with existing resources in hospital and in primary health care (PHC) is created, in 2006 the RNCCI by Decree Law nº101/2006, dated June 6, assuming an opportunity to impulse the development of an inpatient and outpatient in Palliative Care and appears against the diagnosis of the situation on palliative care in Portugal and health policies under the government program.


which one of the strategic objectives is to promote the diversification and the availability of home-based care and interaction with RNCCI.

✓ A working Group (WG) is nominated by the Minister of Health in 2007 by order nº28941 of November 22, with a view to conduct a review of PNCP of June 15/2005 adapting to the requirements of WHO.

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✓ In July 2008 was presented by WG a PNCP proposal and put into public discussion through which has been a new version of the program and delivered in late 2008.

✓ Decree Law Nº 28/2008 of February 22 - Create groupings of health centers (ACES) in which to accomplish its mission, among others, the ACES active health promotion and disease prevention, care and disease in connection with other services for continuity of care. They also develop activities for epidemiological surveillance and health research through the functional units to provide health care.

✓ Orders Nº 10279 and 12280 (amended by Nº. 3286/2009 of January 19) apply to reimbursement of the medication needed to treat moderate to severe cancer pain.

✓ Decree Law Nº. 81/2009 of April 2, establishing competences for epidemiological surveillance identifies health needs, evaluates the impact of health interventions and management of programs and projects in the defense areas protecting and promoting health among other functions relating to Public Health.

✓ In March 29, 2010 is approved the revision of PNCP by order of the Minister of Health concluding the intervention of WG appointed by the order 28941/2007, and gives the responsibility for presenting the Operational Plan which implements the PNCP in the NHS in the next three years to UMCCI.

2.4 Current Situation

2.4.1 Palliative Cares needs

Ensured and regulated by UMCCI, national coordinator of the RNCCI is responsible for the operationalization of the National Palliative Care (PNCP) the provision of palliative
care in the National Integrated Continuing Care (RNCCI) is based on an intersectorial and multidisciplinary approach. According to the European Association for Palliative care (EAPC) there are different levels of inpatient services in palliative care, depending on the complexity answered which justifies the operational targets - regional socio-demographic characteristics of the regional-of PNCP. In order to respond to different levels of needs among the patients, PNCP takes into account the ratios of resources at different levels - for EIHSCP (Team Intra-Hospital Support in Palliative Care), the number of beds in Care Units Palliative (UCP) in acute hospitals and out of them, for ECSCP (Community Support Team in Palliative Care). The Hospitals, RNCCI and Primary Health Care (PHC) inclusion aim to flexibility and ability to meet the needs of local and regional urban areas, semi urban, rural and sparsely populated. Particularly in these cases are relevant the interdisciplinary teams home with a flexibility of roles and responsibilities are relevant as well as teams who develop inter-hospital functions to the community and supports units of Internment RNCCI. Otherwise, the metropolitan areas have another model of Palliative Care with different levels of complexity compared to rural areas or small areas which often have more limited resources and transversal support teams.

"The planning services relies on existing needs," that is determined as a result of this variability and context specificity based on:

- **Area Type**: urban, semi-urban, rural;
- **Existing resources**;
- **Pathologies threatened** (cancer, dementia, AIDS, others);
- **Complexity** (medium/ high);
- **Mortality** (prevalence).

For the respective numbers of beds we found the following values based on these premises:

- **20-30% of integrated UCP in hospitals** (over 250 beds and specialized in oncology). 30% corresponds to the number of places of internment that would be located at 19-24 per 1 million inhabitans;
- **40-60% in UCP of the RNCCI**: Considering 50% the number of places of internment would be located at 32-40 beds per 1 million inhabitans;
- **20-40% of nonspecific CP units of RNCCI**. The number of places of internment would be located at 13-16 beds per 1 million inhabitants considering the 20%.
2.4.2 Health Care Conceptual Model

The provision of palliative care should be done by professionals with specific training providing the comfort and patients quality of life. The National health Services conceptualizes palliative care as care cross to ensure the involvement of caregivers in the usual patients way of life.

General Measures:

The dissemination of knowledge and consequent enhancement of quality of palliative actions arises through the measures adopted by all health services to improve the delivery of care (protocols, training, etc.) as well as the training level of the Primary Health Care along with supervision and support through ECSCP, EIHSP or Palliative Care Unit and its innovation.

In this sense one can consider a model consisting of:

1. Combine the general measures in conventional services, whose existence is simultaneous with specific services.
2. Intervention teams and services based on specific needs, and complexity, not only on the prognosis.
3. Preventive intervention, flexible and shared by teams and specific services.

“With a focus on palliative care domiciliary care are not separate from the NHS which is an integral element”.

Specific Measures:

- The **Support Teams**: Multidisciplinary in hospital or at home - specific teams or teams composed of elements with training in palliative care.

- **Units in Hospitals** and **Inpatient Units** in RNCCI Internment.

**We must consider in the organization of Services Palliative Care:**

- Is through a network of services, such as structures of admission to home care and support teams in hospitals and communities that palliative care is provided according to the needs of patients with intense suffering, incurable disease and with an advanced or progressive disease.
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✔ The average/advanced formation (classrooms or internship programs) should be required for leaders of major professional groups performing palliative care. Embedded in these health care systems palliative care requires rigorous techniques in order to provide the best services for the neediest ones.

✔ The structure (type of inpatient units, support and home support), the type of patient to attend (stage of illness, disease, levels of complexity) and the implementation of medical units require a well trained team for palliative care.

In addition to intra-hospital support PNCP provides that EIHSCP provide consultancy support to the inpatient units of palliative care of RNCCI and ECCI. So the consultant teams would enhance their ability in continuing education programs screened routinely their activities.

Groupings of Health Centers (ACES) are important in the planning of resources in the Local Coordinating Team (ECL) and at Continuous Care Teams (ECCI) and also in conjunction with the Public Health Unit (USP), which serves as a health centre geo-demographic ACES area.

Figure 1 shows the organizational model of RNCCI to provide palliative care services.
2.4.2.1 Evolution and preview of resources

The current situation of the provision of palliative care is expressed in:

- Number of providers;
- Number of places of internment (LI);
- Activity data and pathologies attended;
- Accomplished formation;
- Technical skills cleared in the teams.

By observing the data of the provision of palliative care available since 2006 until this year, you can observe, in terms of places of internment for palliative care in hospitals and in the internment units for palliative care (UCP) of RNCCI, that the ratios coverage are below those of PNCP (6-8 beds per 100,000 population), as shown in Table 3.
According to data from UMCCI in 2010 the number of inpatient units belonging to RNCCI were around 15 while the number of teams providing palliative care, divided into teams of Intra-Hospital Support in Palliative Care (EIHSCP) and teams of Integrated Continuous Care (ECCI) with training in palliative care, corresponded to 15 and 40 teams, respectively, in August 2010.

Since 2006 until November 2010, the total number of clients assisted in the UCP RNCCI stands at 4183, having been referenced to these units a total of 5178 users, which is a percentage of the number of service users at around 81% as can be seen in Table 4.

The evolution of the number of patients admitted to RNCCI in UCP from 2006 until the first semester of 2010, table 4, shows that responses are increasing, but still considered insufficient for the needs of patients, reaching the occupancy rate in 2010 of 91% and an average delay of stay of 28.5 days at the national level, represented in table 5.
Table 4. Number of referenced patients for the UCP and other types of RNCCI since 2006 until today

<table>
<thead>
<tr>
<th>Period</th>
<th>Referenced patients</th>
<th>Inter-annual increase</th>
<th>Assisted patients</th>
<th>Inter-annual increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.10.2006-31.12.07</td>
<td>255</td>
<td>-</td>
<td>270</td>
<td>-</td>
</tr>
<tr>
<td>2008</td>
<td>1.408</td>
<td>452%</td>
<td>645</td>
<td>139%</td>
</tr>
<tr>
<td>2009</td>
<td>2.198</td>
<td>56%</td>
<td>2.018</td>
<td>213%</td>
</tr>
<tr>
<td>01.01.10-15.08.10</td>
<td>1.317</td>
<td>-</td>
<td>1.250</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>5.178</td>
<td>-</td>
<td>4.183</td>
<td>-</td>
</tr>
</tbody>
</table>

Fonte: Relatórios de monitorização do desenvolvimento e actividade da RNCCI 2007, 2008 e 2009 e dados ad-hoc 1º semestre 2010, UMCCI

Table 5. Average delay and occupancy rate in the UCP RNCCI (2007-2010)

<table>
<thead>
<tr>
<th>Period</th>
<th>Average delay of internment</th>
<th>Occupancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.10.06 – 31.12.07</td>
<td>26</td>
<td>70%</td>
</tr>
<tr>
<td>2008</td>
<td>32</td>
<td>s.d.</td>
</tr>
<tr>
<td>2009</td>
<td>25</td>
<td>89%</td>
</tr>
<tr>
<td>2010</td>
<td>31</td>
<td>91%</td>
</tr>
<tr>
<td>Média</td>
<td>28,5</td>
<td>83%</td>
</tr>
</tbody>
</table>

Fonte: UMCCI
Table 6. Most common diagnoses at the UCP of RNCCI (2010)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncological Diseases</td>
<td>87%</td>
</tr>
<tr>
<td>Neuro-degenerative diseases</td>
<td>7%</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>3%</td>
</tr>
<tr>
<td>Other diagnoses</td>
<td>3%</td>
</tr>
</tbody>
</table>

Fonte: UMCCI

Regarding the previous table we can observe that the most frequent diagnosis in the UCP of RNCCI in the first half of 2010 were the oncological diseases (87%), to which followed the neurodegenerative (7%), cardiovascular (3%) and other diagnoses which include diseases of the respiratory system (2%) (UMCCI, 2010). It shows us that, the Palliative Cares of the RNCCI are intended mainly for patients in oncology and are provided to terminally ill patients, because the average time of hospitalization until death is 5 days, Table 6.

We emphasize here the need to change this approach to palliative care, which requires from of all of the health professionals, a team work of changes, that allows to set early in the illness a plan of care, by establishing a relationship of support and security between patients and their families and the health professionals who support them, enhancing, therefore, the results of health care provided.

Concerning the quality indicators of the process of referral of clients for the UCP of the RNCCI, in the first semester of 2010, the average delay of admission in these units stood at 7 days, and this average time ranges from two days (North, Alentejo and Algarve) up to 20 days in LVT (UMCCI, 2010), which is directly related to the places of internment available in various types of RNCCI and volume of demand.
In what concerns to training activities undertaken by UMCCI in the area of palliative care, between 2006 and 2010 were held 21 formation sessions, which comprised a total of 542 participants (UMCCI, 2010).

Despite formation efforts initiated, there is still a lack of training in palliative care. According to a survey conducted in December 2009 (UMCCI), applied to the professionals of several ECCI in the country, it was found that the universe of respondents (68%), 36% of doctors and 18% of nurses reported having no formation in palliative care. Figure 3 illustrates the results.

*Chart 3. Level of formation in palliative care among professionals from ECCI*

In tables 7 and 8 we can observe the current situation in terms of structural resources, as well as its preview based on ratios established in PNCP, to be achieved at the end of the implementation in 2013.
### Table 7. Coverage ratios of needs, number of resources foreseen in the PNCP

<table>
<thead>
<tr>
<th>Type</th>
<th>Current situation</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EIHSCP</strong></td>
<td>15 Equipas</td>
<td>1 per hospital</td>
</tr>
<tr>
<td><strong>Internment places (LI)</strong></td>
<td>-</td>
<td>648 – 810 LI</td>
</tr>
<tr>
<td><strong>30% in acute hospitals</strong> (hospitals with more than 250 beds and specialized in oncology) designed to an acute and complex profile.</td>
<td>50 LI, between 21% a 26% of expected.</td>
<td>194 to 243 LI</td>
</tr>
<tr>
<td><strong>50% in UCP of RNCCI, for treatment for chronic conditions and less complex</strong></td>
<td>126* LI of UCP in the RNCCI (Agosto 2010): between 31% to 39% of expected.</td>
<td>324 to 405 LI</td>
</tr>
<tr>
<td><strong>20% for the provision of CP, in non-specific RNCCI.</strong></td>
<td>-</td>
<td>Between 130 to 162 LI</td>
</tr>
<tr>
<td><strong>ECSCP</strong></td>
<td>In the PNCP are considered not fulfilled the necessary conditions for its generalized development in the short term.</td>
<td>Will be planned its creation in areas where the population density to justify it.</td>
</tr>
<tr>
<td><strong>ECCI with formation in CP</strong></td>
<td>40 ECCI with formation in CP.</td>
<td>1 ECCI per UCC with formation in CP.</td>
</tr>
</tbody>
</table>

It is noteworthy that 66% (83 LI) of installed capacity comes from the conversion of resources of hospitals services.

Under the program Model I and II, were awarded financial support that allows to extend the number of LI in 190 (99% predicted).

**Sources:**
- PNCP, 2009
- Population estimates 2008, INE
- Installed capacity in the RNCCI August 15, 2010 (UMCCI)
- HR Survey of the ECCI with specific formation in CP, 2009 (UMCCI)
Table 8. Number for places of internment in Palliative Care needed in Portugal, by level and by region, according to 80% of international ratios

(Valor máximo: 80 LI por 1 M habitantes. Valor mínimo: 64 LI por 1 M habitantes)

<table>
<thead>
<tr>
<th>Region</th>
<th>Population (INE 2008)</th>
<th>Total number of LI in CPI needed in Portugal mainland (80% international ratios - Minimum and maximum)</th>
<th>Total number of LI in UCP in acute H. (30%)</th>
<th>Total number of LI in UCP of RNCCI (50%)</th>
<th>Total number of LI in UI of RNCCI non specified in CP (20%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>3.745.439</td>
<td>239 299 72 90 120 150 48 60</td>
<td>72 90 120 150 48 60</td>
<td>48 60</td>
<td></td>
</tr>
<tr>
<td>Center</td>
<td>1.786.692</td>
<td>114 143 34 43 57 71 23 29</td>
<td>34 43 57 71 23 29</td>
<td>23 29</td>
<td></td>
</tr>
<tr>
<td>LVT</td>
<td>3.665.613</td>
<td>234 293 70 88 117 146 47 59</td>
<td>70 88 117 146 47 59</td>
<td>47 59</td>
<td></td>
</tr>
<tr>
<td>Alentejo</td>
<td>507.481</td>
<td>32 41 10 12 16 20 6 8</td>
<td>10 14 17 5 8</td>
<td>5 7</td>
<td></td>
</tr>
<tr>
<td>Algarve</td>
<td>430.084</td>
<td>27 34 8 10 14 17 5 7</td>
<td>8 10 14 17 5 7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>10.135.309</td>
<td>648 810 194 243 324 405 130 162</td>
<td>194 243 324 405 130 162</td>
<td>130 162</td>
<td></td>
</tr>
</tbody>
</table>

Fonte: PNCP, 2009; INE - Estimativas da população, 2008

Table 9. Number for places of internment for CP in existing hospitals to 30.11.10 and number of for places missing, according for the international ratio (80%)

<table>
<thead>
<tr>
<th>Region</th>
<th>No. LI in UCP - acute H. (30% of international ratios)</th>
<th>No. LI of UCP in Hospitals (30.11.1010)</th>
<th>No. LI of UCP at Hospitals lacking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum value</td>
<td>Maximum value</td>
<td>Minimum value</td>
</tr>
<tr>
<td>North</td>
<td>72</td>
<td>90</td>
<td>20</td>
</tr>
<tr>
<td>Center</td>
<td>34</td>
<td>43</td>
<td>25</td>
</tr>
<tr>
<td>LVT</td>
<td>70</td>
<td>88</td>
<td>5</td>
</tr>
<tr>
<td>Alentejo</td>
<td>10</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Algarve</td>
<td>8</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>194</td>
<td>243</td>
<td>50</td>
</tr>
<tr>
<td>%</td>
<td>-</td>
<td>-</td>
<td>21-26%</td>
</tr>
</tbody>
</table>

Fonte: PNCP, 2009; INE - Estimativas da população 2008
In what concerns to the technical competence of the ECCI to provide palliative care, the results of the survey conducted in 2009, table 10, show us the need of a formation plan for these teams.

Table 10. Technical competence of the ECCI at Palliative Care

<table>
<thead>
<tr>
<th>Technical competence by the ECCI to provide CP</th>
<th>%</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t have</td>
<td>38%</td>
<td>-</td>
</tr>
<tr>
<td>Has technical competence</td>
<td>23%</td>
<td>-</td>
</tr>
<tr>
<td>Has competence but requires specialized backup support</td>
<td>39%</td>
<td>68% Uses services in hospitals; 32% Uses other ECCI.</td>
</tr>
</tbody>
</table>

Universe of answer: 57
Source: Survey ECCI (2009)

2.4.2.2 Interconnection with other programs of the PNS

The National Programme for Control of Pain (PNCDOR) 2008, states that ".... The cancer pain often viewed as a major cause of chronic pain represents a small percentage of patients who suffer of chronic pain, however, it has a particular significance by the condition of being the second cause of death in Portugal and for existence of moderate to severe pain in 90% of patients suffering terminal cancer. " The generalization of the evaluation and register of pain intensity might have a significant impact in the treatment of pain in the units providers of health care and provide a qualitative leap in the humanizing of care they provide"

The fulfillment from guidelines of the Normative Circular of 14/06/2003, from the General Administration of Health, in wish is required the register and regular evaluation of pain intensity at all types of RNCCI, is a good clinical practice and is considered one of the indicators for quality of the provision of health care RNCCI.

The implementation of the National Program of Control of Pain assumes the participation and cooperation of several entities related to the health sector, including the CSP, Health Care Hospital (CSH), the National Network of Continuous Care, linking the areas that are tangent to PNCP, with specific formation and further intervention
measures which aim strengthening the organizational capacity and development of a good practice in the management of pain approach models.

The Development Program of Prevention and Disease Control in the Oncology 2007/2010, in which the operational aims in the area of CP for 2010 include: Promotion and implementation of instruments to evaluate symptoms and quality of life, creation of a team or palliative care unit in all hospitals included in the referral network, publishing of recommendations for supportive care and palliative care to cancer patients. The achievement of these goals will necessarily be a major breakthrough in providing palliative care either within the network either for the whole NHS.

For the next three year period 2011 – 2013, will be strengthen the coordination with these and other programs of the National Health Plan 2011 - 2016, as well as scientific societies, professional bodies and civil society, with the aim of improving the disciplinary and Multidisciplinary conduct in providing palliative care. Work experience and the growing membership of professionals for the creation of multidisciplinary teams for palliative intervention active in critical illness, incurable and progressive and support in the terminal stage of life, is already an evidence that palliative intervention can be integrated at all levels of care in the NHS and is also an integral part of health care and social support that the RNCCI relies in.

2.4.2.3 Conceptual model of the level of needs from patients in CP

Studies carried out, estimate that 37.5% of patients with palliative care needs suffer from intermediate or complex situations that may require the intervention of specific palliative care teams and the remaining 62.5% are suffering from situations that could be resolved at the level from CSP, although all patients can move around at any moment during the course of the disease at different levels of care, as in the following figure.
These flows are guaranteed in RNCCI through the mobility processes in the network, from the ECCI, EIHSPP, UCCI, UCP ECSCP.

It means that it is advisable a basic level of formation in all units of RNCCI and advanced level for caregivers of a user population of 37.5% of all patients with palliative care needs.

We may, beside these studies, combining with studies of other authors, at which they advance to establish an adequate cover care teams in specific palliative care for 60% of cancer patients and 30% for not cancer patients, just taking into account only the 9 selected causes by McNamara, heart failure, kidney failure, liver failure, chronic obstructive pulmonary disease, neurodegenerative diseases (amyotrophic lateral sclerosis, Parkinson's disease, Huntington's disease, Alzheimer's disease) and HIV / AIDS.

This means that each country can match the answers to their needs, according to the human and financial resources available.

Observing the following figure we can see the Organizational Model for Palliative Care of OMS, in which palliative care apply earlier during the illness, combined with other treatments that can prolong the lifetime of the patient. This kind of approach of the
team to meet the needs of the patient / caregiver provides a better care delivery that will influence the quality of life and course of the disease.

*Figure 4. Organizational Model of Palliative Care, OMS*
2.5 THE INFORMAL CAREGIVER: A VALUE RESOURCE

The multi and interdisciplinary approach necessarily implies a new way to include the informal caregiver in the care plan not only to educate the patient, but also himself, towards their vulnerability, due to the impact of the disease in the caregivers. Nowadays, the caregiver's role became clearer and absolutely necessary in the evolution of a society that is needed more human in the provision of full health care, which together with other providers of health care contributes to the physical well-being, psychological and emotional of the patient. For all these this reasons it is necessary to protect him from the increased risk of physical and mental illness, than the rest of the population, as well as support the needs identified.

The RNCCI integrating the informal caregiver / family in your care program through Integrated Intervention Plan (IIP) in all types of the network and also "The unity of long-term maintenance can provide the internment for a period less than expected in the previous number (90 consecutive days) in the temporary situations, resulting from family support difficulties or need of rest of the primary caregiver, up to 90 days." This caregiver beyond from health gains that represents for the patient, is also an economic added value, from the point of view of cost to health care and social security, making it an important pillar to be considered in the any program supporting directed to these two components, centered on the patient continuous integrated care requirement, specifically in the area of Palliative Care.

In situations where you lose the autonomy to self-care, people receive support from their relatives, according to multiple studies on this subject, concluded that "... 80% of the time committed in the health care is offered as informal care, compared to 12% of the time that is dedicated from the formal system, including public and private." Therefore, it can be considered that are fundamental to the health of the patient, as can gives a great value to the habits and customs to those receiving it, adding customized forms of care. Therefore it is necessary to consider the informal systems of health as an important resource for both the sick and for communities and health institutions.

In this context, family and the nearby social environment must be considered from the beginning, as part of the intervention process. In fact, home is the place where terminally ill patients spend most of their time and it is here that families provide 80 to 90% of the care, although they might die in the hospital.

According to Palliative Care in the European Union, the rate of patients who die at home, have been suggested as an indicator of quality, given that patients prefer to
remain at home until death. Despite this, in Europe almost two thirds of the patients spend their last days in the hospital.

It is probably for this reason that informal caregivers have a higher mobility and therefore should be targeted of intervention.

In Portugal there are no studies that tell us how many patients and which the main diseases, that are at home at care of the informal caregiver.

The recognition of the needs of the caregivers and support the implementation of intervention programs targeted to them are of essential importance for each one can decide in the how to provide the best care to their sick relative.
3. STRATEGIC GUIDELINES DEVELOPMENT
3.1 REGARDS

The evolution of the Continuous Care in its side of palliative care in most European countries, in conjunction with scientific and technical advances in this area, gave the knowledge of the characteristics of advanced disease or terminal, the criteria of definition of the levels of care, of the identification of people's needs and the specific reality of patients and families that should be included in the care plan of Palliative Care. There are several models of intervention, based on different levels of complexity.

Palliative Care in the PNCP is intended essentially to patients, having limited life prognosis, intense suffering, problems and needs of difficult resolution requiring special support, organized and interdisciplinary. It also discusses the criteria of priority and intervention that must be considered multi-factorial and related to the complexity that patients have.

The several dimensions of the care provision at patients in the advanced or terminal stages of illness are of major importance, having their elements classified in the following big groups: disease assessment, physical, psychological, social, spiritual needs and cares in agony, and grieving process. There are no universally recognized indicators to evaluate the palliative care effectiveness. Better structural quality (ratios of professionals, population coverage and coverage areas) does not necessarily mean better results, given that factors such as motivation and enthusiasm, or volunteer work, can significantly contribute to the results. The holistic approach and empathetic, central to palliative care, it is difficult of assess.

The PNCP by outlining the operational goals, calls the attention to the Regional Health Administrations of his dynamic role in local responses to ensure adequate and quality solutions to the target population, ensuring the existence of different formation sites, respecting the continuity of care principle and promoting effective coordination between the different types and levels of CP in each geographic area.

Identifies and defines the structural and functional requirements: Palliative Care Unit, Hospital Support teams, Community Support Teams.

The development strategy of the National Palliative Care is the result of the evaluation of an entire implementation effort already conducted at national level and still being carried on, accepted by the different professionals at the different levels of care. Embody, also, the operational program through their priority axis, establishing guiding principles and recommendations, and also an action plan at national and regional levels, in order to be realized by the end of 2013.
Allows more flexibility in the development of the operation through regions, so that at different levels of development in the respective program in late 2013 to jointly have achieved all the objectives presented in accordance with the priority axis.

3.2 PRIORITY AXIS I - Political fundraising and determination of the organizational models

General Objective 1

To have an organizational model at the level of structural and human resources of palliative care, according to the needs of patients in a process of continuity of care in five regions of the country in late 2013, that replies to all patients in needs of Palliative Care.

Specific objectives:

1.1 Establishing a Palliative Care Program, integrated into regional plans in all regions of the country

Recommendations

✓ All regions should have a regional palliative care program in late 2013, with objectives and operational goals, including levels of care, organic and functional dependencies, and quality assurance, monitoring and evaluation indicators.
Continuous Care Mission Unit
Development strategy for the National Palliative Care Program

1.2 That all the teams who provide palliative care including home visits, have a referential support, particularly on more complex situations.

Recomendações

- Improve the channels of informal communication with the "target services", including the units of pain management;
- Encourage the creation of in-hospital consulting;
- Promote the creation of places of internment in short term;
- Promote the "visiting relationship" / familiarize the user with the C.P. teams;
- Establish a regional references network for more complex cases.

1.3 Provide palliative care to all patients who are living in assisted residences, nursing homes, institutions, on equal terms comparing with the general population.

Recommendations

- Improve the interconnection with the local authorities mentioned above, in order to survey the CP needs;
- Simplify the access of the CP teams to the relative entities;
- Cursos de formação em CP a cuidadores e trabalhadores destes serviços.

1.4 Implement a supporting system and follow the emotional aspects of professionals working with patients in advanced / terminal stage.

Recommendations

- Interconnect at regional level with the Colleges of Psychology in the support and supervision through partnerships / protocols;
- Develop protocols and specific measures to identify risks and vulnerabilities, particularly, stress, the need to rest, emotional support and recognition of accomplished work.
General Objective 2

1.1 Ensure mobility between different levels of the NET swiftly, for the Palliative Care.

Recommendations

✓ Adapt at regional level, the measures to ensure a swiftly response to the identified cases;
✓ Promote the active management of waiting lists, by users priority;
✓ Ensure the appropriate reply to the needs of the patient / informal caregiver;

General Objective 3

1.1 Promote the informal caregiver as an important factor in the comfort and welfare of the patient.

Recommendations

✓ Support any eventual request to rest from the informal caregiver, as a response of improvement provision of health care;
✓ Ensure education / information / formation of caregivers and enhance their role in providing care;
✓ Establish the necessary partnerships (particularly colleges) to identify / boost / train voluntary actions aiming the creation of a specific CP voluntary movement.
3.3 PRIORITY AXIS II - Ensuring quality care

General Objective 4

By late 2013, be able to provide patients with advanced or terminal disease, as well as their families / caregivers, adequate health care and integrated into the National Health Service (SNS) through the RNCCI.

Specific objectives:

1.1 Identifying patients with advanced or terminal disease

*Recommendations*

✓ Adopt criteria to define and identify situations with needs of palliative care at different levels of care, CSP, CH, and RNCCI, based on the “Gold Standards Framework”.

1.2 Have a therapeutic and interdisciplinary plan of care, Individual Intervention Plan (IIP), a work tool to be applied to all patients requiring CP.

*Recommendations*

✓ Include in this tool the pain classification and other symptoms which include identifying non-compensation risk factors, functional capacity and addiction level, cognitive recovery, psychosocial evaluation, therapeutic plan, individual intervention plan;
✓ Apply to all the CP working teams, the established working tool;
✓ Apply the symptoms evaluation tool, at established periods, for all CP services / teams providers;
✓ To fulfill with the recommendations for supportive care and palliative care to cancer patients (Goal for 2010 - National Plan for Prevention and Control Cancer);
✓ Promote the teaching to the patient (advanced care planning) – foresee a list of predictable scenarios of CP needs
1.3 Evaluate the patient's family, with special emphasis on the primary caregiver, with the purpose of preventing fatigue, promote self-care and trust in the team.

**Recommendations**

- Adopt a scale to evaluate the health status of primary caregiver
- Monitoring the impact on RNCCI from the demand for the caregiver rest hospitalization type and to identify the health problem that contributed most to this request;
- Evaluate the need of psychosocial support in the grieving process, after death.

1.4 Evaluate the capacity to care and provide educational support to caregivers.

**Recommendations**

- Promote and emphasize in the individual intervention plan, the primary caregiver of the patient and their family and social support network;
- Promote the teaching of informal caregivers (in person or telephone) as well as their effort;
- Implement a protocol to identify the risk of "failure" of the main caregiver;
- Implement a risk protocol of pathological pain, which includes children, teenagers, spouses of advanced age and people with little or no social support;
- Establish protocols with specialized services (psychology, psychiatry) for complex pain situations.

1.5 Continuous monitoring of the patients to whom are provided CP in advanced or terminal phase in the context of the UCP.

**Recommendations**

- Develop an Information System for CP.
- Particular attention to pressure ulcers, falls, confusion syndromes and incontinence.
- Recognize / identify patients with difficulties in oral expression of pain and evaluate it through direct observation of informal caregivers.
- Systematically evaluate the satisfaction of patients and families to whom are provided care.
General Objective 5

Provide all patients with advanced or terminal disease, the best care based on best practices and scientific evidence.

Specific objectives:

1.1 Apply the intervention model of palliative care, transversal along the disease, until the terminal phase.

Recommendations

✓ Improve the "information" and basic formation in palliative care among all health professionals;
✓ Lead, the "Information Campaign" to citizens about Palliative Care

1.2 Implement action guides for clinical practice according with quality standards established in the SNS.

Recommendations

✓ Develop clinical practice guidelines, with the collaboration and agreement among different professionals, according with the complexity of care.
✓ Establish a plan to make its promotion.
✓ Promote pilot projects of palliative intervention and to promote them.

3.4 PRIORITY AXIS III - Formation and research

Beginning

Being the oncologic pathology the greater demand for internment in the network to the typology of palliative care so far, the accessibility to the treatment of cancer pain, it’s therefore, an imperative and an ethical duty to the patient with cancer, preventing the fatality of disease continues to be followed with the expectation of a painful suffering unavoidable. Should be considered as a sensory experience, emotional, social, subjective and unpleasant.

The formation is one of the basic pillars for development of Palliative Care by registering this at different levels of care provision from different professionals, but also the creation of "standard" formation and certification skills for curriculum implementation of future professionals.
The purpose of basic formation is to enable knowledge for palliative action and to recognize the appropriate referral of patients to different levels of Palliative Cares.

The UMCCI did a survey in terms of types of RNCCI providing Palliative Care; of the professionals with formation in the palliative care area; being the ECR responsibility of to identify formation needs. The provision of palliative care within the network obliges specific formation (Section 2, art.40 of Dr.n 101/2006 of 6 June).

In this context the UMCCI established the formation following principles:

- **Partnership with the Portuguese Institute of Oncology Lisbon Francisco Gentil, EPE (IPOLFG) to be a reference center in Palliative Cares, with elements of theoretical and practical formation and expert consulting:**

- **Formation of about 1,000 professionals who will provide care in the RNCCI’s inpatient units in Chronic Pain and Palliative Care**

- **Specific Mentoring**

### General Objective 6

Establish in along with the National Program Coordinator for the Control of Pain, a timeline for formation appliance in this area, considering the RNCCI needs and giving priority to existing resources in the field.

### Specific Objectives:

1. **1.1 Ensure that all professionals working in CP, dispose of adequate formation at the level of care they provide**

   **Recommendations**

   - Develop the creation of formation centers at regional level;
   - Promote a survey for the formation needs on CP, in the different professional areas at regional level;
   - Encourage / Promote regularly continued formation programs on CP by professional area and / or multidisciplinary at regional level, scheduled and with formative contents to be annually advertised
   - Ensure formation for professionals according with the level of complexity of the patients under their care.
1.2 Aware the other professional areas working in CP for specific formation and the significance of interdisciplinary work in the support of the patient / informal caregiver.

**Recommendations**

- Encourage the formation of all doctors of CSP for the referral of users with CP needs;
- Promote among other relevant areas in patient support / informal caregiver (psychology, sociology, physical therapy, and others), a specific formation to work with this type of patient;
- Promote peer discussion;
- Value the "Spirituality" as a factor of comfort and the patient welfare.

**General Objective 7**

1.1 Setting at national, regional and local levels, priority research areas and promote financing mechanisms, with the Ministry of Health, nongovernmental organizations dedicated to research and study of cancer and other chronic disabling illnesses.

**Recommendations**

- Do a survey and advertise the number of works and articles published, financed and/or supported by UMCCI and also specific projects that add value to RNCCI in the area of CP;
- Encourage scientific communities, professional associations and others developing priority investigation contents;
- Promote thematic networks construction in CP in an integrated and interdisciplinary way;
- Promote research of RNCCI potential needs, of a possible 24-hour telephone coverage every day of the week, to the patient and their caregivers at home in an integrated way, avoiding unnecessary use of emergency services and hospital (mainly a regional and linked with the referral network by complexity).
3.5 PRIORITY AXIS IV - Continuous monitoring and evaluation

General Objective 8

Integrate in the RNCCI’s Information System the minimum data registry necessary for monitoring the best practice in CP.

Recommendations

All regions should proceed with the periodic and systematic monitoring indicators consensual with the national level, including those to be established in PNS 2011-1016.

3.6 INDICATORS AND TARGETS

With regard to the monitoring and evaluating indicators for the quality of care, will be published by the UMCCI, following the WHO guidelines and the European Parliament "the guarantee of the quality of palliative care is necessary but the discussion about quality evaluation and ideal monitoring it’s still open". Concerning to the others evaluation indicators, they are included in Q.2.

Targets

The National Programme of Palliative Care - 2010 as well as the Strategy for the Development of the National Palliative Care from 2011 to 2013 show the operational targets to be achieved annually until the end of its implementation in 2013, Q.1., Q.2.

The goals presented reflect the health needs in Palliative Care in Portugal and establish a number of possible indicators to determine, so that all the interveners at different levels of care and the care organization monitor the development of respective program
## Table 11. National Program for Palliative Care goals for 2013

<table>
<thead>
<tr>
<th>National Program for Palliative Care goals for 2013</th>
<th>Goals for 2011</th>
<th>Goals for 2012</th>
<th>Goals for 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>InHospital Teams of Support in Palliative Care (EIHSCP)</strong></td>
<td>In 60% of the Hospitals with more than 250 beds</td>
<td>In 80% of the Hospitals with more than 250 beds</td>
<td>in 100% of the Hospitals with more than 250 beds</td>
</tr>
<tr>
<td><strong>Comunity Teams of Support in Palliative Care (ECSCP)</strong></td>
<td>3</td>
<td>To be determined according to identified needs</td>
<td>To be determined according to identified needs</td>
</tr>
<tr>
<td><strong>Continuous Care Teams with Palliative Care competences</strong></td>
<td>40</td>
<td>_</td>
<td>1 ECCI por UCC</td>
</tr>
<tr>
<td><strong>Number of internment vacancies in acute Hospitals</strong></td>
<td>50</td>
<td>_</td>
<td>194 a 243 LI</td>
</tr>
<tr>
<td><strong>Number of internment vacancies of Palliative Care integrated in RNCCI</strong></td>
<td>126</td>
<td>163</td>
<td>324 a 405 LI</td>
</tr>
<tr>
<td><strong>Number of vacancies in other typologies of RNCCI with Palliative Care Competences</strong></td>
<td>To be determined</td>
<td></td>
<td>130 a 162 LI****</td>
</tr>
<tr>
<td>Operational Goals of the National Program for the Palliative Care in 2013</td>
<td>Goals for 2011</td>
<td>Goals for 2012</td>
<td>Goals 2013</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Average Time to admission in Palliative Care Units on REDE</td>
<td>48h to 72h</td>
<td>48h</td>
<td>24h</td>
</tr>
<tr>
<td>Occupation tax n Palliative Care Units on REDE</td>
<td>&gt; or =85%</td>
<td>&gt; or =85%</td>
<td>&gt; or =85%</td>
</tr>
<tr>
<td>Number of patients admited in PC, for Informal Caretaker rest</td>
<td>70% of referenced to PC, for Caretaker rest</td>
<td>85% of referenced to PC, for Caretaker rest</td>
<td>100% of referenced to PC, for Caretaker rest</td>
</tr>
<tr>
<td>Number of Regions with Anual Region Program of PC</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Number of Regions wich implements sistematic and continuous monitorization</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Number of regions with a Formation Plan to PC Professionals</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Number of referenced Centers for Theorical and Pratical Formation</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Number of Clinical/Regional audits</td>
<td>50% of units</td>
<td>70% of units</td>
<td>90% of units</td>
</tr>
<tr>
<td>Number of Organizational/Regional audits</td>
<td>50% of units</td>
<td>70% of units</td>
<td>90% of units</td>
</tr>
</tbody>
</table>

*20 to 30% of National vacancies
**50% of the National vacancies
***20% of National vacancies
****Number of possible vacancies occupied by patients with PC needs.