The Proposals of the National Committee for the Development of Day Surgery in Portugal (CNADCA)

*National Committee for the Development of Day Surgery in Portugal**

Abstract

This paper aims to present in a summarised way the conclusions obtained by the National Committee for the Development of Ambulatory Surgery (CNADCA) to identify the main barriers that slowed the expansion of ambulatory surgery (AS) in Portugal, as well as the incentives measures proposed for the promotion of this practice in the hospitals of the National Health Service (NHS). The lack of day surgery units specifically designed for that practice, insufficient human resources (anaesthesiologists and surgeons from certain surgical specialties), and the absence of economic incentive measures were the main constraints found to justify the low percentage of elective surgery performed on a day surgery basis (27%), during the year 2006. Amongst the 45 proposals advanced by the CNADCA for more effective promotion of AS in Portugal, highlights are a 50% reduction of patient fees in relation to AS, free delivery of patient medication for the first post-operative days, assign of several financial and organisational measures seek to continuously improve quality around AS programmes. The CNADCA believes to be possible to achieve the "magic" barrier of 50% of elective surgery performed on a day surgery basis by 2009, if the proposed measures are approved, which would be a decisive goal and an irreversible step forward in the Portuguese Health Policy.

Keywords: Ambulatory surgery in Portugal; Organisation; National Committee; Activity.

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Preface

The Governmental Programme of the XVII Portuguese Constitutional Government stresses the importance of promoting the national development of Ambulatory Surgery, in order to increase effectiveness, quality of healthcare and efficiency in the hospital organization. In spite of the well known advantages of day surgery, this surgical regimen has a reduced rate of implementation in Portugal compared to other European and North American countries [1]. Trying to advance beyond the present reality, the National Committee for the Development of Day Surgery in Portugal (CNADCA) was constituted by Health Ministry Dispatch [2] on the 19th November 2007, with the goals to study and propose a strategy in order to promote the development national-wide of day surgery in the Portuguese National Health Service (NHS).

The mission of CNADCA included:

- identification of physical, human resources or other constraints;
- description of the Day Surgery Unit specific needs, both clinical and administrative organizational;
- specific professional education for day surgery;
- adaptation of informatics systems for specific recording of surgeries performed on a day surgery basis;
- analysis of the financing models and contracts for day surgery activity, and making proposals for its promotion;
- selection of indicators that will allow continuous improving quality in day surgery programmes;
- continuous monitoring and evaluation of day surgery projects in terms of their efficacy, efficiency and quality.

CNADCA was composed of 37 members, centred in an executive committee who coordinated the work and enacted the decisions of the national committee. CNADCA was based in a multi-professional team (doctors, nurses, managers), with representatives from different clinical specialties, coming from all kind of hospitals in terms of its size, legal status, or location, trying to carefully represent the entire country. The National Committee benefited from the support of a Technical Group coming from institutional partners of the Portuguese NHS and a Consultation Body with members representing Nurses (General Nursing Association), Health Regulatory Entity (ERS), and the society itself (Patient Association).

This project had many challenges, many of them from the cultural point of view:

- To remove the indicator hospital "bed" as a basic principle to define the hospital size, complexity and specialization. That is, the distinction and importance of a hospital department is no longer based on its square meter of occupancy or in the number of beds that it has, but in the quantitative, quality and specialization of its production – CHANGE IN THE HOSPITAL PHILOSOPHY.
- To understand the evolution of medicine and to face day surgery without prejudices as the surgery of the future: to consider day surgery, rather than inpatient surgery, the norm for all elective procedures – CHANGE IN CLINICAL PERSPECTIVE
- To face the independence of the day surgery unit (DSU) as a key factor for the success of these programmes with dedicated staff to the project. To understand the central role of nurses in day surgery programmes (humanization, safety and quality), and the need of a careful, professional and motivational selection of this staff. To structurally separate day surgery facilities from inpatient ones and consider this as critical aspect for the success

of the project. It's not enough to practice day surgery: if this isn't performed according to the current legis artis, many benefits will be lost, namely the efficiency and proper management of operating rooms and human resources – A WASTED OPPORTUNITY.

- To institute an empowerment policy around day surgery: recognising health professionals and institutions, their status, and creating benchmarking between hospitals. The acknowledgment of comparison is crucial: it is necessary to recognise the value of day surgery in the professional career, saying that this surgical approach is performed by the best of the surgeons (more experience, higher skill and major responsibility) – THE MAJOR TYPE OF SURGERY FOR THE BEST SURGEONS.
- To realize that technically, day surgery is not a new invention but just an innovation of what is being done in the surgery field. The key-word for the change is Organisation, that should be multidisciplinary and patient centred – A QUALITY ORGANIZATION CENTRED IN THE PATIENT.

This National Committee aimed to publish a comprehensive report where several proposals would be made to the Health Ministry in order to overcome identified barriers that slow the process of implementation of day surgery programmes nationwide. The Committee also aimed to have a national conference to present its conclusions, and to support a media campaign to spread information regarding day surgery amongst the Portuguese society.

By 2009, if the CNADCA proposals will be followed by the Health Ministry, it will be possible to achieve the magic level of 50% of all elective surgery performed on a day surgery basis, which would constitute an important step and an irreversible FORWARD????way in the Portuguese Health Policy.

National ambulatory surgery survey

In order to characterize the actual performance, level of organization, barriers to the development of day surgery in 2006, the first task of CNADCA consisted of doing a national survey involving all hospitals of the NHS. The picture obtained gave a real description of the state of day surgery in Portugal and most of all clarified the constraints, namely logistics, human resources and education, that limits the expansion of AS.

The study included all NHS Hospitals with surgical activity during 2006. Only 10% of these did not have any day surgery programme running at the hospital. Nevertheless, there was a great heterogeneity in the organization itself (separated programmes with dedicated units, total independent; integrated and mixed programmes) most of them without well defined pathways in caring these patients.

In 2006, AS represented 27% of the total elective surgery (i.e., 79,067 procedures), which reflected a 7.7% increase in relation to 2005. However, few institutions used clinical indicators to evaluate the quality of their performance. It seemed that the results found in the national survey justified the creation of such a national committee: the country continued to perform AS at half of the European rates with a deficit of the clinical and organizational criteria internationally recommended for a high quality day surgery practice.

The lack of day surgery units specifically designed for its practice, the insufficient human resources (anaesthesiologists and surgeons from certain surgical specialties), and the absence of incentive economic measures were the main constraints found to justify the low percentage of elective surgery performed on a day surgery basis during the year 2006.

Ambulatory surgery production

In addition to the results obtained through the national survey directly from each Hospital, the CNADCA believed that the official data from the Central Administration of the Health System (ACSS) should be studied and to monitor the main indicators of AS. The 2004-2006 period registered a positive evolution with an increase in the AS rate from 27% in 2004 to 30% in 2006. It should be be noted that the number of procedures resulted in the application of the ACSS criteria for AS based only in time duration of admission, and not in the overall organisation as it was for the data obtained in the national survey. This explains the difference found between both entities: the National Survey (with data from Hospitals), and the ACSS.

From another database (integrated general system for patients registered for surgery – SIGIC) a different result of AS rate was obtained, with only 16% of all elective procedures being performed on a day surgery basis. A difference was also perceptible when information about the fees charged on day surgery patients was obtained according to the division of the hospital requested. In fact, the AS concept varies a lot from the perspective of the professional involved: manager (economic-finance concept), doctor or nurse (clinical concept), or secretariat (administrative concept).

So, there is an urgent need to standardise definitions and informatics systems, in order that all health professionals speak the same language in order to obtain reliable results in the activity of AS.

Considering that AS allows increasing efficiency in maximizing operating room facilities, it is to be expected that when in the presence of higher AS rates, there is lower waiting time for inpatient surgery. Although there was no linear relation between these two factors, there was observed a general relationship with the median of the waiting time for surgery for the extreme values of the AS rates (i.e., hospitals with higher AS rates have lower median waiting time for surgery).

Access to health care services – the waiting list for surgery:

The CNADCA studied the accessibility of patients to our healthcare system, through the surgical waiting list in order to evaluate the dimension of the problem and the evolution during the recent years to analyse the impact of AS in this process.

There has been a reduction in the last two years of the number of patients waiting for surgery (17%). Yet, the most important fact was the reduction of the time waiting for surgery by 50% (median of 8.6 months on the 31st December, 2005 to 4.4 months on the 31st December, 2007).

The maximization of the operating room resources and the presence of common AS procedures on the surgical waiting list, make AS one of the most powerful tools in the reduction of the surgical waiting list. Eight or nine of the surgical procedures top ten on the waiting surgical list, are typical day surgery procedures that represent about 50% of the actual waiting surgical list.

Study about perception and patient satisfaction in ambulatory surgery programmes

In order to understand the satisfaction of health professionals, patients and citizens with AS, the CNADCA made a national survey with the following conclusions:

1. Citizens have heard about AS programmes through the media (44%), patients and relatives (27%), and health professionals, especially general practitioners (22%).
2. The most important advantages of AS programmes are for citizens, the avoidance of the inpatient discomfort (47%), the benefits from being accompanied by a relative (37%) and to speed up the recovering process getting back to the familiar / professional activity (21%).
3. The most important reasons for the citizens to choose the inpatient regimen are the fear of complications after being discharge home (51%) and not have the same conditions at home in regard to those having at hospital (15%).

Knowing the main concerns of citizens we can interact pro-actively trying to avoid them. So, all activities that improve the sense of security, such as written clinical and organizational information regarding the entire surgical process, opportunity to visit to the DSU before surgery, availability of a telephone number contact of the surgical team for the first 24 hours after surgery, and telephone contact by the facility on the day after the surgery, will lead to a reduction of feeling not cared for that could follow patient discharge.

There is a need to explain to patients and relatives that the hospital environment is not as safe as they thought. There are lots of real risks, such as hospital acquired infections and professional mistakes. In contrast, the familiar home environment can be in selected cases more effective for recovery.

The aspects related to the information, clarifying of doubts and the follow-up period after surgery are the most decisive facts in the creation of positive patient opinion. More than 95% of patients in this survey who had had AS were satisfied or very satisfied. When these patients were asked if they would be interested to recover at home if they had another surgical procedure, 88% of patients would answer "Yes". This fact shows the great level of satisfaction among patients that should be maximized: "AS has become a patient right, but a duty of the NHS to provide it".

Planning A Day Surgery Unit (DSU)

Dedicated AS facilities are one of the main constraints identified to explain the reduced presence of AS in Portugal. For that reason, there has been a movement towards the construction of new DSUs.

DSU's model is crucial for improving the efficiency and efficacy of an AS programme. As a result, the CNADCA developed a DSU self-contained unit on the hospital site where operating theatres and ward are dedicated to AS programmes, carefully establishing the independent flow of AS patients, healthcare professionals and goods, and the adequate dimensions of all spaces especially the recovery areas, in order to maximize the through-put in a secure and high quality surgical programme.

Evaluation of the economic viability of a DSU

It was intended to demonstrate before the Administrative Board of Hospitals, Health Regions and the Health Ministry itself, the economic advantages that we should expect from this type of AS programme, in particular when specific dedicated DSU are designed and constructed.

In this analysis, construction costs (for new or renewed facilities), general and medical equipment, human and logistic resources, operational and amortizing costs, versus profits coming from the surgical caseload, where considered. The CNADCA concluded that for any different scenario studied, DSU projects have a positive income with a pay back period of 4 years time, with the model without extended recovery (same day surgery) the best one.

Contracts and financing

The issue of contracts and financing was one of the main limitations identified by CNADCA for AS development. It would be crucial to change this situation, creating at the same time economical incentives for those performing day surgery in comparison to inpatient surgery, but avoiding penalising the latter.

CNADCA proposals for changing the contracts and surgical financing should include:

a) Up to date inclusion of all surgical procedures feasible to be done in AS programmes without economic constraints. The decision of a surgical procedure to be included in these programmes should be based on medical (clinical and social) criteria and not on financing-administrative criteria.

b) Up to date financing for the procedures performed on a day surgery basis, reducing the difference for the amount paid for the same surgery in the inpatient setting.

c) Reducing the surgical bed capacity for admitting patients at hospitals, using this possible constraint as an instrument of cultural change.

d) Increase the weight of ambulatory surgery in programme-contracts in comparison to inpatient surgery.

These proposals are aimed to create an irreversible dynamic changing towards AS among health professionals with a policy based on incentives over 3 years, expecting after that time to have an adequate rate of AS similar to other European NHS.

Moderating fees

The Portuguese NHS is almost completely free for all national citizens. Nevertheless, after 2007 the Portuguese Government established moderating fees for surgical procedures with the purpose to moderate the healthcare expenditure. The application of these fees to AS now corresponds to two days of hospital admission. This decision can be viewed as a driving force against the development of AS, motivating CNADCA to propose a 50% reduction of the fee, corresponding to just to one day of admittance, and reduce the costs transference to patients that could be created when we move from inpatient to AS setting.

Informatics system:

One of CNADCA's goals was to make proposals so that the informatics systems are adequate for the real needs of AS programmes. Results could not be compared because the providers of those data were from different entities. As a result of this, CNADCA proposed a changing in the informatics systems concept, based on:

a) The necessity to clarify the terminology used, separating AS (with or without extended recovery) from the inpatient setting (surgery with admittance, even if this is during a period less than 24 hours) and minor surgery.

b) The necessity to identify from the beginning of the surgical

proposal all the information need to make the registration feasible, namely if the patient has the surgical, medical and social criteria required to be carefully selected to AS programme.

c) The recommendation that certain types of surgery should being inserted by the informatics systems to be performed on a day surgery basis by default, meaning that if not possible the clinician should justify the reason why.

d) The creation of a list of quality indicators to be automatically produced by the informatics system in order be obtained and known easily.

Quality in ambulatory surgery

A major CNADCA goal is to increase the AS rate in the country. However, this goal must be accompanied by an accurate Quality Process with the inclusion of adequate clinical indicators that can demonstrate the security and quality of the programmes. Thus, CNADCA proposed the creation of a list of quality indicators, easy to compare between Health Institutions, to be automatically generated by the informatics systems. These indicators should be available on the website aimed to Hospitals, Health Professionals and Patients, to know how good are the results of each DSU.

CNADCA also recommends the creation of a Quality Manual, Satisfaction Surveys, and in cooperation with the Portuguese Institute of Quality, the establishment of a specific norm for DSU certification.

Education in ambulatory surgery

One of the key elements for the success of AS programmes is the education of well trained and motivated health professionals. CNADCA has identified deficits in the education of health professionals in relation to AS, not only in the pre-graduate level (Medicine or Nurse Degree) but also in the post-graduate level (namely in the curricula of residents) and even among Professionals with many years of practice.

The necessity to explain the day surgery concept and organisation as part of the Faculty of Medicine and Nursery, the inclusion of specific training for this surgical regimen in Internships in Anaesthesiology and Surgical Specialties, and for Specialists without experience in this practice, are central initiatives to overcome the limitations detected in the country. In addition, the education of other groups, including Hospital Managers, General Practitioners and Patient Representative Associations, was regarded as essential initiatives in changing this process.

Visits to public hospitals and the involvement of the media

CNADCA members' visits to public hospitals were considered most relevant for the strategy and the success of its mission. Preliminary results demonstrated that this was an important instrument that led to a significant dynamic progress for the development of AS in our public hospitals.

With these visits, CNADCA came to know hospitals, evaluated hospital management strategies and identified the main constraints for the development of AS programmes. In addition, they learnt of successful programmes, situations of healthcare excellence, and the different solutions implemented. Having the opportunity to promote AS discussions inside the Hospitals motivated health professionals for its practice and stimulated and distinguished those with good practices. These visits were indeed an excellent opportunity to promote amongst the community all the advantages associated to ambulatory surgery, through the media.

CNADCA has visited 37 public hospitals (60% of the public hospitals with surgical activity), being present more than 510 members of their Administrative Board. More than 100 media (newspapers, radio stations or televisions) were represented in these visits, which allowed for the Members of the executive committee to travel over more than 7,250 km.

AS achieved a new dimension and was considered one of the main topics of all the Public Hospitals visited.

Table 1 Summary of the CNADCA proposals made to the Health Ministry.

Priorities	Measures	Time	Responsables
01. National Survey on Ambulatory Surgery	1. Immediate adoption of basic criteria on AS programmes	1 year	Hospitals
	2. Preparation for adoption of recommendable criteria on AS programmes	1 - 3 years	Hospitals
02. Ambulatory Surgery Production	3. Implementation of a clear registration of all procedures performed on a day surgery basis	2008	ACSS, SIGIC/UCGIC, Hospitals
03. Access to healthcare – surgical waiting list	4. Elected procedures identified by default for AS in the surgical proposal	2008	ACSS, SIGIC/UCGIC, Hospitals
04. Perception of the satisfaction with Ambulatory Surgery	5. Amplification of the visibility of AS	2008	Primary Health Care, Patient Associations, Hospital Friends Leagues, Social Assistant
	6. Reinforcing the receptivity to AS	2008	Hospitals, Observatory Centre of Ambulatory Surgery
	7. Fight barriers against AS	2008	ACSS, Hospitals, Observatory Centre of Ambulatory Surgery
	8. Quality improvement of AS	2008	Hospitals
	9. Monitoring AS development	2008	ACSS, Hospitals, Observatory Centre of Ambulatory Surgery
05. Planning & Designing of a DSU	10. Built or rebuilt day surgery facilities, accordingly the CNADCA proposals methods	1 - 3 years	ACSS, Hospitals
	11. Creation of parking areas for patients and relatives	1 year	Hospitals
06. Evaluation of the economic viability of a DSU	12. Creation of spaces and surgical operating periods for operation to children and adolescents	1 year	Hospitals
07. Contract & Financing	13. Establishment of prices for AS for all DRG codes with inferior limit of 5 days of admittance	2008	Hospitals
	14. Inclusion of Medical DRG codes 316, 317, 369, 465 and 466 for AS	2008	ACSS, ARS, Hospitals
	15. Same price for identical DRG procedures (inpatient or day surgery basis) when inferior limit equal to one day	2008	ACSS, ARS, Hospitals
	16. Establishment of 73,2% of the similar DRG for inpatients, for all DRG with inferior limit below 5 days and above 1 day	2008	ACSS, ARS, Hospitals
	17. Establishment of the inferior limit equal to 1 day of admittance for all DRG with AS price	2008	ACSS, ARS, Hospitals
	18. Payment of the marginal surgical production of AS in the same financing conditions of the basic production	2008	ACSS, ARS, Hospitals
	19. Establishment of the ICM value of the previous year, for the hospital contracts	2008	ACSS, ARS, Hospitals
	20. Reduction of the surgical inpatient beds in a mean value of 5-10%/year, during 3 years	2009-11	ACSS, ARS, Hospitals
	21. Increase in the weight of the AS in the total of elective surgery, in a mean value of 15%/year, during 3 years	2009-11	ACSS, ARS, Hospitals
	22. Creation of a prize of 10% for each AS DRG, during a period of 3 years	2009-11	ACSS, ARS, Hospitals

Priorities	Measures	Time	Responsables
08. Moderated Fees	23. 50% Reduction in the moderate fees applied to AS	2009	Health Ministry
09. Informatics Systems	24. Obstruct the Central Informatics Systems named "SONHO" to accept AS to a procedure coming from an urgent episode	2008	ACSS
	25. Creation in the "SONHO" Informatics System, a sub-speciality dedicated to AS in each Surgical Specialty	2008	ACSS
	26. Allowance of all functionalities of the operating room module of the "SONHO" application without limits or constraints	2008	ACSS
	27. In the operating room module of the "SONHO" application, consider the different types of surgery: Inpatient Surgery (with discharge longer than 24 hours or with short inpatient stay less than 24 hours); AS (with or without extended recovery); Minor Surgery	2008	ACSS
	28. The surgical proposal must identify the necessary information to make the registration feasible, namely if the patient fulfils all the selection criteria: medical and social.	2008	ACSS
	29. Establishment in the "SONHO" Informatics System , the most frequent procedures in AS programmes	2008	ACSS
	30. Identification in the surgical proposal of all pertinent registration data, namely Primary Health Care Centre, General Practitioner and relative responsible for the patient	2008	ACSS
	31. Creation of specific outcomes for AS in the "SONHO" Informatics System, namely: Patient Submitted to Surgery; Failure to Arrive; Cancelled Surgery; Patient Admitted; Patient without surgical indication	2008	ACSS
	32. Inclusion in the "SONHO" Informatics System (Primary Health Care version) and in the "CLINICS" Modules, the possibility of the General Practitioner to send the patient directly to AS programmes	2008	ACSS
	33. Establishment of 3 levels of database in the Informatics System: Hospital, Regional and National	2008	ACSS
	34. Construction of an informatics application exclusive to the AS pathway	2008	ACSS
10. Quality in Ambulatory Surgery	35. Construction of Quality Manuals	1 year	Hospitals
	36. Performance of periodic satisfaction surveys	2008	Hospitals, Observatory Centre of Ambulatory Surgery
	37. Accreditation / Certification of Day Surgery Units	1-3 years	Accreditation Group for Ambulatory Surgery Programmes
11. Education in Ambulatory Surgery	38. Establishment in the Health Colleges (Medicine, Nursing, Hospital Management), modules dedicated to the AS practice	1-3 years	Health Colleges
	39. Creation in the Internship Curricula, educative modules to allow experience in AS	1-3 years	General Medical Association
	40. Development of post-graduated educational programmes for nurses working in day surgery units	1-3 years	General Nursing Association
	41. Implementation of educational programmes to Primary Health Care professionals and social initiatives with Patient Associations	1-3 years	Hospitals, ARS, Patient Associations, Hospital Friends Leagues, Social Assistant

Priorities	Measures	Time	Responsables
12. Suggestions & reclamations	42. Inclusion of AS in the Informatics System "Yes-Citizen"	1 month	Programme "Yes-Citizen" (ACSS or DGS)
13. Monitoring the development of Ambulatory Surgery	43. Creation of the Observatory Centre of Ambulatory Surgery	1 year	DGS
14. Promotion of Ambulatory Surgery	44. Creation of an "Annual Prize" to the most distinguish day surgery unit of the year	1 year	Observatory Centre of Ambulatory Surgery
	45. Establishment of a "National Day for Ambulatory Surgery", where Day Surgery Units should open their organisation to the public, showing the work conditions, and their results		

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APPENDIX 1

Table 2 – Constitution of the CNADCA

EXECUTIVE COMMITTEE

- Fernando Araújo, MD, PhD, Vice-President of the Administrative Board of the Northern Regional Health Administration, Public Institute (ARSN-IP), which was the President of the Committee;
- José Gaspar Pais, Phd (Econ), President of the Administrative Board, Centro Hospitalar da Póvoa do Varzim/Vila do Conde, Public Enterprise Entity (EPE);
- Manuel Seca, MD, General Surgeon, Coordinator of Day Surgery Unit, Centro Hospitalar do Porto, EPE;
- Maria Isabel Rocha Macedo, Chief-Nurse of the Operating Room, Centro Hospitalar da Póvoa do Varzim / Vila do Conde, EPE;
- Paulo Lemos, MD, Anaesthetist, Responsible for the Board Committee of the Integrated Centre of Ambulatory Surgery, Centro Hospitalar do Porto, EPE;
- •Silvestre Carneiro, MD, PhD, General Surgeon, Coordinator of Day Surgery Unit, Hospital S. João, EPE;
- Victor Herdeiro, PhD (Law), Member of the Administrative Board, Unidade Local de Saúde de Matosinhos, EPE.

PLENARY COMMITTEE

- Fernando Araújo, MD, PhD, Vice-President of the Administrative Board of the ARSN-IP, which was the President of the Committee;
- Alexandra Costa, Chief-Nurse of the Day Surgery Unit, Centro Hospitalar do Baixo Alentejo, EPE;
- António Castanheira Dinis, MD, PhD, Ophtalmologist, President of the Administrative Board, Instituto Gama Pinto;
- António José Carvalho Capelo, MD, General Surgeon, Director of the General Surgery Department, Centro Hospitalar de Coimbra, EPE;
- Armando Mansilha, MD, PhD, Vascular Surgeon, Hospital São João, EPE;
- Carlos Sousa, MD, General Surgeon, Director of the General Surgery Department, Hospital do Litoral Alentejano;
- Fátima Figueiredo, MD, Anaesthetist, Coordinator of Day Surgery Unit, Unidade Hospitalar de Santo Tirso - Centro Hospitalar do Médio Ave, EPE;
- Francisco José Espinha Ribeiro de Carvalho, MD, Plastic Surgeon, Clinical Director, Hospital Distrital de Santarém, EPE;
- João Bernardes, MD, PhD, Gynaecologist/Obstetrician, Hospital São João, EPE;
- João Manuel Varandas Fernandes, MD, Orthopaedic Surgeon, Director of the Emergency Department, Centro Hospitalar de Lisboa Central, EPE;
- Jorge Martins, MD, General Surgeon, President of the Administrative Board, Hospital Arcebispo João Crisóstomo;
- Jorge Manuel Machado Rola, Chief-Nurse of the Day Surgery Unit, Hospital Distrital de Santarém, EPE;
- José Aníbal Soares, MD, General Surgeon, Centro Hospitalar do Baixo Alentejo, EPE;
- José Gaspar Pais, Phd (Econ), President of the Administrative Board, Centro Hospitalar da Póvoa do Varzim/Vila do Conde, Public Enterprise Entity (EPE);
- Luís Gabriel Pereira, MD, General Surgeon,, Coordinator of Day Surgery Unit, Centro Hospitalar do Baixo Alentejo, EPE;
- Luís Meireles, MD, ENT Surgeon, Centro Hospitalar do Porto, EPE;
- Manuel Gonçalves Carvalho, MD, General Surgeon, Clinical Director, Hospital do Espírito Santo, EPE;
- Manuel Seca, MD, General Surgeon, Coordinator of Day Surgery Unit, Centro Hospitalar do Porto, EPE;

- Manuela Mota Pinto, PhD (Econ), Member of the Administrative Board, Centro Hospitalar de Coimbra, EPE;
- Maria Isabel Rocha Macedo, Chief-Nurse of the Operating Room, Centro Hospitalar da Póvoa do Varzim / Vila do Conde, EPE;
- Maria Fátima Aguiar Pereira, MD, General Surgeon, Hospital Visconde Salreu;
- Mohamede Americano, General Surgeon, Director of Day Surgery Unit, Centro Hospitalar do Barlavento Algarvio, EPE;
- Nilza Maria Lopes Rocha Araújo Lima, Chief-Nurse of the Day Surgery Unit, Hospital Curry Cabral, EPE;
- Óscar Gonçalves, MD, Vascular Surgeon, Director of the Vascular Surgery Department, Hospitais da Universidade de Coimbra;
- Paulo Dinis, MD, PhD, Urologist, Hospital São João, EPE;
- Paulo Lemos, MD, Anaesthetist, Responsible for the Board Committee of the Integrated Centre of Ambulatory Surgery, Centro Hospitalar do Porto, EPE;
- Silvestre Carneiro, MD, PhD, General Surgeon, Coordinator of Day Surgery Unit, Hospital S. João, EPE;
- Victor Herdeiro, PhD (Law), Member of the Administrative Board, Unidade Local de Saúde de Matosinhos, EPE.

TECHNICAL GROUP

- Ana Leça, MD, Director of the Clinical Quality Department, Directorate General for Health (DGS);
- Claúdia Borges, PhD (Econ), Operational Unit of Contracts and Financing, Central Administration of the Health System (ACSS);
- Fernando Mota, Vice-President of the Administrative Board, ACSS;
- Fernando Tavares, MD, Coordinator of the Studies and Planning Department, ARSN-IP;
- Pedro Gomes, MD, Coordinator of the Central Unit of the Waiting Surgical List (UCGIC);
- Sofia Coutinho, PhD (Arch), Coordinator of the Functional Unit of Projects and Equipments, ACSS.

CONSULTATIVE BODY

- Ana Paula Santos Silva, Nurse, General Nursing Association;
- Eurico Alves, Member of the Administrative Board, Health Regulatory Entity (ERS);
- Isabel Machado, PhD, Member of the Administrative Board of the Patient Association "Plataforma Saúde em Diálogo".