



Permanent PaSQ Network - Years 2015+

Proposal 7 April 2014

1.4



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1. Executive Summary

The objective of this document is to present a proposal for a permanent network on Patient Safety and Quality of Care (PaSQ) involving Member States and European stakeholders, building on the Network on Patient safety and Quality of Care (PaSQ) Joint Action experience (<http://www.pasq.eu/>).

The **European Union Network for Patient Safety and Quality of Care, PaSQ Joint Action** is co-funded and supported by the European Commission within the Public Health Program. The network approach on Patient Safety and Quality of Care proposes to further invest in Knowledge Transfer through exchange mechanisms and implementation of good practices corresponding to member states needs. The added value of this approach is to avoid duplication of effort and to allow enough margin of manoeuvre in implementation to ensure adaptation to local needs and buy in from end users.

The network should promote a culture of patient safety across healthcare systems. At EU level, the future network will encourage a system analysis approach when studying adverse events, in an effort to understand how human factors, medical devices, healthcare organisations, pharmaceutical products, etc., all interact to create safe conditions in the health sector. Furthermore, close cooperation between healthcare professionals, patients and authorities is of paramount importance to ensure patient safety. This cooperation may include areas such as patient empowerment, health literacy, the management of chronic conditions as well as working conditions due to the existing potential to reduce incidents and ensure patient safety.

In the first half of the PaSQ Joint Action, Member states and stakeholders expressed their needs through the Network Sustainability Survey and through the Exchange Mechanism data collection. They identified as their most important priorities patient involvement/empowerment reporting and learning / rapid exchange systems, quality improvement systems, implementation of good clinical practices.

The PaSQ network resulted in more than 335 Patient Safety Practices (PSPs) and 118 Good Organizational Practices (GOPs) reported at mid term to the database and more than 30 Exchange Mechanism (EM) events are planned. Safe Clinical Practices are implemented in 200 Healthcare Organisations (HCOs) in 18 countries to ensure patient safety in relation to the procedures involved by 4 themes: safe surgery (*Surgical Safety Checklist*), medication safety (*Medication Reconciliation*), paediatric care (*Paediatric Early Warning Scores*), and medical activities (*Multimodal intervention to increase hand hygiene compliance*).

The main aim of permanent network is to learn and share knowledge and experience to enhance patient safety and quality of care as agreed in the Council Recommendation on Patient Safety (2009/C 151/01).

This objective will be achieved through face to face interaction and web based tools like Patient Safety and Quality of Care database and exchange mechanism. PaSQ knowledge transfer (KT) tools will be developed to achieve the 4 priorities areas identified by member states during the first half of Patient Safety and Quality of Care Joint Action through:

1. Patient and public involvement and empowerment (PPI/PPE)
2. Implementation of selected Patient Safety Practices in clinical settings
3. European peer review for Care Quality Improvement will propose a review of the organisation and main principles of national or regional Quality Improvements by peers (experts involved in, national or regional Care Quality Improvement in other countries participating to the peer review system).
4. Rapid Exchange Mechanism of Patient Safety Incidents and Solutions: SEaL (Share, Exchange and Learn) a voluntary web-based system for issuing patient



safety incidents and patient safety practices within member states.

Involvement in the key functions for the PaSQ Permanent network is optional according to the interest of participating member states. They can share and exchange the information or participate to the PaSQ exchange mechanisms. They can voluntarily participate to implementation exercises or they can be directly involved to the implementation tools development.

Partners of the permanent network will be designated by Member States and the European Commission for representatives of civil society. The government structure will comprise two bodies with each its specific tasks and responsibilities: the Steering Committee and the Executive Board.

2. Introduction

Recent OECD studies¹ suggest that the prevalence of adverse event mortality in the European Union is close to 1 death per 100 000 inhabitants. This would mean that almost 5000 persons die every year because of adverse medical events. These figures, even if quite alarming, are largely underestimated because they rely on reporting by health care professionals.

National studies targeting hospital settings in the UK, Spain and France² have estimated that the real figures could approach 100 000 deaths annually. In primary care (PC) settings a Spanish study (APEAS)³ has suggested that adverse events occur in 1,1% of all patients visits. Considering the frequency of use of PC services in Spain we could expect 3 million AE per year (6% of all consultations).⁴ The Council Recommendation on Patient Safety (the Recommendation)⁵ declared that “it is estimated that in Member States [MS] between 8% and 12% of patients admitted to hospital suffer from adverse events whilst receiving healthcare

As stated by the European Parliament: “Ensuring patient safety is above all a matter of improving quality of life, but harm caused to patients by adverse events during treatment also places a significant burden on society, which is aggravated in times of economic crisis. For example, in certain Member States growing numbers of patients are contracting *Clostridium difficile* infections, which account for about 5% of all HAI in Europe and are estimated to be the cause of 2% of hospital readmissions. The financial burden of such infections on Europe’s healthcare systems is estimated to be EUR 3.7 million in 2013. Quite apart from the obvious benefits for patients, investment in patient safety could therefore be a source of potential cost savings: emphasis on patient safety reduces the costs incurred in treating patients experiencing adverse events associated with healthcare, and therefore means better use is made of financial and human resources. With a view to achieving these goals, the culture of patient safety can be significantly enhanced in a number of ways.”

The objective of this document is to present a proposal for a sustainable network on Quality of Care & Patient Safety involving MS and European stakeholders; among them

¹ OECD Health data

² Etude nationale sur les événements indésirables graves associés aux soins: ENEIS: — Michel P., Minodier C., Lathelize M., Moty-Monnereau C., Domecq S., Chaleix M., Izotte-kret M., Bru-Sonnet R., Quenon J.-L., Olier L., 2010, « [Les événements indésirables graves associés aux soins observés dans les établissements de santé](#) », *Dossiers Solidarité et santé*, DREES, n° 17

³ *Ministero de Salud y Consumo*, APEAS Study: *Patient Safety in Primary Healthcare Summary* (in Spanish), 2005 (http://www.msc.es/organizacion/sns/planCalidadSNS/ec03_doc.htm, accessed 24 April 2010)

⁴ Aranaz et al. *European Journal of Public Health*, Vol. 22, No. 6, 921–925)

⁵ Council Recommendation 2009/C 151/01 of 9 June 2009 on patient safety, including the prevention and control of healthcare associated , Brussels 2009



representatives of patients who are the ultimate beneficiaries of collaboration in the network. This proposal takes into account the European Union context (legislation/initiatives having a potential impact on the PSQC field) and the information captured during the data collection of PaSQ, which contribute to set the rationale of the proposal.

3. Regulatory Framework.

The permanent network should contribute to the provision of safe and high quality healthcare for all EU citizens in the framework of the following EU legislation/initiatives:

3.1. points 2 & 7 of Art 168 of the LISBON Treaty 6:

“2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarities of their health services in cross-border areas.”

“7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.”

3.2. Directive on the application of patients' rights in cross-border healthcare, and namely provisions relating to standards and guidelines on quality and safety in full respect of national competencies in organising and delivering healthcare (*Directive 2011/24/EU*)

3.3. Council Recommendation 2009/C 151/01 of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections,

3.4. European Directive 2005/36/EC on Mutual Recognition of Professional Qualifications that regulates the sectoral professions (doctors, nurses, midwives, dentists, pharmacists and dentists).

3.5. Other EC initiatives in the field: Options promoting EU standards for health services to contribute to the provision of safe and high quality healthcare for all EU citizens are discussed by the EC: Health services are now included in the scope of European standardisation regulation. The recently published annual work programme for European standardisation proposes to assess whether EU standards for health services could be an option for EU harmonisation of health services.⁷

4. Rational:

⁶ LISBON TREATY ON THE FUNCTIONING OF THE EUROPEAN UNION

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF>

⁷ (COM(2013) 561 final: COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL AND THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE)



PaSQ will propose a sustainable voluntary collaboration among Member States and key relevant stakeholders on Patient Safety and Quality of Care. The rationale of the proposal is built on:

4.1. The expected outcomes mentioned in PaSQ contract for sustainability:

To build a permanent collaborative network on Patient Safety (PS) that will be enlarged to address quality and safety issues and reinforced by assuring long-term Member States (MS) engagement in the PaSQ network, together with the EU stakeholders and European Commission.

To implement a collaborative business model with a financial sustainability approach.

4.2. Member States and stakeholders needs, expressed in the first half of the PaSQ joint action through the PaSQ Network sustainability survey and through the Exchange mechanism data collection. Priority areas identified were:

- patient involvement/empowerment
- reporting and learning / rapid exchange systems
- quality improvement systems
- implementation of good clinical practices

They should be addressed with instruments promoting face to face interactions and web based tools

4.3. The first achievements of PaSQ demonstrate the added value of the network approach: to avoid duplication of effort and to allow enough margin of manoeuvre in implementation to ensure adaptation to local needs and buy in from end users. MS regions and health care facilities can benefit from the knowledge and experience of others by sharing experiences and solutions in Patient Safety and related aspects of Quality of Care. The permanent network will aim to implement and monitor a handful of good practices in accordance with the Council Recommendation on PS. This work should also contribute to the establishment and maintenance of national PS and quality networks or platforms involving all relevant national stakeholders, including patients and patient organisations. These networks should promote the exchange of information via all the communication means, including IT, which support knowledge and advancement in patient safety and quality of care.

Within PaSQ 335 Patient Safety Practices and 118 Good Organisational Practices were reported at mid term to the PaSQ database and more than 30 Exchange Mechanism events are planned to in order to share knowledge, learn from each other, implement council recommendations. The overall aim is to build capacity in individual MS, enhance Quality of Care and avoid harm to patients, as involve patients in health care. Knowledge Transfer is about sharing, learning and exchanging information, knowledge, skills, and experiences related to Patient Safety Good Clinical Practices and Good Organisational Practices – this will happen through PaSQ database of good practices (PaSQ WP 4 & 6).

Exchange Mechanisms created during PaSQ are:

- Wiki- Interactive Platform for display of all Patient Safety Practices and Good Organizational Practices and Exchange Mechanisms
- Multiple partner collaboration
- Webinar/Online project sharing
- Information and discussion meeting
- Workshop
- Study tours
- Twinning programs



PaSQ network is demonstrating that knowledge exchange and mutual learning via existing PaSQ web tools should efficiently complete the work already accomplished by European standardisation in the Health Care field (products and equipment).
(see Annex 1: PaSQ first results)

5. Key Functions proposed for the permanent network

Objectives of permanent network :

- To maintain the PaSQ database for reporting of Good Organisational Practices and Patient Safety Practices as a basis for mutual learning
- To propose forms of cost-effective efficient exchange mechanisms e.g. based upon the PaSQ experiences, including by using the IT.
- To build on the existing strategies or systems for patient safety and quality of care, aiming at raising the approach to the state-of-the-art level.

A sustainable system for **knowledge transfer** (KT) system will be developed building on the PaSQ tools and methods for sharing and learning across borders in EU with a specific focus on 4 priority key functions identified by member states:

1. Patient and public involvement and empowerment (PPI/PPE)
2. Implementation of selected Patient Safety Practices in clinical settings
3. European peer review for Care Quality Improvement. A review of the initiative and main principles of the methods applied. The review can be initiated at local, national or regional level and performed by peers (experts involved in local, national or regional Care Quality Improvement in other EU countries).
4. Rapid Exchange Mechanism of Patient Safety Incidents and Solutions: SEaL (Share, Exchange and Learn) a voluntary web-based system for issuing patient safety incidents and patient safety practices within member states.

5.1. Patient involvement and empowerment (PPI/PPE) is an effective mean to achieve, enhance and sustain safe and high quality healthcare delivery :The permanent network will propose: ((see Annex 2:)

- To provide an overview of good practices in MS of patient involvement and empowerment, including: health literacy, a participatory approach of patients, shared decision-making, mechanisms collecting feedback from patients, and use of patient experiences in improving safety and quality. The good practices should be evaluated for their quality, e.g. using the Value+ criteria of meaningful patient involvement⁸.
- To make an inventory of identified good practices at the clinical level in healthcare facilities/Member States, and possibly to develop training tools for the interaction between patients and healthcare provider.
- To provide an inventory of identified good practices at the organisational and systems/policy level, and possibly to develop training tools on patient involvement for interested healthcare providers/Member States.
- Selected good practices should be shared among Member States through either an Exchange Mechanism and or the PaSQ interactive WIKI-platform for sharing and learning.

⁸ The Value+ Handbook for project leaders and coordinators (2009), pp. 57-59. Available for download at http://www.eu-patient.eu/Documents/Projects/Valueplus/doc_epf_handbook.pdf



The permanent network will build this work on the outcomes of relevant initiatives which will produce results by 2015, such as the EC study on patient empowerment 'EMPATHiE'⁹, and the EC-funded mapping study on health literacy¹⁰.

5.2. Implementation of selected Patient Safety Practices in Healthcare Organisations (HCOs): - PaSQ, the European Union Network for Patient Safety and Quality of Care aims to promote European cooperation on issues related to quality of health care, including patient safety and patient involvement.

One of the means to achieve this is by selecting, implementing and monitoring Safe Clinical Practices (SCPs) in Health Care Organizations (HCOs) of the participating Member States (MS)

A selection of 4 Safe Clinical Practices was chosen for implementation in 18

European Member States:

- WHO Surgical Safety Checklist
- Medication Reconciliation
- Multimodal intervention to increase hand hygiene compliance
- Paediatric Early Warning Scores (PEWS).

All of them address important patient safety issues and enable the active involvement of patients. Participation in these issues is voluntary and it remains voluntary to select the specific patient safety practices at the national level from the practices offered through the network taking into account the experiences(strength and weaknesses) of the work process.

200 HCOs from 18 countries are recruited and take part in WP5 implementation. The big amount of recruited HCOs shows that there is a deep interest in implementing the SCPs selected for WP5 in the MS. The implementation of the selected PSPs increases the patient safety culture in HCOs. In order to guide the HCOs through the WP5 implementation process, a tool box for each SCP was developed. The tool boxes include information on the specific SCP and additionally, they offer a selection of specific implementation tools like videos, checklists and guidelines which can be used and/or adapted by the HCOs.

In summary it can be said that the experiences and results of this work can be expanded in a permanent network. More HCOs can join the implementation, more Safe Clinical Practices can be chosen for implementation, more tools can be added to the WP5 tool boxes, the tool boxes can be further developed due to the feedback received from the HCOs which will have used the tools. (see Annex 3).

5.3. European peer review for Care Quality Improvement (CQI):

Knowledge about QM in the EU may aid in understanding the principles on which they are built and operationalised, and assist the discussion of common effective principles for the long-term future. This voluntary exchange of experiences could be the basis of a peer review system for quality management initiatives in health care in Europe. (see Annex 4)

- The Future permanent network will focus on the planning, organisation, implementation and evaluation etc. of quality improvement initiatives and their way to develop and implement improvement for Health Care services at local, regional and national level to establish efficient principles for these systems in the EU.
- Through the European Peer review arrangement a review of the main principles of a local, national or regional Quality Improvements initiative is possible by peers (experts involved in similar local, national or regional Care Quality Improvement initiatives in

⁹ Final report due by mid-September 2014.

¹⁰ Forthcoming



other countries).

- The request for a review of an initiative will come from the responsible for the initiative itself.
- Based on the PaSQ exchange mechanism experience, specific workshops or study tours will be organised by representatives of a local, national or regional quality improvement initiative to invite experts involved in quality improvement initiatives of other member states to review and mirror their system(s), and share views and solutions for the future.
- Peer review based on the PaSQ exchange mechanism concepts represents a dynamic form of exchange, allowing mirroring, question and guiding each other and it can create a synergic collaborative effect among peer organisations across the EU. Though this form of review can be done by invited guest of the host organisation. Experts knowledgeable in that specific type of initiative (e.g. accreditation, indicator monitoring, patient satisfaction, improvement methods) can collaborate with relevant structures of the national health care system.
- The review will be based on agreed methods (e.g. questionnaire addressing the main points of the initiative, planning, organisation, transparency, methods used to develop and implement the initiative, influencing context factors, standards, patient involvement and empowerment...)

A summary will be written after the review to summarize in an agreed way comments and proposals for future developments.

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As stated by the European Parliament: “Ensuring patient safety is above all a matter of improving quality of life, but harm caused to patients by adverse events during treatment also places a significant burden on society, which is aggravated in times of economic crisis. For example, in certain Member States growing numbers of patients are contracting *Clostridium difficile* infections, which account for about 5% of all HAI in

¹¹ OECD Health data

¹² Etude nationale sur les événements indésirables graves associés aux soins: ENEIS: — Michel P., Minodier C., Lathelize M., Moty-Monnereau C., Domecq S., Chaleix M., Izotte-kret M., Bru-Sonnet R., Quenon J.-L., Olier L., 2010, « [Les événements indésirables graves associés aux soins observés dans les établissements de santé](#) », *Dossiers Solidarité et santé*, DREES, n° 17

¹³ *Ministero de Salud y Consumo*, APEAS Study: *Patient Safety in Primary Healthcare Summary* (in Spanish), 2005 (http://www.msc.es/organizacion/sns/planCalidadSNS/ec03_doc.htm, accessed 24 April 2010)

¹⁴ Aranaz et al. *European Journal of Public Health*, Vol. 22, No. 6, 921–925)

¹⁵ Council Recommendation 2009/C 151/01 of 9 June 2009 on patient safety, including the prevention and control of healthcare associated , Brussels 2009



Europe and are estimated to be the cause of 2% of hospital readmissions. The financial burden of such infections on Europe's healthcare systems is estimated to be EUR 3.7 million in 2013. Quite apart from the obvious benefits for patients, investment in patient safety could therefore be a source of potential cost savings: emphasis on patient safety reduces the costs incurred in treating patients experiencing adverse events associated with healthcare, and therefore means better use is made of financial and human resources. With a view to achieving these goals, the culture of patient safety can be significantly enhanced in a number of ways.”

- Follow-up (dissemination of the report, implementation of some of the solutions) will be under the responsibility of the MS who asked for the review

5.4. Rapid exchange mechanism of Patient Safety Incidents and Solutions: SEaL (Share, Exchange and Learn) a mutual alert system across EU. (see Annex 5).

It is a voluntary web based system for sharing and exchanging information about patient safety issues (incidents) and patient safety practices (initiatives) between member states. It provides a voluntary collaborative mechanism to Member States, allowing them to put information into the mechanism and also to access and act upon the information within it.

- The aim of the mechanism is effectively and rapidly disseminate information to MS about patient safety issues and initiatives to prevent the occurrence of clinical incidents depending on their seriousness and necessity for response.
- SeAL will be an extension of the PaSQ database.
- Sufficient resources will be allocated
 - to review and check the quality of reported information prior to display,
 - to exchange mechanism (face to face, webinars), to support the possibility to share information on patient safety issues, which required immediate action to prevent occurrence of serious clinical incidents-
- Serious adverse events which are covered by EU mandatory reporting to other databases are not targeted by the PaSQ SeAL system, but adverse events which are not covered by such a mandatory reporting should be shared through the SeAL system
- One network-partner from each Member States acts as national contact and coordination point. He is responsible for the validation and uploading of the information into the SeAL system.
- National contact points will establish ways of spreading the alert in their own country to make sure the information reaches the clinical field, where actions should be taken.

6. Options of collaboration

The options of collaboration and Involvement in the key functions for the PaSQ Permanent network are voluntary and can vary according to the interest of participating member states from simple sharing and exchanging of information to the participation to implementation tools development:

Option 1: sharing and exchange of information (on a voluntary basis). Participating to knowledge transfer

Option 2: Participating to the exchange mechanism

Option 3: Voluntary participating to implementation exercise(s)

Option 4: Participating to implementation tools development..

7. Organisation and Governance Structure (cf. Figure)



Partners of the network will be designated by MS (taking into account Council Recommendation 2009/C 151/01) and the European Commission (COM) for representatives of civil society (EU stakeholders). In each MS, one partner will serve as National Contact Point (NCP) coordinating all activities of the network at national level.

The government structure will comprise two bodies with each its specific tasks and responsibilities: the Steering Committee (SC) and the Executive Board (EB).

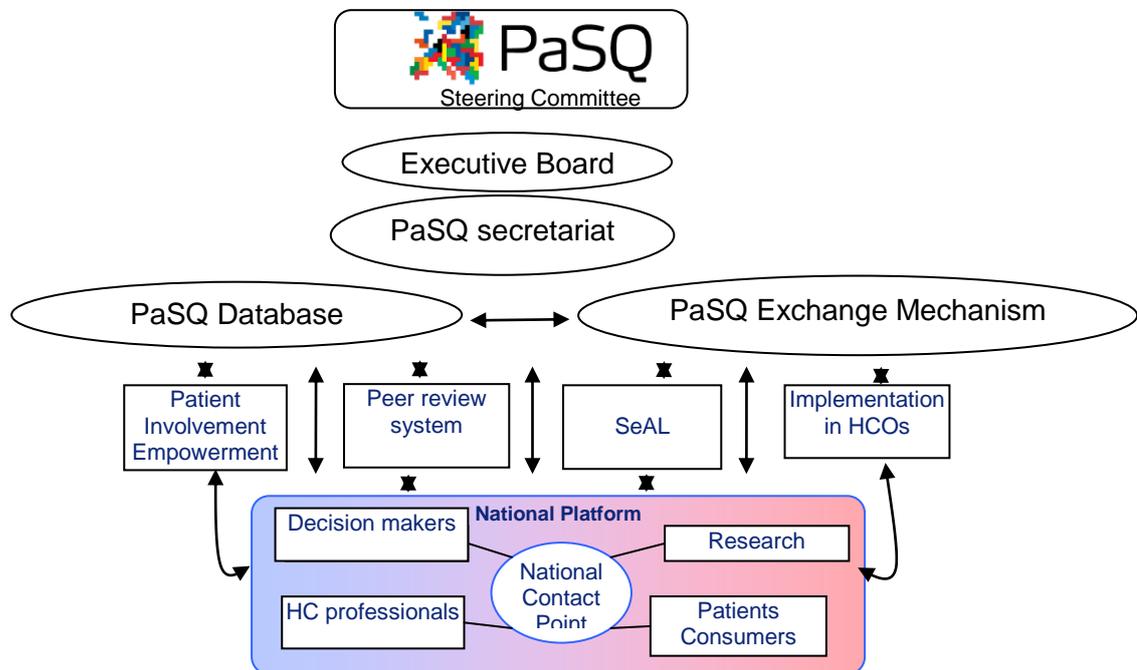
The Steering Committee (all partners of the network) is the decision making body of the network. It will more specifically:

- validate work plans, annual reports, budget
- adopt strategic plans and future developments plans

The Executive Board (key functions leaders and representatives EC institutions) has the following tasks:

- to supervise the Secretariat
- to prepare work plans and monitor outcomes
- to follow-up implementation, reviewing of performance and resources allocation.

Figure



8. Funding:

Based on PaSQ experience, costs of the permanent network should around 2 millions Euros per year depending on MS involvement in proposed activities. (cf annexe 6)

With 60% EC funding and 40 partners (27 MS and 13 EU stakeholders) the annual cost per partner will be **on average** 20 000 Euros (50 person/days or 0.22 FTE)



Annex 1: PaSQ first results

Analysis of the WP6 Questionnaire parts 1 and 2: quality management systems

- **Objective:** to collect information about the structure of the health care system (HCS) in relation to quality of care (QC) and patient safety (PS) and to collect information about specific activities displayed to assure and improve the quality of care in the different EU Member States (MS)
- **Results:** In total, 37 countries and regions returned the questionnaire (15 countries and 12 regions).

- Structure and activities of the HCS:

Almost all countries and regions responding indicate that they have the aspects of the service delivery structure in place; about 50% indicate the financing structure is arranged; and the legal structure is present in about 90%. Financial incentives related to QC&PS. Incentive structures vary between countries and settings but especially during the past ten years various experiments have been set up to link performance to payment. The (financial) incentive system could be designed in such a way that it pays to deliver good quality care. Activities aimed at health care organizations In hospitals, health care is provided through a combination of professionals, medical products and technologies in an organizational setting. . .

The results provide insight into the degree to which 13 of the activities explored are used by MSs (candidates) and the way in which these are organized. Overall, all countries and regions reported the use of multiple activities, but which activities are being used differs amongst countries and regions. Almost all countries deploy activities to improve QC by professional licensing and professional learning programs. The use of accreditation of integrated health services, peer-review, and the re-validation of professionals are least often reported by countries and regions. The level on which the activities are organized tend to be on both national and regional level, although this highly depends on the activity. In cases where the activity was organized only at one level, this tended to be national level. The activities that were organized as a private initiative were less often used/present in countries and regions as opposed to activities that were obliged.

- Activities aimed at patients

Overall, (a mix of) activities aimed at patients is used by the MS (candidates), however the degree to which the individual activities are present differs. Almost 70% of all respondents reported that patient organizations are involved in the development of policies that address quality and safety of health care provision. In 60% both consumer organizations and patient organizations are involved in the development of these policies. In the majority of countries and regions, the involvement of patients is organized at both national and regional level at the same time. The status that patient organizations have in their countries is in 60% that of an advising body and not a formal body, this is the case only in 20% of the countries and regions. In three quarter of the countries and regions, the provision of information on patients' rights is obliged, and shared decision making is obliged in about half of the countries and regions. The use of patient surveys to systematically monitor quality and safety of health care is in most countries recommended and obliged in one third of the countries and regions. Patient complaint mechanisms are obliged in almost all of the countries and regions and are organized on both national and regional level.



- Conclusion:

Most countries have the structures that can assure and improve quality and safety of health care in place. These structures offer the basic conditions for quality and safety of patient care. However, there is a large diversity in countries and regions when it comes to more advanced, integrated activities that are, on meso and micro level aimed at improving quality of care. The information in this report can be used by countries and regions to learn from others that do have organized those activities. Exchange of knowledge and experience can help countries to develop towards more advanced health care systems in terms of quality and safety which will ultimately lead to higher quality of care for their citizens.

Full text:

<http://www.pasq.eu/Portals/PaSQ/Dokumenti/WP6%20Questionnaire%20analysis%20Parts%201-2.pdf>

Summary of the data collection on Good Practices in patient safety and quality of care (WP4 and WP6)

Introduction

Based on the assumption that continuous safety and quality improvement could be effectively pursued by promoting actions aimed at identifying innovative practices, and enabling/accelerating their diffusion to the community of healthcare professionals throughout Europe, we set out to identify and share information on Good Practices.

Aims and conceptualisation

The aims were to collect information on Good Practices of patient in safety and quality of care applied in the health care systems of the EU member states, to identify perceived needs of EU member states in sharing with and learning from each other and finally to share Good Practices through:

- the PaSQ online wiki platform
- the Exchange Mechanism (EM) e.g. national or European meeting, workshops, study tours, webinars

Good Practices were comprised of Good Organisational Practices (GOP) and Patient Safety Practices (PSP), where the PSP were understood as Clinical Practices (CP) and Clinical Risk Management Practices (CRMP).

GOP were defined as *“Plans, strategies or programs at national or regional level (encompassing structure and process) oriented to improve the QC that can be useful for other HCS (states or regions)”*.

CP were defined as: *“An operating procedure or practice in health care and within the institution. The aim of a clinical practice is to enhance a clinical patient safety problem, where the patient is directly affected”*.

CRMP were defined as; *“An operating procedure, policy, strategy, or practice in health care, and within the institution. The aim is to enhance the organizational function, and to reach an optimal balance of risk, benefits, and costs. The patient is indirectly affected but could be directly involved”*.



Identification of Good Practices

Parallel data collections were initiated in the time from November 2012 to February 2013. The data collections focused specifically on:

- The system level; aiming to collect information about the most relevant transferable Good Organizational Practices (GOP) to be shared by MS and to identify the perceived needs of MS for learning from transferable GOP through the Exchange Mechanism (EM).
- The institutional level; aiming to collect information about Clinical Practices (CP) and Clinical Risk Management Practices (CRMP) identify the safe and transferrable practices and set up possibilities to share these practices and learn from each other across the EU.

Patient Safety Practices were reported by professionals at local level while Good Organizational practices were reported by EU Member States, Regions and PaSQ EU Stakeholders.

All reported practices were reviewed twice, before their display on the public part of the PaSQ webpage, to ensure they included the appropriate information to facilitate their understanding and transferability.

The Good Practices identified and displayed on the PaSQ webpage should be considered within the context in which they have been implemented. If considering to adopt some of these practices, one must consider ones own context prior to implementing.

Results Good Organizational Practices

118 GOP were submitted by organisations from 20 EU MS, 61 GOP were provided by National organisations, 38 by Regional bodies and 18 by Stakeholders.

GOP were classified in 18 categories based on the type of activity or topic covered: Quality improvement project was the most popular topic, with 18 GOP submitted (15% of the total), followed by Accreditation (12.7%), Clinical guidelines or pathways (10%) and Incident reporting and learning system (8.5%).

Most member states shared GOP covering different topics, showing that MS are working on different areas related to quality improvement and patient safety at the system level.

Over 60% of the respondents reported that they had found some barriers during the implementation phase. Resistance to change, lack of motivation from staff, funding, budget or resources constraints and lack of time from staff / extra work needed are the barriers most frequently cited. Implementation barriers were found in most of the GOP from some topics, such as incident reporting and learning system (90%) or patient safety system (87.5%) whereas barriers were rarely found in GOPs from other topics such as audit system and patient complaint mechanism (0%) or inspection (33%).

Regarding the implementation level, 55% of the GOP were implemented at national level 36.4% were implemented at regional level and 9.3% were implemented only at local level.

In regards to perceived needs of EU member states for learning from Transferable Good Organisational Practices respondents were invited to select the topics for which they would be wishing to learn GOP. Accreditation captured the highest interest, with 48 survey



respondents willing to learn about this topic. Other areas of high interest were patient safety system, incident reporting and learning system, quality indicators and clinical guidelines or pathways.

For every single topic explored, the learning interest was higher than the number of good organisational practices submitted.

Full text :

<http://www.pasq.eu/mwg-internal/de5fs23hu73ds/progress?id=BEW1KJwLqj>

Results Patient Safety Practices

339 PSP were submitted by healthcare professionals and organisations from 14 EU. In total 139 CPs and 69 CRMP qualified for the public display on the PaSQ online wiki platform. The remaining 101 PSPs are for the time being only accessible for the PaSQ network. In the results below all reported PSP are accounted for.

The CPs were reported according to 26 clinical topics, were *clinical guidelines* was the most frequent topic used 39 times. CRMP was reported according to 13 risk management topics, with Implementation of patient safety initiatives/activities being most used 24 times. Each PSP could be allocated two topics.

The CPs and CRMP were classified according to a framework taking into account; the state of implementation and the proven effectiveness of the practice. Classification of the CPs and the CRMP was as listed in the table below.

	CP	CRMP	Total PSP
Safe	70	29	99 (48%)
Potentially Safe	13	5	18 (9%)
Not proven effective	5	2	7 (3%)
Not Implemented	3	1	4 (2%)
Not evaluated	48	32	80 (38%)
Total	139	69	208 (100%)

Of the 339 PSPs 219 were fully implemented (65%), 109 were partly implemented (33%) and 7 (2%) had not yet need implemented.

A PSP was assess as transferable when it had proven itself effective in a different health care system, health care context, or specialty than originally designed for/implemented or tested in. In total 52 PSPs were assessed as transferable as per the table below. 17 of the 339 reported PSP were classified as fully implemented and having shown a positive effect between the pre and post effect measures (= classified as safe) and being transferable.

Transferable	CP	CRMP	Total PSP
Safe	17	15	32 (62%)
Potentially Safe	3	1	4 (8%)
Not proven effective	1	0	1 (1%)
Not Implemented	0	0	-
Not evaluated	6	9	15 (29%)
Total	27	25	52 (100%)



Results regarding Patient Safety Initiatives Implementation (WP5)

- Safe Clinical Practices (SCPs) for implementation collected and selected
 - Criteria for the selection of SCPs defined: Demonstrated effectiveness; Transferability; Feasibility; Existing implementation tools; Patient involvement
 - Literature Review of SCPs conducted: 1st set of SCPs compiled
 - Feedback from PaSQ Member States (assessment of relevance, completion of further SCPs) gathered: Final set of SCPs defined – WHO Surgical Safety Checklist; Medication Reconciliation; Multimodal intervention to increase hand hygiene compliance; Paediatrics Early Warning Scores (PEWS)
- Implementation tools collected and tool boxes put together
 - Criteria for the collection of implementation tools defined: Available in English; Adaption and application achievable within PaSQ timeframe; Easy access; Copyright; Developed since 2006; Applied / tested in practice; Provision of required information for completion of the template; Transferability to other EU countries / healthcare systems; The implementation tools originate from various healthcare contexts; Application requires neither certification nor external training courses; Translations or adaptations of WHO tools which are not listed on WHO websites will not be included in the WP5 tool boxes due to WHO permission and licensing restrictions (<http://www.who.int/about/licensing/en/>); Innovative character.
 - Template for the collection of implementation tools developed
 - Questioning of Member States for gathering implementation tools: More than 55 tools were reported
 - Results collated and an implementation tool box for each SCP compiled (publicly available on PaSQ Website: <http://www.pasq.eu/Wiki/SCP/WorkPackage5ToolBoxes.aspx>)
- Healthcare Organisations (HCOs) for the implementation of SCPs recruited
 - Requirements for participation defined
 - List of 200 HCOs in the 18 PaSQ Member States who participate in WP5 implementation compiled (publicly available on PaSQ website: <http://www.pasq.eu/Wiki/SCP/OverviewofSCPImplementationinPaSQMemberStates.aspx>)
- Implementation of SCPs in 200 HCOs in 18 PaSQ Member States started
- Monitoring and assessment of implementation process started
 - Baseline questionnaires on the SCPs for the HCOs designed and forwarded to the 18 PaSQ National Contact Points: 258 baseline questionnaires were filled in



Annex 2: Patient involvement and empowerment

Patient involvement and empowerment is a cross-cutting objective of PaSQ work-packages (WPs), from WP4 to WP7. It is more developed in WP4 and WP6 as built-in elements of good organisational and patient safety practices collected from project partners, but exists also as an added value of Safe Clinical Practices implemented by healthcare organisations in WP5. Within WP7, which focuses on sustainability of PaSQ network, patient involvement and empowerment is one of the four priority key functions identified by member states.

Patient involvement and empowerment in the area of patient safety has been addressed at EU level in the Council recommendation of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections. However, it remains an under-implemented area in most Member States.¹⁶

Moreover, the experience from the PaSQ project shows differences in using and applying the concepts of patient safety¹⁷ and quality of care¹⁸, as well as those of patient involvement and empowerment.

Therefore, sharing good practices through the sustainable network would contribute to adjusting the health care services to the needs of patients through their involvement and empowerment, and including the feedback of patients into actions which positively impact on the life of patient communities across the EU.

Evidence from the field, meaning examples from practices implemented in different EU countries, at different levels: such as macro, meso or micro, will be shared through a web-based platform as well as through the Exchange Mechanisms developed during the PaSQ project.

Additionally, patient involvement and empowerment will be show-cased in a strategic document as an effective approach with positive effects for the healthcare system, within WP7, task 5: Patient involvement. This will further develop on clarification of patient involvement and patient empowerment concepts defined in PaSQ Glossary.

This approach considers, as an example, the findings related to health literacy, which is an essential component of patient empowerment. Recent findings show that limited health literacy is associated with poorer health outcomes, use of healthcare services, and high health system costs; as an example, it was estimated to cost more than US\$ 8 billion or 3–5% of the total health care cost at system level in Canada in 2009.¹⁹

The EU Health Literacy Survey completed in 2012 showed that limited health literacy is prevalent in many EU countries, not just among vulnerable populations.²⁰

¹⁶ COM(2012) 658 final, 13.11.2012.

¹⁷ Patient safety is the reduction of the risk or harm associated with health care to an acceptable minimum. An acceptable minimum refers to the collective notions of i) given current knowledge, ii) resources available and iii) the context in which care was delivered, weighed against the risk of non-treatment or other treatment.

(Based upon the World Health Organization, World Alliance for Patient Safety. Conceptual Framework for the International Classification for Patient Safety Version 1.1. Final Technical Report. Geneva: World Health Organization.2009)

¹⁸ The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality of care means that a health system should seek to make improvements in six areas or dimensions of quality: (1) effective, (2) efficient, (3) accessible, (4) acceptable, (5) equitable, and (6) safe. "Quality of care : a process for making strategic choices in health systems", World Health Organization, 2006.

¹⁹ Eichler K, Wieser S, Bruegger U, "The costs of limited health literacy: a systematic review", Int J Public Health, 2009;54(5):313-24; Berkman ND et al. "Low health literacy and health outcomes: an updated systematic review", Ann Intern Med. 2011 Jul 19;155(2):97-107.

²⁰ Comparative report on health literacy in eight EU member states. The European Health Literacy Project 2009–2012. Maastricht, HLS-EU Consortium, 2012. <http://www.health-literacy.eu>



Furthermore, PaSQ project will build on the theoretical background of patient involvement and empowerment in order to provide partners and other interested parties with basis for setting their strategies and / or actions on solid ground of the existing regulations at EU level, relevant research, practices tested and validated at either international or European level.

The paper will include examples from the field collected through WP4 and WP6; special attention will be given to the WP5 practices, which are implemented based on the models provided through the 4 selected Safe Clinical Practices. Although these practices do not specifically emphasize on PI and PE, elements of these approaches might be developed during the implementation from July 2013 to September 2014. Therefore, the evaluation of practice implementation (presented in Annex 3) will allow describing the elements which lead to participation and empowerment of patients.

Good Organizational Practices focusing on patient involvement and empowerment in patient safety (collected through WP6) will be shared among Network members. They are collected through a specific questionnaire on the PaSQ webpage.

The first set of information on these practices included only a brief description of PI/PE, so they will be further analysed, and details on the participation of patients will be described by project partners responsible for this task in the second phase.

The second phase will involve discussions with contact persons who contributed information concerning the practice in order to find out specific elements of PI/PE, which are listed in a second-phase questionnaire focusing on GOP content analysis.

The definitions of patient empowerment and patient involvement developed for the PaSQ Glossary^{21, 22, 23} will be further developed, given the significant overlap and complementarity between the two concepts which should nevertheless be conceptually distinct. There will be considered the outcomes of the relevant initiatives, such as the forthcoming EC research study on patient empowerment.

A first draft of the integrated proposal will be presented at the coordination meeting in Rome in September 2014.

²¹ "The extent to which patients and their families or caregivers, whenever appropriate, participate in decisions related to their condition (e.g. through shared decision-making, self-management) and contribute to organisational learning through their specific experience as patients (e.g. patient reporting of adverse events or participation in root cause analysis related to their care).

Collective patient/public involvement is the extent to which patients and citizens, through their representative organisations, contribute to shaping the health care system through involvement in health care policy-making, organisation and delivery." (European Patients Forum for PaSQ, adapted from the Value+ project: <http://www.eu-patient.eu/Initatives-Policy/Projects/EPF-led-EU-Projects/ValuePlus/>)

²² Meaningful patient involvement = concept developed by EPF in the Value + project. Please refer to: <http://www.eu-patient.eu/whatwedo/Projects/EPF-led-EU-Projects/ValuePlus/>

²³ A multi-dimensional process that helps people gain control over their own lives and increases the capacity of people to act on issues that they themselves define as important. (Luttrell et al. (2009), Understanding and operationalising empowerment. Overseas Development Institute working paper.)

A process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and take political, social, and cultural action to meet those needs.

(Deepening our Understanding of Quality improvement in Europe; <http://www.duque.eu/>)



Annex 3: Implementation of selected Patient Safety Practices in Healthcare Organisations (HCOs)

PaSQ, the European Union Network for Patient Safety and Quality of Care aims to promote European cooperation on issues related to quality of health care, including patient safety and patient involvement. One of the means to achieve this is by selecting, implementing and monitoring Safe Clinical Practices (SCPs) in Health Care Organizations (HCOs) of the participating Member States (MS) as it is being conducted in Work Package 5 (WP5) of the project.

The following achievements show what have been accomplished in WP5 so far and why a sustainable support of these activities is important.

Collection and Selection of Safe Clinical Practices for Implementation:

Five criteria for the selection of the Safe Clinical Practices for implementation in WP5 were defined. Demonstrated effectiveness or transferability can be given as examples for these criteria. A literature review to collect potential SCPs was conducted and a first set compiled and presented in templates. Feedback from the MS was gained via an online questionnaire and the final set of SCPs for implementation in WP5 was decided on:

- WHO Surgical Safety Checklist
- Medication Reconciliation
- Multimodal intervention to increase hand hygiene compliance
- Paediatric Early Warning Scores (PEWS).

All of them address important patient safety issues and enable the active involvement of patients.

Implementation Tools and Webinars to Support the Implementation Process:

In order to guide the HCOs through the WP5 implementation process, a tool box for each SCP was developed. The tool boxes include information on the specific SCP and additionally, they offer a selection of specific implementation tools like videos, checklists and guidelines which can be used and/or adapted by the HCOs. Furthermore, generic implementation tools related to patient safety and quality of care were collected. They are provided in order to give HCOs further support when working in these fields. The gathering of the tools was conducted through a literature/web search, aiming to identify the most important tools offered by major international institutions, and through the questioning of PaSQ National Contact Points (NCPs) and EU stakeholders. More than 55 tools were reported and new tools can still be added. The tool boxes are available on the PaSQ website free of charge: <http://www.pasq.eu/Wiki/SCP/WorkPackage5ToolBoxes.aspx>. For this reason and because most of the tools are in English, the WP5 tool boxes provide a sustainable support for HCOs all over the world which are interested in implementing one of the WP5 SCPs.

In addition, webinars are planned and coordinated. This is done in cooperation with the PaSQ NCPs and experts from the PaSQ MS during the main implementation phase (September 2013 to September 2014). The aim of these webinars is to foster the exchange of knowledge and experience on the topics related to the WP5 SCPs.

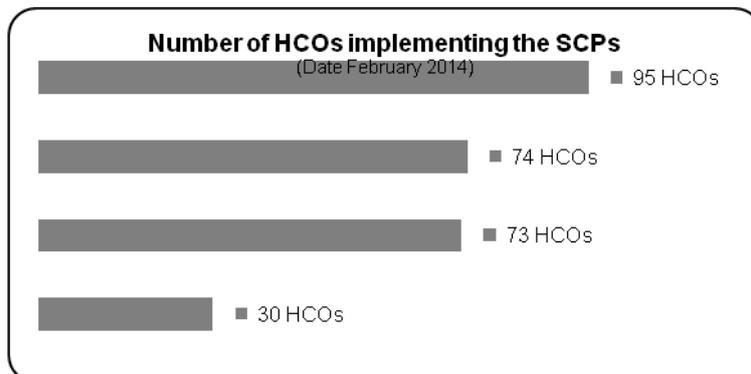
Recruiting of HCOs for Implementation:

For the recruitment of the HCOs in the participating PaSQ MS a recruitment package was developed and sent to the PaSQ NCPs. One component of the recruitment package was a short description of each SCP selected for implementation within WP5 which also contained some basic information on implementation and key resources, so that the PaSQ NCPs and



the HCOs were aware of the implementation requirements. An overview of the SCP implementation in the PaSQ MS and the participating HCOs can be found here: <http://www.pasq.eu/Wiki/SCP/OverviewofSCPImplementationinPaSQMemberStat.aspx>. 200 HCOs from 18 countries are recruited and take part in WP5 implementation. Several HCOs apply more than one SCP. The HCOs involved in WP5 implementation joined the project at various levels. In some of the participating countries campaigns or programs are already underway to implement these practices. The big amount of recruited HCOs shows that there is a deep interest in implementing the SCPs

selected for WP5 in the MS. Even more HCOs can take part in the implementation and benefit from the experiences gained until the end of the project. Interested HCOs can directly contact the HCO coordinators via the corresponding PaSQ NCP to ask for an exchange.



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Monitoring and Assessment of Implementation Process:

The monitoring and assessment of the implementation process is also part of WP5 work. The evaluation component focuses on the feasibility and transferability of implementing the SCPs selected in WP5, according to their description provided in the tool boxes. For this reason the central question is whether the practices were implemented as proposed in the tool boxes with the tools provided and if not, why it was done differently. Since the implementation phase which can be assessed within PaSQ lasts one year (September 2013 to September 2014), it is of further interest to assess the implementation progress made within this timeframe. The following list gives an overview of some evaluation questions for which data will be collected:

- Were the WP5 tool boxes helpful in the implementation process? If so, which components and tools were helpful? If not, why not? Which further implementation tools did the HCOs use?
- Which activities were undertaken to ensure that patient involvement is an integral part of the practice?
- Which barriers and facilitators were encountered in the implementation process?
- Which benefits were seen as a result of participating in the PaSQ project?
- How satisfied was the HCO coordinator altogether with the practice implementation?

For this purpose, baseline questionnaires were administered to the HCOs from September to November 2013. 258 baseline questionnaires were filled in. Endline questionnaires will be administered one year later. There is one baseline and one endline questionnaire per Safe Clinical Practice to be implemented in WP5.

Conclusion:

In summary it can be said that the experiences and results of WP5 work can be expanded. More HCOs can join the implementation, more tools can be added to the WP5 tool boxes, the tool boxes can be further developed due to the feedback received from the HCOs which will have used the tools.



Annex 4 - European peer review for Care Quality Improvement (CQI)

Definition: Peer review: The review of Healthcare quality improvement initiatives by other people in the same field in order to propose improvements to the initiative based on reviewers experience. (PaSQ glossary).

1) Rational

- Regulation 1025/2012 on European Standardization recognises role of service standards in support of policy and legislation & provides legal basis for European Commission Mandates in the area of services
- Directive 2011/24 on the application of patients' rights in cross-border healthcare also tries to ensure that care is safe and of good quality
- Interest from the European Commission to explore the role of European standards in relation to healthcare services

2) Principles

- Review of the initiative and main principles of a local, national or regional Quality Improvements initiative by peers (experts involved in a similar local, national or regional Care Quality Improvement initiative in other countries).
- Organised by the relevant level of the health care system (local, regional, national)
- Participation on a voluntary basis
- Non binding recommendations
- Independent secretariat and common guidelines for reviewers

3) Objectives

- To discuss different approaches and solutions to address the same issue: how to improve patient safety and quality of care at local, national or regional level.
- To assist the discussion of common effective principles for the long-term future regarding the quality improvement initiative and the way to extract knowledge and survey the possibility to develop and implement guidelines and standards for Health Care services at local, regional and national level.
- To help EU health care to initiate improvements
- To share principles, exchange solutions and create a community
- To give recognition and credibility

4) Program components:

- Review of Care Quality improvement initiative (method, governance, management, decision making, implementation support, transparency, patient involvement)
- Review of care quality improvement standards development (user focus, planning, standards measurement).
- Review of training programs for Care Quality improvement initiatives e.g. surveyors, skills to facilitate improvement at clinical levels, data for improvement etc.

5) Methods:

- Based on the exchange mechanism experience, specific workshops or study tours will be organised by representatives of a local, national or regional organisation to



invite experts involved in quality improvement systems of other member states to review their system(s) share views and solutions for the future.

- Reviewers will visit the institutions involved in care quality improvement in the host country. Meetings will be organised to exchange views with national or regional experts involved in the system to be reviewed.
- The review can take different forms – e.g. Site visits and meetings or based on interviews addressing the main points of the system (organisation, transparency, methods used to develop standards, improvement capacity and capability etc. – that is up to the host to decide.
- A report will be written after the exchange to summarize in an agreed way comments and proposals for future developments.
- Follow-up (dissemination of the report, implementation of some of the solutions) will be under the responsibility of the MS who asked for the review

6) Outcomes:

- Sharing of experience to avoid duplication of efforts when addressing the same issues in various member states.
- Efficient implementation of good practices based on expert input and experience
- Involvement of local, regional and national experts and stakeholders in discussing new solutions presented by experts who tested them in their home countries.
- Discussion of common principle for quality improvements initiatives in the EU member states.
- **PaSQ network** is demonstrating that knowledge exchange and mutual learning via existing PaSQ web tools are a **credible alternative to European standardization**.
- **Permanent network for Patient Safety and Quality of Care** in the European Union, will in addition contribute to important areas such as *patient involvement and empowerment, implementation of efficient good clinical practices, quality improvement systems as well as reporting and learning*



Annex 5 - **Rapid exchange mechanism of Patient Safety Incidents and Solutions: SEaL** (Share, Exchange and Learn) - a voluntary mechanism for sharing and exchanging information about patient safety.

1) Rational.

The establishment of the rapid exchange mechanism for internationally relevant patient safety topics will be a great measure to unite efforts of MS in the field of PS to ensure the medicines, practices, procedures used by the public are safe and of good quality

2) Principle.

SEaL is a web-based system for issuing patient safety issues (incidents) and patient safety practices (initiatives) within member states. Voluntary mechanism of Member States from putting information into the mechanism through to accessing and acting upon the information within it.

3) The purpose

The purpose of the mechanism is to share, for learning purposes, across the European Union:

1. **Patient safety issues** -a) adverse events which have required immediate action at local level to prevent occurrence of clinical incidents, b) sentinel events which represent potential patient safety issues and require local risk assessment to determine appropriate response and
2. **Patient safety initiatives** that share best patient safety practices, outcomes of patient safety research, upgrades regarding good organizational practices, tools and resources for patient safety reform by dissemination of information without requirement of immediate response.

The aim of the mechanism is effectively and rapidly disseminate information to MS about patient safety issues and initiatives to prevent the occurrence of clinical incidents depending on their seriousness and necessity for response .

4) Methods

Aspects of the mechanism:

1. **input** – designated approved organization at national level, that receives information from national HCOs about patient safety issues and practices, validate the notification, determine the seriousness of reported cases, recommend the response, translate in English and upload to the central mechanism(at present PaSQ web page)
2. **storage** –the uploaded informations are secured and stored on the PaSQ server.
3. **dissemination** –uploaded patient safety issues and practices are accessible for organisations and individuals on PaSQ web page and are automatically send by mails to national designated body (Ministry of Health or National Contact Point) which will disseminate the information within member state

Only approved organisations are able to submit information.

The suggested criteria to be applied to an organisation are:

1. it has a methodology for identifying patient safety issues and;
2. it has a national or regional patient safety reporting and learning system; or
3. it has an in-country mechanism for issuing reports of patient safety issues to healthcare organisations within their remit; or



4. it is recognised by the PaSQ National Contact Points for having a national or regional patient safety reporting and learning system within respective Member State.

A standardised electronic form accessible over the internet will be used to help categorise the report and upload a copy of the report. The form will then be able to provide sufficient information for individuals to understand what the patient safety issue or initiative is.

Suggested fields for the electronic form, which should be mandatory, include:

- Issue/initiative
- Name of report
- Date of release within Member State
- Member State of issuing organisation
- Known causes of problem
- Brief summary of issue/initiative that outlines the purpose of the information, the care setting(s) it applies to; the issue; any suggested actions to prevent it occurring
- Key words related to the issue
- Optional electronic copy of the report/solution
- Contact point for further information within the organisation

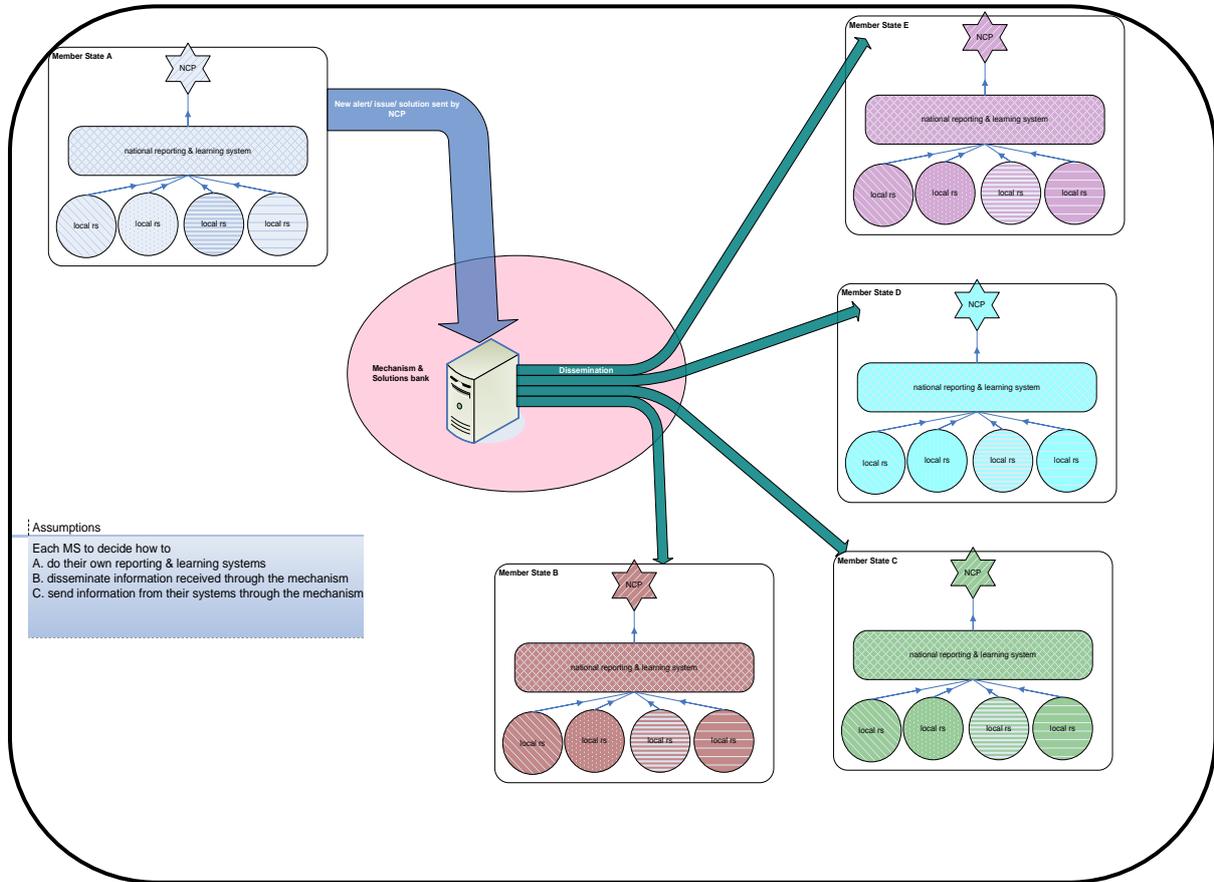
Approach of SeAL for the response to reported cases at MS and EU level:

- Notification of the case (or cases) in a Member State
- Validation of the notification at the level of the Member State; determination of the seriousness of the accident that has occurred and whether it is possible to respond;
- response within the Member State;
- circulation of the information throughout the EU.
- Compiling the notification report at EU level: search of the databases available for similar cases in the EU;
- circulation of the results within the EU; conclusions; reaction at EU level

Language is a key consideration for submitting information. It is suggested that the standardised form will be in English. For those Member States that are not able to share the report or solution in English, an abstract could be submitted with reference to how to get further information.



Figure 1: Overview of the sharing mechanism





Annex 6: Funding:

Based on PaSQ experience, costs of the permanent network should around 2 millions Euros per year depending on MS involvement in proposed activities.

Expenditures	Horizontal activities			Network activities				TOTAL BUDGET PER LINE
	Coordination of the network	IT support & Dissemination	Evaluation	Knowledge exchange	Implementation of GP	Peer Review system	SeAL	
Staff	200 000 €	150 000 €	100 000 €	300 000 €	200 000 €	200 000 €	150 000 €	1 300 000 €
Travel costs and subsistence allowances	200 000 €	10 000 €	5 000 €	60 000 €	50 000 €	20 000 €	20 000 €	365 000 €
Subcontracting Costs		100 000 €	0 €	0 €	100 000 €			200 000 €
Other Costs	60 000 €	2 000 €	2 000 €	20 000 €	10 000 €	30 000 €	10 000 €	134 000 €
Total budget	460 000 €	262 000 €	107 000 €	380 000 €	360 000 €	250 000 €	180 000 €	1 999 000 €

- Coordination:
 - Staff: Management of the network: 2 FTE (440p/d per year)
 - 2 coordination meetings per year:
 - Other costs: 30 000 Euros for each meeting (room renting, catering, invitations of non partner)
 - Travel & subsistence costs: 1000 euros/p 100 participants for each meeting
- IT support and dissemination
 - Staff: Management of the web site and dissemination activities: 1.5 FTE (330p/d per year)
 - Travel & subsistence costs: 1000 Euros/p participation to meetings for dissemination activities.
 - Subcontracting costs: IT development for new activities (i.e. SeAL application, peer review system), maintenance
 - Other costs: meeting organisation, computers
- Evaluation
 - Staff: evaluation tools development data collection, data analysis, reporting 1 FTE (220 p/d per year)
 - Travel & subsistence costs: 1000 Euros/p participation to meetings for evaluation activities.
 - Other costs: meeting organisation
- Knowledge exchange:
 - Staff: Exchange mechanism development (data collection, tool development, participation to exchange events, dissemination and evaluation of events) 3 FTE (660 p/d per year)
 - Travel & subsistence costs: 1000 Euros/p participation to meetings for 10 exchange events per year.
 - Other costs: meeting organisation for 10 events per year
- Implementation of good practices:



- Staff: Selection of good practices, implementation tool box development, recruitment of HCOs, training, evaluation 2 FTE (440 p/d per year)
- Travel & subsistence costs: 1000 Euros/p participation to meetings for training and dissemination.
- Subcontracting costs: for 50 HCOs (2000 Euros per year)
- Other costs: meeting organisation for training.

- Peer Review system:
 - Staff: System development and implementation (review criteria, reviewers recruitment and training, organisation of country visits) 2 FTE (440 p/d per year)
 - Travel & subsistence costs: 1000 Euros/p participation to 5 country visits per year
 - Other costs: meeting organisation for 5 country visits per year

- Rapid exchange system SeAL:
 - Staff: System development, implementation and evaluation (data collection, section criteria for Safety issues and solutions, recruitment of reporting organisations, training, dissemination) 1.5 FTE (440 p/d per year)
 - Travel & subsistence costs: 1000 Euros/p participation to meetings system development, implementation and training.
 - Other costs: meeting organisation for 2 meetings per year.