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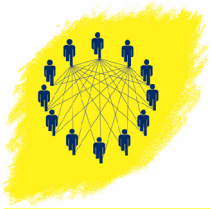
Safety IMprovement for PATients In Europe

Project findings, lessons and future

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www.simpatie.org





SIMPATIE is about:

Using Europe-wide networks of organizations, experts, professionals and other stakeholders to establish, within two years, a common European set of vocabulary, indicators, internal and external instruments for improving safety in health care.





Consortium partners

- AvMA/ (Action against Medical Accidents
LMCA / Long Term Medical Conditions Alliance)
- CoE (Council of Europe)
- CPME (Comité Permanent des Médecins Européens)
- HOPE (European Hospital and Healthcare Federation)
- ESQH (European Society for Quality in Healthcare)
- HAS (Haut Autorité de Santé former ANAES)
- **CBO (Dutch Institute for Healthcare Improvement) consortium leader**

Project is sponsored by the EC / DG SANCO,
as part of the Information for Policy Program

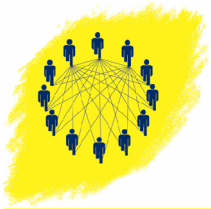




Key Work Packages

- Promotion CoE's recommendation on management of patient safety and prevention of adverse events in health care Rec. (2006)7
 - Knowledge repository of legislation, regulation actions and best practice (national and European)
- Tool box:
- Safety vocabulary (definitions) and indicators formulated
 - External evaluation and instruments for improvement
 - Internal evaluation and instruments for improvement





Mapping exercise

- 22 countries
- Reference, expert group, validation
- Questionnaire: national, local/organization level, specialist resources for safety
- Good practice compendium

Lessons learned:

- Inclusion of all MS difficult
- Useful resource if validated and updated
- Information for professionals, practice, research and policy

Possible way forward:

- ◆ Expert network and Competent Authorities (EUNetPaS project)
- ◆ Information to facilitate cross border movement





CoE Recommendation

- Adopted by Committee of Ministers May 24, 2006
- Draft used for development other WP (glossary, country overview, medication safety)
- Web based forum www.simpatie.org
- Dissemination project and other meetings
- Further publications in preparation

Lessons learned:

- Participation of all member states
- Representation by formal nomination
- Slow process
- More technical expertise could be useful
- Dissemination plan





Tool box: definitions and indicators

- International expert group and literature / sources based in a national centre
- Vocabulary 24 terms: detection- analysis of risk, resulting actions, failure mode
- 43 Indicators: risk-harm reduction, specific

Lessons learned:

- Many national / local lists, EU cooperation has added value
- Relevance/ appropriateness, validity / reliability and feasibility
- Recommendation: use in all MS, some MS, can be used

Next steps:

- ◆ Maintain technical exchange
- ◆ 9-10 Jan 2008 Odense DK
- ◆ Data availability / comparability





Tool box: safety solutions

- National expert group, international resources and consultation, based in national agency
- Tools for analysis of incidents / risk: retrospective and prospective
- Intervention approaches: system / organization and process / professional level

Lessons learned:

- Many interventions being developed all over
- Generic solutions with national / local adaptation
- Similar intervention framework

Future soon:

- ◆ Testing international solutions (High 5s'; WHO/CwF 3MS)
- ◆ Technical cooperation and solutions repository





Consensus conference

- Two third of project period
invitational conference
- Discussed preliminary findings with
participants
- Recommendations on three levels;
EU level, national level,
provider/HCO level

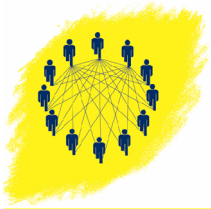




Tool box: external evaluation

- Leading national agency performs an international study including consultation with international experts
- Improvement, accountability; assessing safety initiatives, actual performance, cost efficacy ratios
- Focus: from safety of goods and individuals to clinical standards and governance to dynamic interfaces and patient participation to global management and safety culture
- How do evaluation programs address those issues: definition of requirements (standards, goals, indicators), survey methods, credible decisions and follow-up actions



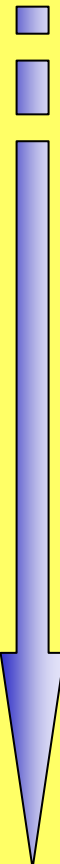


EE lessons and future

European harmonization:

- Common general goals and principles
- Port folio of common methods (a minimum tool platform)
- Common standards
 - Physical standards
 - Clinical governance
 - Organization and system approach
- Monitor performance
- Process of evaluation
- Logic of decision

easy

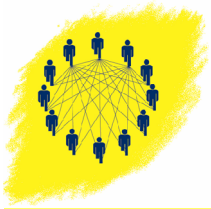


difficult

Proposed European Actions:

- Make existing information available to MS: programs of external evaluation applicable to HCOs and on hospital quality
- Adopt principles for external evaluation (International Accreditation Program of ISQua)
- Incorporate into those principles European requirements on patient safety as they are being adopted





For and with patients

1. Identify

- Patient organizations focused on safety often can not be reached through 'general' patient associations, targeted effort to identify in each MS needed

2. Facilitate and include

- Issue of resources is crucial, mostly voluntary organizations, networking on EU level desired and could be facilitated... coordinate through EPF but assure structural representation in safety issues

3. Involve

- All actions to include expertise on patient experiences and communication with them
- Specific actions on safety priorities as defined by patients





What's next?

- All WPs report available on WWW.SIMPATIE.ORG
- Data to be transferred to Simpatie follow up EUNetPas
- Project coordination by Haut Autorité de Santé (HAS)





SIMPATIE follow up

EUNetPaS;

EUropean Network on Patient Safety

Core WPs;

1. PS culture
2. Education and Training
3. Reporting and learning systems
4. Pilot implementation on Medication Safety

We hope to start in January 2008

Thank you for your attention!



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