Implementation Report on the patient safety Recommendation 2009/C 151/01

Healthcare Systems Unit
DG SANCO

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REPORT FROM THE COMMISSION TO THE COUNCIL on the basis of Member States' reports on the implementation of the Council Recommendation (2009/C 51/01) COM(2012) 658 final

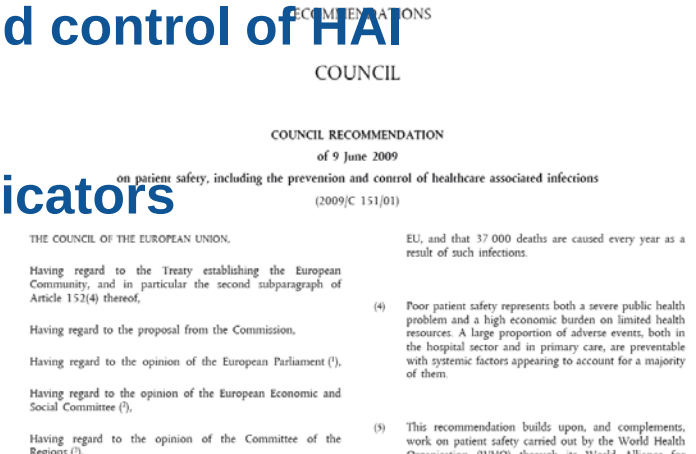
COMMISSION STAFF WORKING DOCUMENT

Detailed analysis of countries' reports on the implementation of the Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections SWD(2012) 366 final

http://ec.europa.eu/health/patient_safety/policy/index_en.htm

Council Recommendation 2009/C 151/01

- *Main actions envisaged at MS level:*
  - **Prioritise PS in public health policies**
  - **Empower patients**
  - **Establish reporting and learning systems on adverse events**
  - **Embed PS in education and training of health workers**
  - **Implement strategies on prevention and control of HAI**
- *Main actions envisaged at EU level*
  - **Propose common terminology and indicators**
  - **Exchange good practice**
  - **Develop research on PS**



RECOMMENDATIONS

COUNCIL

COUNCIL RECOMMENDATION

of 9 June 2009

on patient safety, including the prevention and control of healthcare associated infections

(2009/C 151/01)

THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular the second subparagraph of Article 152(4) thereof,

Having regard to the proposal from the Commission,

Having regard to the opinion of the European Parliament [1],

Having regard to the opinion of the European Economic and Social Committee [2],

Having regard to the opinion of the Committee of the

EU, and that 37 000 deaths are caused every year as a result of such infections.

(4) Poor patient safety represents both a severe public health problem and a high economic burden on limited health resources. A large proportion of adverse events, both in the hospital sector and in primary care, are preventable with systemic factors appearing to account for a majority of them.

(5) This recommendation builds upon, and complements, work on patient safety carried out by the World Health

Implementation Report 2012

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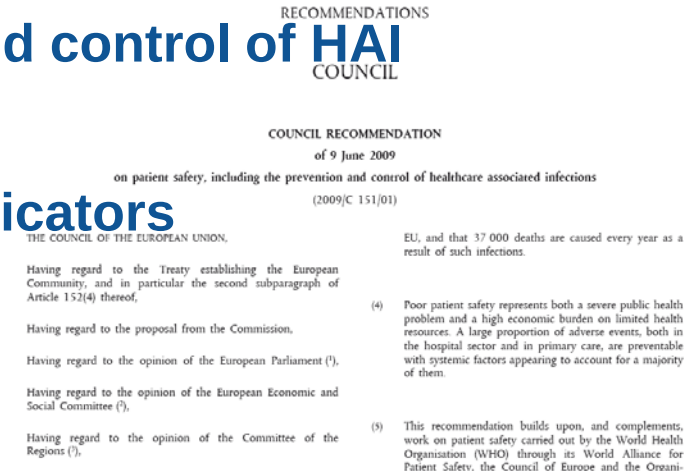

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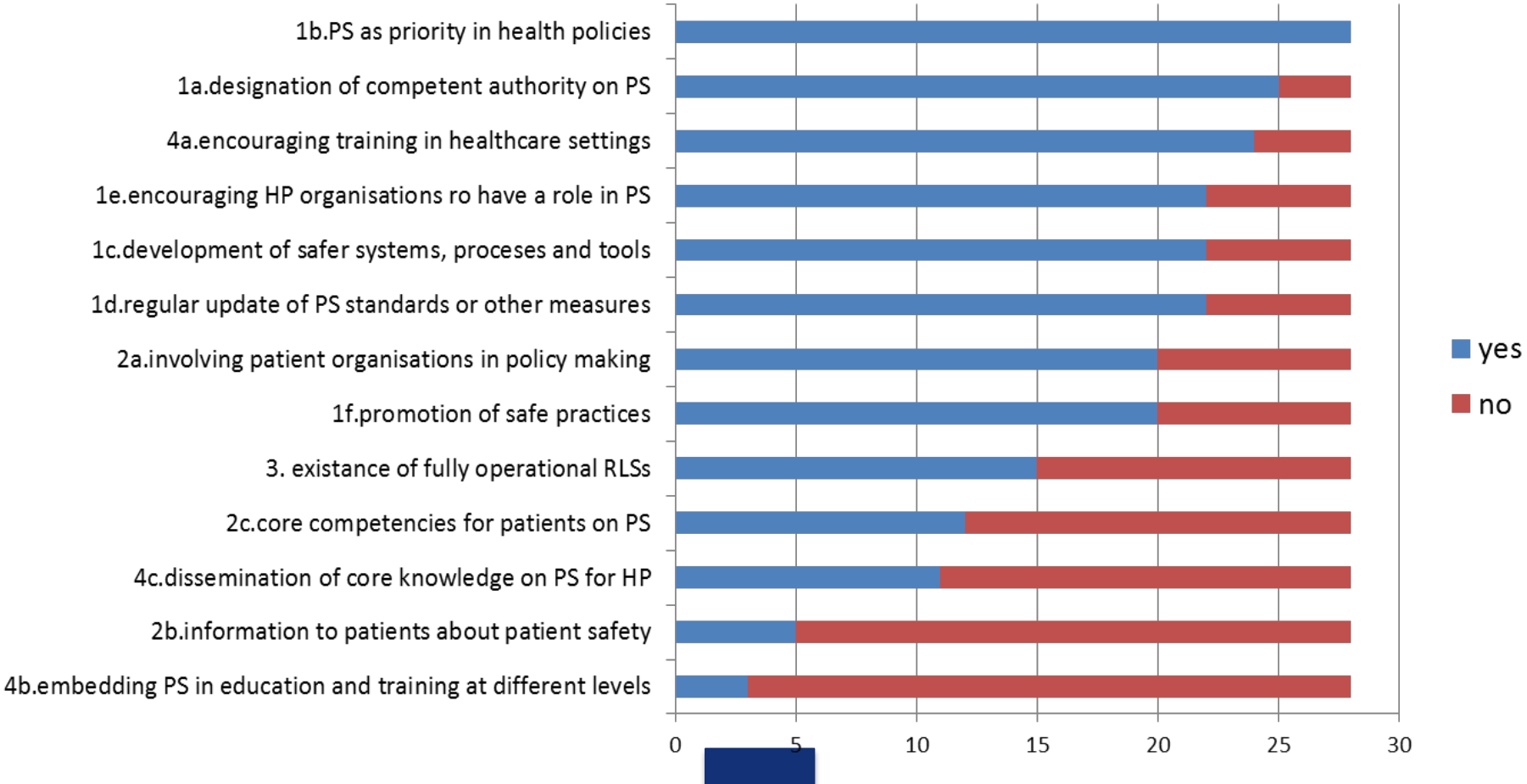
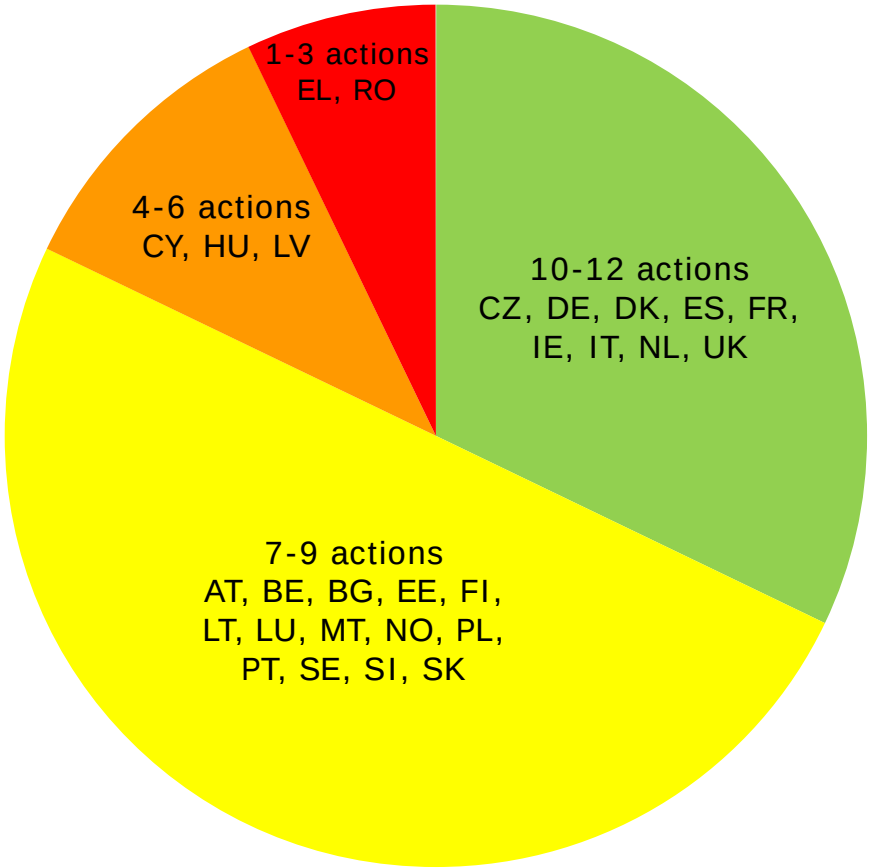
Summary of actions implemented by countries



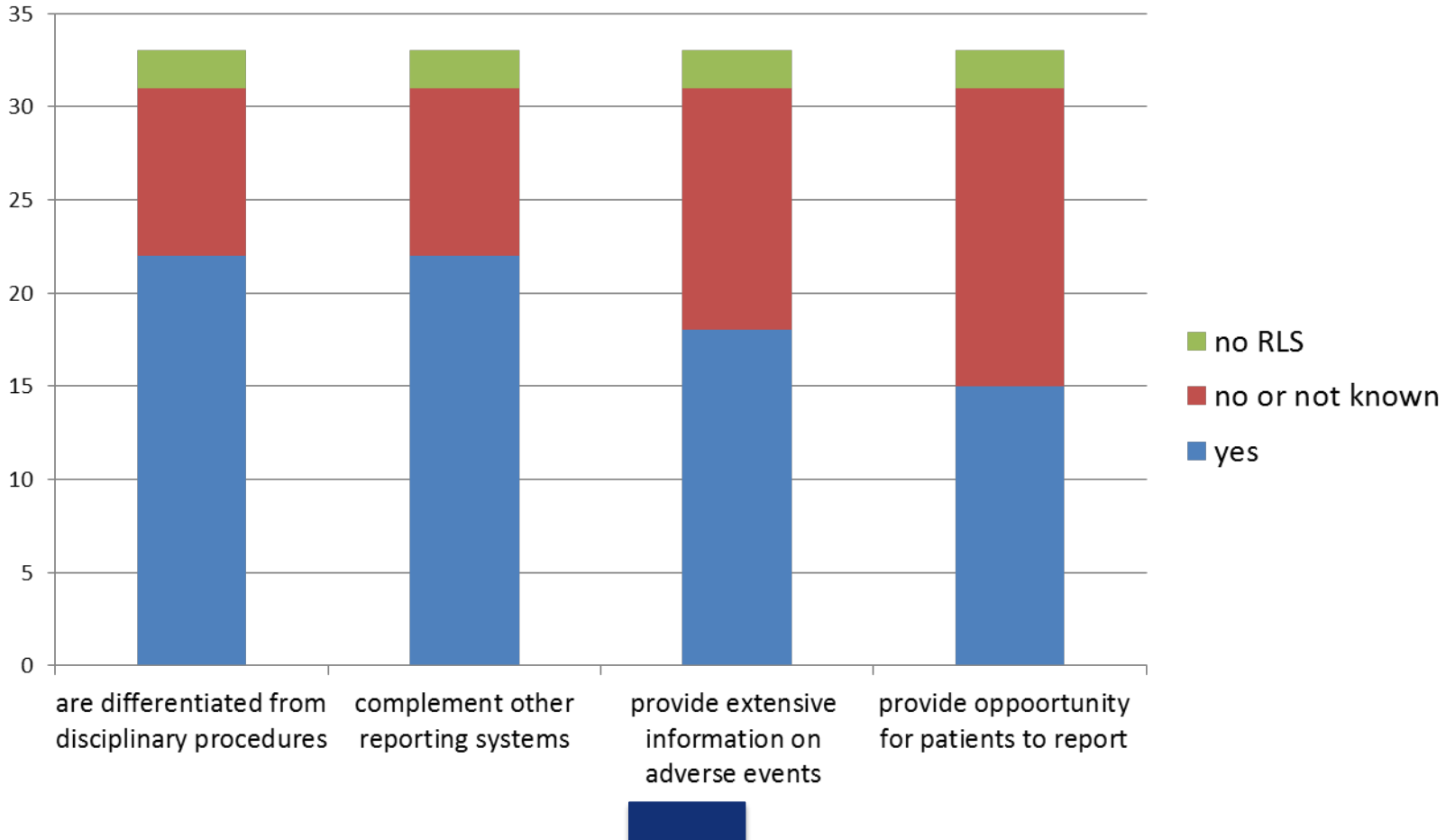
Summary of actions implemented
breakdown by countries



Reporting and learning systems (RLS) (1/2)

- **RLS in place: 22 countries**
  - AT, BE, CY, CZ, DE, DK, EE, ES, FI, FR, HU, IE, IT, LU, LV, NL, NO, PL, PT, SE, SK, UK
- **RLS under construction: 4 countries**
  - BG, LT, MT, SI
- **Among 13 multiple systems, only 6 are interoperable**

Reporting and learning systems (RLS) (2/2)



Common definitions, terminology and indicators

- Common terminology and definitions – no progress to date
- Common indicators – EU co-funding of the OECD HCQI project – 6 indicators published in 2011

Main messages

- Patient safety widely embedded in public health policies
- Progress made in setting up reporting and learning systems but no information about the actual use
- Room for improvement in the areas of patient empowerment and education of health workers
- Initiatives need to cover also non-hospital care
- Progress to be made on EU classification on PS
- 24 countries would welcome a guideline on patient safety standard

Conclusions

- Further effort needed in the areas specified by the Report
- More evidence about cost of unsafe care necessary to help political prioritisation
- Extension of implementation period by 2 years
- A second implementation report by the Commission – June 2014

Aims:

1. Help patients to exercise their **rights to reimbursement** for healthcare received in another EU country
2. Provide assurance about **quality and safety** of cross-border healthcare
3. Establish **formal cooperation** between health systems

Transposition: 25 October 2013

QUALITY AND SAFETY

Transparency and accountability

Information on healthcare providers and on standards applied

Cooperation of Member States

On standards and guidelines on quality and safety

Next steps

reporting and learning systems	• work with the Commission Working Group on Patient Safety and Quality of Care (PSQCWG)
education and training of health workers	• work with PSQCWG on the basis of activities of EUNetPaS
common patient safety classification	• work with WHO 2013-2014
guideline on patient safety standard	• discussions of health ministers 4 March 2013
further exchange of best practice	• PaSQ Joint Action until 2015 • sustainable collaboration after 2015
costs of unsafe care	• studies and research

Thank you !

http://ec.europa.eu/health/patient_safety/policy/index_en.htm