Summary of NHS European Office response to the Open Consultation on Patient Safety in the European Union

The European Commission has undertaken a public consultation on patient safety to inform the development of proposals in this area later this year. The consultation took the form of an online questionnaire with 61 questions. Most of these asked contributors to rate the relative importance of various elements related to patient safety, with relatively few ±free textq questions giving the opportunity to comment in detail on the issues raised. The NHS European Office[1] responded to the consultation, the response having been prepared in consultation with NHS organisations. Rather than reproduce in full the many ±tick boxq questions, this paper gives a summary of the NHS response, drawing mainly on the responses given to the ±free textq questions, in which we set out views on the wider issues raised in the consultation.

Summary of the NHS response

Elements of patient safety initiatives

Which types of adverse events should be priority areas for action?
The consultation asked contributors to rank the following in order of importance: medication-related events, medical device or equipment-related events, healthcare associated infections, diagnostic errors, surgery-related events, communication problems, other (please specify).

In general, a sensible approach might be to prioritise action according to the incidence of events. Data from the National Patient Safety Agency (NPSA) for England and Wales for the period October 2006-September 2007 shows that the most commonly reported type of incident was patient accidents, which accounted for 35% of all incidents. This was followed by:

- treatment/procedure incidents (9%),
- medication incidents (9%),
- access/admission/transfer/discharge incidents (8%),
- infrastructure incidents (including staffing, facilities and environment) (6%),
- documentation incidents (including records and identification) (5%),
- clinical assessment incidents (including diagnosis, scans, tests and assessments) (5%),
- disruptive/aggressive behaviour (4%),
- consent/communication/confidentiality incidents (4%),
- medical device/equipment incidents (3%),
- self-harming behaviour (3%),
- implementation of care incidents (3%),
- infection control incidents (2%)
- abuse of patient by third party (1%).

However, in the above data, 66% of incidents were recorded as resulting in no harm to patients. So, alongside incidence, it is also important to consider the

[1] The NHS European Office was launched in September 2007. It represents the English National Health Service. Its role is to inform the NHS of EU issues and to ensure that the NHS contribute positively to EU developments.

degree of harm caused by different types of incidents. Some types of incidents may occur less frequently, but may tend to be associated with severe harm and therefore it might be appropriate to prioritise work in these areas. Obstetric events might be one such example. This is though, a difficult area, as cases where patients die may often be captured by risk management systems even when it is not clear that there has been a patient safety incident. Furthermore, the relationship between an incident and the outcome for the patient is not always straightforward, as the patient may be suffering from a life-threatening condition. This is, therefore, an area which could benefit from further work.

In addition, it might also be appropriate to prioritise issues that are of particular concern to patients and the public, or where we know small changes can have a big impact, such as healthcare-acquired infections (HCAIs) and failures in communication between health and social care teams. Alongside national priorities, organisations should be able to identify their own priority areas for action at a local level. This is likely to foster greater ownership of the patient safety agenda and innovation in ideas and approaches.

What are the essential components of a patient safety strategy?

Leadership is the single most important factor. This means commitment at the highest levels to make patient safety a core part of business and to devote the resources to support this. In addition, patient safety should be part of education and training, induction and continuous professional development for all staff. Better data and intelligence is needed on patient safety, including data from an individual patient level to team, local, regional and national levels to support analysis and understanding of the issues. Staff and patients need to be fully involved in developing patient safety initiatives and indicators so that there is real ownership and understanding of the work involved.

Healthcare quality regulators and commissioners of care should be emphasising the importance of patient safety and using the levers they have to provide incentives for change. Financial support is generally important and may be useful, for example, to pump-prime projects, but at the same time patient safety needs to be an intrinsic part of healthcare, and therefore sustainability is essential . patient safety must not depend on dedicated financial support.

What further action, if any, needs to be taken in your country to improve the involvement of patients and the public in patient safety policies and programmes?

Engagement with the public must be genuine, transparent and open. This means patients should have access to information on patient safety, but also that consideration needs to be given as to how information can be presented in a way that is meaningful and helps patients and the public to understand their own role in promoting patient safety. In the UK for example, HCAI

surveillance data is routinely made public, but there is a real challenge about how to help patients and the public interpret this appropriately.

Patients and the public can offer a different perspective on patient safety issues, and therefore it is important that they are involved as key stakeholders in efforts to improve patient safety at every level. However, dictating a certain model or mechanism for involving patients and the public in work on patient safety may be counter-productive as this risks a lack of real engagement at the local level. It should therefore be for local organisations to determine how best to involve patients and the public in their efforts to improve patient safety.

What further action, if any, needs to be taken to improve health professionals' knowledge and awareness of patient safety issues and increase the application of safer practices?

Awareness needs to start at the top. This means educating NHS leaders at the most senior levels to take ownership of patient safety in their organisation, and to require that all their staff do the same. Clinical leaders should hold accountability for their team's outcomes, with quality and safety built in as a key part of all staff roles with review as part of appraisal systems.

This needs to be backed up by access to data on outcomes at team level, better patient safety training and access to expert support and advice. Support should be available for patient safety development opportunities and initiatives to improve patient safety, but this should be seen as a core part of healthcare and not an 'add-on' for those with a special interest. The aim should be to create a culture where there is continuous learning and improvement, with all staff able to raise concerns and suggest ideas for improving patient safety.

Should we have minimum patient safety standards subject to external assessment? Who should set these and monitor performance against them? Should we have a common patient safety classification or terminology to allow pooling of data at European level as a common resource?

Minimum standards of patient safety are a key part of healthcare quality, but need to reflect the organisation of health systems. As such they should be set and monitored at national level by the authority responsible for regulating healthcare quality (in the UK, currently the Healthcare Commission). The EU could set out key issues or principles to be considered in setting minimum standards, but should not go further than this.

Standards tend to have better ownership when they are developed at the local or regional level and therefore healthcare organisations could be encouraged to develop and adapt their own higher standards. These could be subject to self-assessment, with the possibility of outcomes being available to the public.

Turning to patient safety data more generally, whilst pooling of information at European level might have some benefits, this should not be done if it means imposing one set of indicators, standards or a patient safety terminology

which mean that the value of the data is lost to the organisations that collect it, or it increases administrative burdens. Patient safety data must be useful to local organisations in understanding, learning from, and planning action to improve, the local patient safety situation.

Which patient safety issues should be a priority for research? Would a European database of patient safety research add value? If so, who should be responsible for maintaining the database and what information should it hold?

More research into harm outside acute settings would be valuable, in particular as regards vulnerable individuals, as this is an area where information is lacking. Research into the economic costs of harm to patients, in particular the costs associated with responding to incidents and near-misses, could be valuable for making the case for investment in more robust systems or initiatives to improve patient safety. A European or International database bringing together the results of patient safety research might add value, but the wider issue is how to ensure that the results of patient safety research are widely available in a form that allows clinical teams to understand what measures work and how they can implement them in their organisations to increase patient safety. Another area for research might therefore be looking at how best practice can be translated into practical measures in different settings and strategies for embedding these at local levels.

What (further) action needs to take place in your country at the national, regional and/or local levels to improve patient safety?

The NHS has made very considerable efforts to address patient safety in recent years, and good progress has been made, in particular through work led by the NPSA and the NHS Institute for Innovation and Improvement. However, there is still much more to be done to spread this throughout the NHS as a whole and to ensure that patient safety and quality is at the heart of everything the NHS does.

If a culture that %patient safety is everybodyqs business+ is to be successfully instilled, the leaders of NHS organisations must place safety and quality right at the top of their agenda, and cascade this throughout their organisation, so that clinical teams are supported and encouraged to actively review outcomes and act on this to continuously improve safety and quality. More education, better access to data and access to expert advice and solutions would support this. In addition, better links need to be made across networks, especially between health and social care.

There is also a challenge in terms of educating patients and the public about their role in patient safety. For example, changing the actions of patients and their visitors is an important element in tackling HCAIs.

In which areas of patient safety should the European Community play a role in supporting Member States in their efforts to address patient safety concerns and how should this support work in practice?

The NHS is committed to putting patient safety first, and welcomes work to increase awareness of patient safety issues. But it is important that European efforts are in line with and donq cut across or contradict existing national or International strategies. Equally, there would be little value in simply duplicating existing work, and any European strategy should build on the work already underway in different Member States and through the WHO.

Although the need to tackle patient safety is a common issue, the challenge is different in different EU Member States. The actions required and the structures to implement these will need to be tailored to the circumstances of each Member State, to reflect the differences in how health systems are organised and managed. In view of this, a European strategy should not aim to implement highly detailed, prescriptive guidelines or requirements, nor should it try to impose a one-size-fits-all model for implementing and monitoring work on patient safety. Each Member State will need to develop its own arrangements in partnership with key stakeholders . particularly leaders, staff and patients and the public . if patient safety is to be successfully embedded in all aspects of healthcare.

European work should instead focus on issues where there is a clear European dimension. For example, patient safety could be increased by ensuring that when healthcare professionals cross borders within Europe, the professional regulators share information about any disciplinary procedures against individuals, and not just about their initial qualifications.

In addition, a European strategy could add value by providing mechanisms for exchange of experiences and best practice, which will also help to identify areas where information is lacking, for example, on incidents outside acute settings. More research could then be encouraged in these areas through European funding opportunities, in particular the FP7 research programme.