Together for Quality!

Collaboration and cooperation between health workforce, patients and other stake-holders for high-quality health systems

European Hospital & Healthcare Federation

Report on the HOPE Agora

Vienna, 13-15 June 2025

Contents

Introduction

From 19 May to 13 June 2025, around 150 healthcare professionals in management positions in different departments participated in a 4-week hospital exchange across 21 countries in Europe.

In line with this year's HOPE Agora theme, 'Together for Quality!', participants were asked to observe how hospitals and health care services are using principle of collaboration to ensure high-quality healthcare. They identified good practices, shortlisted examples, and on 13 and 14 June shared them at HOPE's Agora in Vienna.

HOPE President Eamonn Fitzgerald, chair of the day, welcomed around 200 participants from across Europe. He was joined by HOPE Secretary-General, Pascal Garel, who moderated the event the following day.

The conference started off with a presentation by the coordinators of the RE-SAMPLE project, which HOPE is part of. The presentation explained their unique model of integrated care in complicated COPD cases, illustrating the importance of collaboration between clinicians and patients to improve the care of people with multi-morbidities.

The policy and political discussions were led by members of the Head of the Austrian Ministry of Social Affairs, Health, Care, and Consumer Protection. These focused on key facets of Austria's new healthcare reforms linked to patient safety and quality, presented by Verena Nikolai, Isabella Weber, Eva Potura, Daniela Rojatz, and Lukas Teufl.

These introductory presentations laid the ground for the country-by-country best practice presentations led by HOPE exchange participants and informal discussions at the World Café, which took place on Day 2 of the HOPE Agora.

This document summarises the proceedings of the event. The presentations are **available online here**.

Conference

Presentation 1 - RE-SAMPLE Project

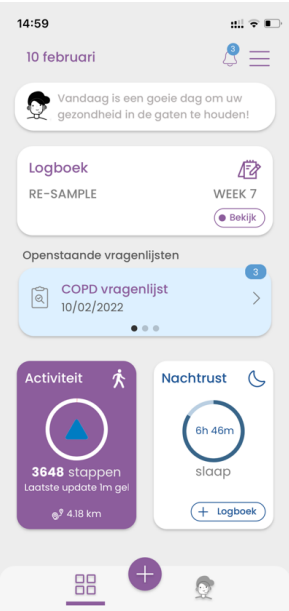
Monique Tabak (UT-EEMCS), Anke Lenferink (UT-BMS), and Serge Autexier (DFKI)

RE-SAMPLE's lead coordinators, Monique Tabak and Anke Lenferink from the University of Twente (UT), were joined by Serge Autexier (technical coordinator) from the German Research Centre for Artificial Intelligence (DFKI), to present the project's preliminary results. HOPE is part of the project consortium, which is making use of real-world data monitoring and Artificial Intelligence (AI) to improve understanding of COPD and comorbidity (two or more chronic conditions). The aim is to ensure that patients with complex chronic conditions receive the right care at the right time.

The presentation at the HOPE Agora focused on explaining the federated learning workflow piloted in three consortium hospitals, as well as the implementation of other processes. The speakers began the presentation by describing a use-case scenario of an 80-year-old woman with COPD and diabetes to illustrate the complicated clinical journeys of patients with multimorbidities.

One of the issues is that patients undergo stable phases, but also flare-ups, which are unpredictable. Thus, time-based visits do not provide a full clinical picture. This means that:

- insights into what happens in-between planned and emergency consultations remain limited;
- care oscillates between planned and reactive care;
- patients cannot receive extensive lifestyle guidance; and,
- self-management is difficult.



Ex.: RWD Monitoring tool

During the intervention stage, RE-SAMPLE has sought identify what could exacerbate COPD symptoms and analyse data from patient-reported outcomes (diaries), lung function readings and biomarkers, physical activity (Garmin smart-bands), healthcare visit reports, and medication use. This information has fed into the project's virtual companionship programme, action plans, shared decision making, and coaching, personalised eHealth programme, a service model for integration in daily care, and the development of a policy paper to foster acceptance.

The AI component of the project has focused on providing AI-supported predictions and privacy-preserving infrastructure. Tasks have included developing data-driven machine learning, federated learning, and privacy-preserving RE-SAMPLE platform. The project relied on clinical and patient-reported data, which fed into the machine

learning model training to generate AI recommendations used to make shared decisions (patients and health professionals).

Presentation 2 - Austrian Ministry of Social Affairs, Health, Care, and Consumer Protection

Verena Nikolai, Isabella Weber, Eva Potura, Daniela Rojatz and Lukas Teufl

HOPE Exchange participants received a welcome message from the Head of the Austrian Ministry of Social Affairs, Health, Care, and Consumer Protection. This was followed by a series of presentations about the key facets of Austria's new healthcare reforms linked to patient safety, presented by Verena Nikolai, Isabella Weber, Eva Potura, Daniela Rojatz, and Lukas Teufl.

Importance of the work on quality, Verena Nikolai

Verena Nikolai introduced this session by underscoring the need for a comprehensive approach to improve various aspects of health care delivery. Even when honing into the issue of patient care and safety specifically, the Austrian government's newly minted 'Patient Safety Strategy 3.0' (adopted and soon to be published) targets various dimensions, which will be discussed below: integrated care, second victim, and patient involvement.

The goal of this new strategy is to guide the improvement of a "patient-centred, safe, and effective healthcare system," stated Nikolai. In addition, the dimension outlined above, the strategy also sets out a vision to improve communication by leveraging digital tools to strengthen onboarding before outpatient care even begins. All this will be accompanied by methods to measure the effectiveness and efficiency of quality initiatives, as well as education and trainings on patient safety for health professionals improving integrated care.

Integrated Care, Isabella Weber

Isabella Weber's presentation focused on integrated care, which is often defined as a "patient-oriented, continuous, cross-sectoral and/or multi-professional care based on standardized care concepts. It includes process and organizational integration."[1] This is the definition adopted by the Austrian health system to encompass far more than just disease management. To further clarify the approach of the 'Patient Strategy 3.0', Weber put it in context. Austria is still catching up in terms of integrated care, and some of the issues listed below reflect this lag:

- the health system still contends with high hospitalization rates;
- case/patient management programs have not been adopted nationwide;
- there is a lack delegation of tasks from doctors to trained healthcare and nursing staff;

[1] Source: ÖSG 2017 - Österreichischer Strukturplan Gesundheit, 2017.

- information about patients' state of health is not consistently available;
- care services are not equally accessible to all patients.

Looking to the future based on current trends, the steady rise of chronic illness in Austria may further compound the issues outlined above. This is partly why there is renewed political commitment to improve integrated care, which will focus on chronic diseases, starting with Type-2 Diabetes & chronic heart failure. To achieve this, steps will be taken, including:

- Improving digital access to patient data: Every healthcare provider who works with patients must have digital access to patient data relevant to the respective medical/nursing care.
- Making electronic documentation in ELGA available: Information about patient's health status is available holistically in a national system.
- Ensuring that collaboration between different healthcare providers and care levels runs smoothly and efficiently.
- Supporting all healthcare professions with technical possibilities.
- Establishing framework conditions as prerequisite for implementation.
- Fostering knowledge-building for healthcare providers & patients.
- Safeguarding quality assurance through monitoring & evaluation.
- And strengthening patient empowerment.

Second victim, Eva Potura

Eva Potura began her presentation by clearly defining 'second victim' as it has remained an unfamiliar term for many people. The concept of 'second victim' is used to describe situations when a "health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury, becomes victimized in the sense that they are also negatively impacted."[2]

However pervasive it may be, many health practitioners do not know what a Second Victim is, and even when they do, they are unlikely to self-identify as such when they are asked about it. This, together with incidents involving suicide and/or substance abuse, led researchers in Austria to study the impact of 'second victim' in various medical contexts nationwide. First, they studied the case of paediatricians. They discovered that many health workers did not know what second victim was. 89 per cent of those who did know what second victim entailed self-identified as such, and a worrying 14 per cent reported they had been suffering constantly from it for more than a year. And 90 per cent wanted peers to talk to. Respondents observed that the pandemia was not the cause of this.[3]

[2] Source: European Research Network on Second Victims, ERNST, 2022.
[3] Source: Second Victims among Austrian Pediatricians (SeVIDA-A1 Study), Eva Potura et al, *MDPI Healthcare*, 2023.

The researchers also studied Second Victim among Austrian Nurses. Nearly 1,000 returned the survey, indicating that 82 per cent are second victims. In the nurses cohort, the number one reason involved aggressive patient and/or patient's family behaviour.[4]

Second victim has become a priority because Austrian studies among Health Care Workers show that second victimhood affects confidence and increases mistakes, forming a vicious cycle that can harm patients.

To address this, the Austrian health sector drafted a Multidimensional Action Plan based on the research of Seys, D., Panella, M., Russotto, S. et al. It works as follows:

- Level 1: Prevention (individual and organization)
- Level 2: Self-Care of Individual and/or team
- Level 3: Support by Peers and Triage
- Level 4: Structured Professional
- Level 5: Structured Clinical Support[5]

With this guide, the Austrian health sector has developed context-specific modules to train peers to look out for red flags and asses when a colleague may need further support that cannot be given peer-to-peer. The implementation of the program is funded in part by the EU's Support Rescue Cost Innovation Grant 19113. The Austrian Second Victim Association works on the following levels to date:

- Level 1: producing podcasts and raising awareness, creating a network of researchers, midwives, Emergency Care experts, anaesthesiologists, and holding an Annual Action Day Symposium.
- Level 2: teaching HCP, 1 session/month.
- Level 3: establishing the first Austrian Independent Peer Education program.
- Level4/5: Funding 230 counselling.

Patient Involvement, Daniela Rojatz and Lukas Teufl

Daniela Rojatz and Lukas Teufl began by defining participation as it is broadly done by major organizations and governmental bodies. The World Health Organization, for instance, defines participation as "social participation as empowering people, communities and civil society through inclusive participation in decision-making processes that affect health across the policy cycle and at all levels of the system." Meanwhile, Article 10 (sec. 3) of the Treaty on the European Union states that "Every citizen shall have the right to participate in the democratic life of the Union. Decisions shall be taken as openly and as closely as possible to the citizen."

[4] Source: Second Victims Among Austrian Nurses (SeViD-A2 Study), Eva Potura et al, *MDPI Healthcare*, 2024.
[5] Source: In search of an international multidimensional action plan for second victim support: a narrative review, Seys, D., Panella, M., Russotto, S. et al, *BMC Health Services Research*, 2023.

The importance of participation – and in this case patient participation – can be categorized as follows:

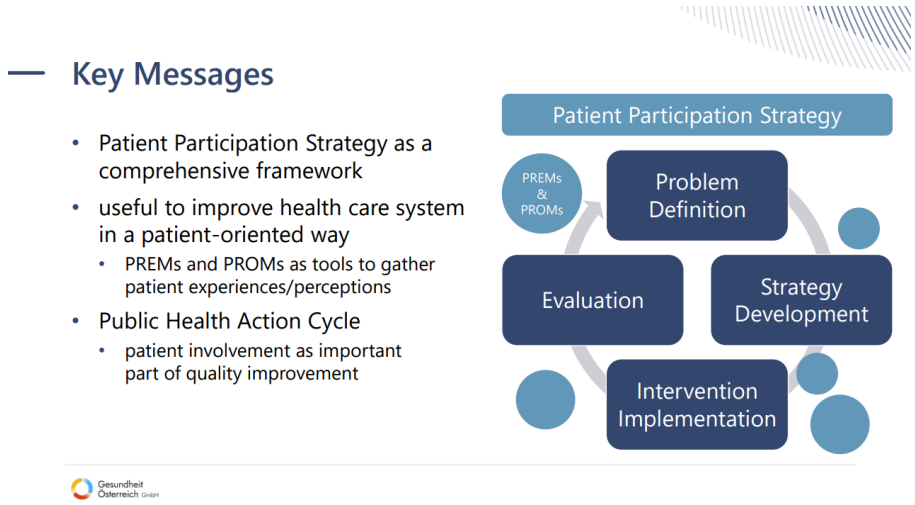
- Normative reasons: participation and deliberation lend legitimacy and transparency to decisions in democratic systems.
- Functional reasons: participation can improve the effectiveness and quality of healthcare services.
- Empowerment reasons: participation helps improve health literacy and in turn supports informed decision-making.

Rojatz and Teufl presented a concrete example of patient participation at the Wienerberg Diabetes Centre, which incorporated the various categories described above. From online consultations to the joint development of guidelines, the process informed patients and policy alike to improve health care and gain insights into patients' experiences in their care and medical journeys.

Austria is currently developing a patient participation strategy for the health care system. This strategy will define, among other things: who can and/or should directly represent patient/population interests, in which processes (e.g., strategy development, committee work, etc.) participation is possible and how this takes place, and how participation processes will be supported (e.g., further training, resources, sustainability, etc.)

Rojatz and Teufl closed their presentation by delivering key messages:

- Any strategy to involved patients in a meaningful way should offer a comprehensive framework.
- PREMs and PROMs (Patient-Reported Experience Measures and Patient-Reported Outcome Measures, respectively) are important patient-oriented tools to gather patient experiences and perceptions.
- Patient involvement is an important part of quality improvement, and policies should reflect this.



World Café

HOPE organised the sixth annual *World Café* during this year's Agora. Each year, exchange participants share their opinions regarding the most interesting examples of good practices identified during the HOPE Exchange Programme. Members of each team split into various groups to take part in three rounds of discussions. On this occasion, discussions centred around improving quality in health care.

The *World Café* methodology is a simple, effective, and flexible format for group dialogue. It aims at harnessing collective wisdom and not at reaching a resolution. The process begins with the first of three 20-minute rounds of conversation for the group seated around a table.

At the end of each round, all group members move to different tables. Staying behind on each table was the table host for the next round, who welcomes the following group and briefly filled them in on what happened in the previous round. Each round focuses on questions/statements designed for the specific context and desired purpose of the session. Afterwards the individual group members are invited to share the insights from their conversations with the rest of the large group.

Ieva Lejniece chaired the session, and in the context of this year's thematic, discussions revolved around four topics summarized in the next pages.

1. Integrated Care and Digitalization

Participants highlighted the importance of using digital tools to improve continuity of care and efficiency:

- **E-consultations and telemedicine**: To enhance access when clinically beneficial.
- **Digitalization of processes**: E-referrals, e-check-in systems linked with room booking, automated call systems, and e-vaccination calendars with reminders.
- **Integrated care pathways**: Individual digital care programs such as Finland's "Health Village"; virtual wards for chronic conditions (e.g., COPD in Denmark, Finland's virtual ward project).
- **Interoperability**: Shared patient histories across providers, national data centers with standardized formats, and Estonia's national system as an example.
- **Data use for decision-making**: Live dashboards at ward/unit level to track patient progress and needs; benchmarking with centralized data.
- **New technologies**: AI in diagnostics (e.g., radiology), VR for training (e.g., for nurses), and facility management systems (UK example).
- **Capacity building**: Training staff to effectively use digital solutions.

2. Strengthening Patients' Participation and Digital Health Literacy

Patient empowerment was a central theme:

- **Patient as central partner**: True participation in clinical decisions, supported by face-to-face dialogue and involvement of patient associations.
- **Accessible information**: Intuitive and reliable resources such as webpages, videos, and patient schools. Example: Sweden's 1177 health line; Netherlands' plain-language clinical websites.
- **Digital engagement**: Online surveys, apps, and communication channels for patients and caregivers.
- **Community support**: Infrastructure like quick Wi-Fi, libraries sharing responsibility for education, and Italy's community houses.
- **Trust and transparency**: Public relations efforts to build trust, ensuring information reliability and data backups.
- **Family and peer roles**: Families assisting patients; trained patients teaching others to manage chronic conditions.

3. Health Workforce Safety

Workforce safety was linked directly to patient safety. Discussion was organized into prevention, support after incidents, and innovative practices:

Preventive measures (before incidents):

- Risk management: Collect and analyze data, implement and evaluate prevention strategies, communicate results.
- Training and programs: Regular education, de-escalation training, compulsory hygiene programs, ergonomic improvements, and violence prevention protocols.
- Infrastructure: Secure facilities, alarms, ergonomic adjustments, protective barriers, ventilation considerations.
- Support systems: Psychological support availability, regular team debriefings (e.g., traffic light check-ins), intranet platforms for sharing experiences.
- Incentives and wellbeing: Free breakfast for participants in programs, sleep pods after night shifts, physiotherapy or health promotion sessions offered by employers.

Support after incidents:

- The "second victim" concept: Peer support, psychological, legal, and social assistance without stigma.
- Open culture: Focus on improvement rather than blame, recognition of staff efforts.
- Debriefing: Structured reflection and data collection after critical incidents.

Innovative practices:

- Traffic light system for emotional check-ins, daily short meetings.
- Automated surveys and digital reporting tools.
- Technological solutions: Video cameras in high-risk areas, robots for blood collecting, protective equipment (e.g., knife-proof jackets).

4. Patient and Stakeholder Involvement

Collaboration between patients, communities, and healthcare organizations emerged as a key driver of innovation:

- **Institutional mechanisms**: Patient advisory boards, patient councils at hospitals, and patient liaisons (e.g., in Germany).
- **Co-design and peer-to-peer support**: Patients training other patients in chronic disease management (paid or volunteer), schools of patients where newly diagnosed individuals learn from peers and professionals.
- **Community engagement**: Municipal partnerships to promote healthy activities (e.g., Portugal prescribing well-being activities like dance classes). Volunteer support in hospitals (examples from Denmark, Spain, Greece, Portugal).
- **Digital and data use**: PREMs and PROMs for measuring outcomes; patient access to their own data; digital feedback tools (manual, QR codes).
- **Awareness projects**: Denmark's "One of Us" anti-stigma initiative; Cantabria Cohorte personalized medicine project.

- **Patient experience**: Initiatives such as food choice in hospitals (Basel, Riga).

Summary: Key Cross-Cutting Themes

- **Integration across levels of care**: From primary to hospital services, enabled by digital tools.
- **Culture change**: From blame to improvement, from paternalism to shared responsibility with patients.
- **Equity**: Ensuring accessibility and inclusiveness in digital health and workforce support.
- **Innovation through collaboration**: Hospitals, patients, families, and communities co-creating better systems.

Presentations by HOPE Exchange Programme participants

Every year, following four weeks abroad, HOPE Exchange Programme participants gather for the Agora conference, where they share a maximum of three examples of good practices they identified during their exchange. This year, participants focused on practices aimed at fostering high-quality health systems via collaboration between health workers, patients, and other stakeholders. The following summarises their presentations.

SWEDEN

National Coordinator:	Erik Svanfeldt
Exchange participants 2025:	Faustino González Menéndez, SPAIN Marjo Huovinen-Tervo, FINLAND

The HOPE Exchange team in Sweden started off by presenting some contextual elements about the Swedish health care system, which is tax-financed and decentralised in regions (both financially and in terms of health care delivery).

Centrally-speaking, however, there is a special phone and online service called 1177, which the Faustino González and Marjo Huovinen-Tervo selected as one of the good practices they observed in Sweden. Citizens can call 1177 and/or consult the online version (1177.se) to retrieve information, communicate with healthcare providers, make appointments, and renew prescriptions. Additionally, healthcare workers can consult quality assured care manuals, national care and intervention programs, etc. at a specific 1177 portal for healthcare professionals (*1177 för vårdpersonal*).

Some information is available also in other languages and exchange participants observed that communication between patients and healthcare professionals has improved, as has the health literacy of citizens. The benefits for healthcare professionals are also clear, they can consult scientific journals, facilitate communication, and reduce unnecessary in-person visits, thereby avoiding overcrowding healthcare sites.

In terms of policy, HOPE Exchange participants also singled out the national, regional, and local approaches to maintain quality and safeguard public health. At the national level, the 2018 National guidelines on lifestyle factors target preventable conditions, such as those caused by physical inactivity, high alcohol consumption, and smoking. Sweden developed dialogue-based interventions according to the level of severity (e.g., from patients who only need to increase their exercise and eat more fruit to more serious cases involving addiction

for instance). Thus, healthcare providers have structured intervention plans, which involve a series of steps but follow this a simple pathway: IDENTIFY → ACT → FOLLOW-UP.

The aim of these targeted health dialogues is to reduce the incidence of and in some cases prevent cardiovascular diseases, which are associated with nine preventable risk factors (high cholesterol levels, smoking, psychological health, high blood pressure, Diabetes Type-2, abdominal obesity, low intake of fruits and vegetables, alcohol intake, and physical inactivity).

These dialogues are integrated into the national public health guidelines, and they are often carried out first in primary care. However, there are region- and local-specific initiatives that work symbiotically with the centralized approach. For instance, at regional levels, people can consult the level of difficulty of individual bike paths and hiking trails, which are determined not only by the level of expertise required but also physical state and health. Furthermore, public health authorities engage local municipalities, sports clubs and grocery stores to reach out to members of the community and deliver information (e.g., nutritional content, etc.).

MOLDOVA

National Coordinator: Olga Schiopu
Exchange participants 2024: Betina Tradsborg, DENMARK
Faizan Rana, UNITED KINGDOM

The HOPE Exchange team in Moldova began the presentation by providing a snapshot of the country's healthcare system. It is a mix of public and private institutions overseen by the Ministry of Health, which also oversees emergency services and insurance providers. Betina Tradsborg and Faizan Rana concentrated on three dimensions of good practice in the stroke care implemented nationwide.

In every context, treating strokes is very challenging. For instance, timely access to care is crucial. The chances of making a full recovery decrease over time, and the chances of dying rise exponentially as well. The time issue is further compounded by the fact that not everyone is specialized in treating strokes and its complications. In Moldova specifically, geographic barriers and staffing constraints have hindered timely access to care, resulting in stroke mortality above the EU average.

To address this, Moldova has implemented a successful three-pronged approach:

- The establishment of two High Performance Stroke centres in carefully selected regions to ensure timely access in underserved areas.
- These centres are supplemented by eleven Primary Stroke Centres across the country, which serve as a first line of emergency and preventive treatment.
- Finally, the national telemedicine model supports these establishments.

Thus, all regional units are connected to a central stroke hub. Medical points where there is no local expertise, connect patients to experts who examine them remotely taking note of symptoms and reviewing radiology results performed onsite. Depending on the severity of the cases, treatment recommendation plans are drawn up with treating physicians.

Thanks to the mixed method approach to stroke care, the average time from the onset of stroke symptoms to hospital admissions was reduced from 905 minutes in 2023, to 423 minutes in 2024. Furthermore, treatments such as thrombolysis, which involves the breakdown of blood clots, are more available now. In turn, such steps have made the quality of care more consistent and optimised resource management. Stroke care in Moldova has improved prognoses for many, and alleviated care disparities.

To achieve this, collaboration has been key. Staff and initiatives are evaluated not only by their peers but also through patient feedback. Accountability measures help foster trust in the system. And the spirit of collaboration extends beyond the existing health workforce Through health simulations with actors playing patients, young physicians learn early on how to engage in respectful communication, to listen to what their patients report, and seek the opinion of their peers in complicated clinical cases.

GERMANY

National Coordinator: Doris Voit

Exchange participants 2025:
Iina Tuomainen, FINLAND
Jeanette Knutsson, SWEDEN
Patrice Gerressen, THE NETHERLANDS
Shaista Zaidi, IRELAND
Merilin Piirsalu, ESTONIA
Claudia di Santo, ITALY
Edoardo Trebbi, ITALY
Alberto Castagna, ITALY

The HOPE Exchange team in Germany was sub-divided and hosted by three hospitals: the Katholische Kliniken Rhein-Ruhr hospital of the St. Elisabeth Gruppe in Herne, Pfalzklinikum in Klingenmünster, and Asklepios in Bad Tölz. In each, the group identified good practices feeding into the institutions' overall quality of healthcare.

The St. Elisabeth Gruppe has developed a programme called 'Education for Quality and Health', which is implemented in all its hospitals. The aim is to address shortages of nursing staff, which is a problem that countries across the EU are facing, including Germany. To meet this challenge, the St. Elisabeth Gruppe has opened a campus in 2024, to provide onsite nursing education and training. The inauguration class boasted 888 students. Each hospital hosts an open day to help attract future students. In addition, the campus offers advanced training courses to develop competencies and new skills. Each year, the advanced programme enrolls approximately 150 nurses.

While using a train-animation in their presentation to invite the auditorium on a tour of the German healthcare system, the exchange team presented their next stop, the headquarters of Pfalzklinikum in Klingenmünster. It was established in 1857, but it is now the nodal point of a network of community-based, decentralized psychiatric clinics. The best practice identified in this place involved the 'Curamenta' platform, which connects telemedicine, hospitals, and ambulatory care services. It also has a digital treatment portal tailored for psychiatric care. Users can select on which level they want to enter the system:

- Level 1 is public and offers information on mental illnesses, treatment methods and counselling content.

- Level 2 can only be accessed by logging in. This area offers various topics related to mental health and illnesses.
- Level 3 is for care providers and is highly restricted. This area connects medical practitioners to hospital information systems and prescription information. It also helps health professionals reach out to patients in a confidential manner, and exchange documents (e.g., clinical diaries and questionnaires) with other care providers.

Finally, the last stop on their virtual journey was Asklepios Stadtklinik in Bad Tölz. Here, the HOPE Exchange team identified a collaborative scheme as the third good practice. The programme to recruit nursing staff from abroad was developed in the early 2000s as a project and has now been expanded and refined. Today, the programme has established steady partnerships with countries such as Tunisia, Brazil, the Philippines, Indonesia, India, and Bosnia-Herzegovina. Initial interviews are conducted via Teams by the Chief Nursing Office. Various criteria need to be met, including language proficiency and ability to demonstrate psychological and cultural awareness. The programme in turn offers social integration, support and training to help new nurses to adapt to cultural aspects of the workplace. The method has proven to be replicable and is now part of a broader long-term strategy to ensure quality in the health workforce.

DENMARK

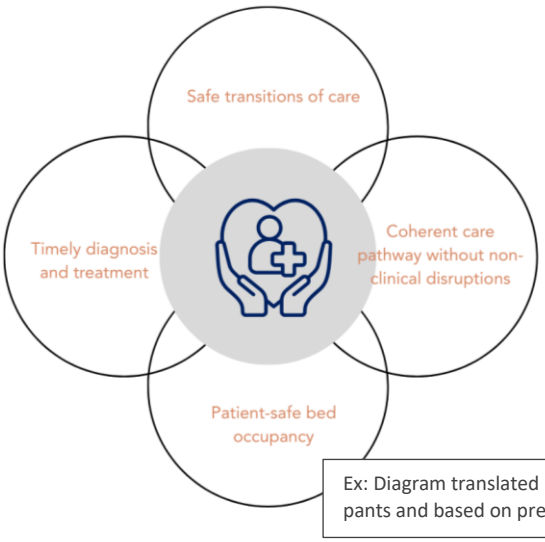
National Coordinator: Lise Elsberg

Exchange participants 2025:
Charlotte Perrey, UNITED KINGDOM
Inga Maulina, LATVIA
Styliani Michailidou, GREECE
Martin Petschl, AUSTRIA
Joost Meijer, THE NETHERLANDS
Mervi Hakala, FINLAND
Sara Biondani, ITALY

The HOPE Exchange team in Denmark focused on two central dimensions of the country's health system approach to quality improvement. This approach is patient-centred and emphasizes collaboration.

One of the main objectives is to keep the patient safe at home and at the same time reduce the chances of admissions and re-admissions. This approach addresses two main concerns, (1) patients tend to prefer to stay closer to home and (2) it expedites treatment. To achieve this, the health system had to improve collaboration across the healthcare sector, from primary to specialised care, and with patients themselves.

Another component that has made this approach possible has been the strategic digitalisation of onboarding processes and health literacy mechanisms, for instance, an online application to prevent falls, as well as the dissemination of patient safety and healthy work environment information.



Ex: Diagram translated by participants and based on presentation.

AUSTRIA

National Coordinator: Klemens Pokorny
Exchange participants 2025: Niccolò Grassi, ITALY
Eric Grely, FRANCE
Isabel Pita, PORTUGAL
Charmaine Zahra, MALTA

The HOPE Exchange team in Austria identified good practices situated in care across the life course. The first stop was the early diagnosis of diabetes and how to reduce hospital visits in the management of the disease. To this end, a specialized centre was established to provide comprehensive care.

Funded through a partnership between the City of Vienna and Health Insurances, the Wienerberg Diabetes Centre is located outside the city of Vienna in a multicultural region with difficult access to Diabetes care. Patients are supported by a team of specialists including doctors, nurses, dieticians and psychologists. These experts provide nutritional counselling and practical cooking courses in a modern kitchen, AI-powered eye screenings enable early detection of diabetic retinopathy, diabetes literacy education programs, both for groups and individuals, to help empower patients in managing their condition.

Active patient participation is a core component. In an effort to increase health literacy, patients are involved in setting treatment goals and choosing the best therapy. The support provided is multilingual and culturally sensitive, and it collects and incorporates patient feedback to continually improve the services.

Next, the exchange team in Austria surveyed the type of care a patient would receive in case they have an accident and break a leg or suffer other trauma. Injuries and patients are different when it comes to pain management, for instance. In order to receive supplemental care, a programme called CLINISERVE supplements the classic nurse call system. Requests are made by the patient via the menu on the patient's screen and received on a smartphone carried by the caregiver. The menu can be individualized per ward and can be translated. The patient inputs their need, details, and severity and the system assigns tasks to the appropriate caregiver.

Health provides have found that some of the benefits of this system include: patients feel more secure as they are able to actively communicate their needs, delays and miscommunication are reduced, and communication and trust in the healthcare system is improved.

Finally, as patients reach older age, there are complications that may arise after surgery. One of these complications involve delirium, due to lengthy hospital stays, anaesthesia, and other complex causes. Delirium causes disorientation, confusion, and inappropriate responses to environmental stimuli. The good news is that up to 40% of delirium cases are preventable and early detection is key.

At Graz University Hospital, an algorithm has been developed to help determine the risk of delirium. In response, this allows nurses and physicians to take measure, such as changing medications, etc.

The team in Austria, concluded their presentation by providing three take-home messages on the importance of patient involvement, digital integration and data-driven decision-making in driving quality improvement and patient safety.

ESTONIA

National Coordinator: Teele Orgse

Exchange participants 2025: Elieke van Sark, THE NETHERLANDS
Denisii Furtuna, MOLDOVA
Annette Blok-Olesen, DENMARK

The HOPE Exchange team in Estonia started off their presentation by providing a snapshot of Estonia's population of 1.3 million inhabitants and its national healthcare system into which the government invests 7% of its Gross Domestic Product. Ninety-nine percent of Estonia's health data is digitized and accessible through a national e-health platform. As a leader in e-health innovation, it is not surprise that HOPE's exchange participants were able to identify good practices in this area.

The exchange team in Estonia visited government minisitries and hospitals across the country. They found that Estonia has been empowered for a long time. The government comprises ministers who went abroad when they were young, but returned with a lot of drive to improve. At the national policy level, leaders want to transform Estonia into Europe's leading IT hub, and they have embedded this approach into the eHealth Strategy for 2025-2030.

To date, Estonia has digitized and centralized patient information to make it accesible. Patients and health providers can book appointments, request an ambulance, and discharge prescriptions, among other services via this centralized platform. The development process involved collaboration between patients, health boards, universities, and ministries.

These stakeholders also worked with start-ups to build other local digital solutions te improve access and quality of care. Some results of such collaborations have been the MARS system, which tracks bed occupancy in real time, the use of AI and cameras to detect unusual behavior exhibited by patients, Lung cancer patient's journey project, etc.

Furthermore, eHealth has also been used to improve medical service quality by increasing the accuracy of diagnoses (via centralized records that give doctors full patient history and allows them to understand the clinical picture and support evidence-based treatment and planning). It also helps reduce errors with ePrescriptions which improves safety. F– E-prescriptions reduce medication mistakes and improve safety. Finally, eHealth helps involve patients, they have access to their health records, which boosts transparecy and empowers patients to help them understand their care pathways.

HOPE's Exchange participants in Estonia closed with the upcoming challenges, which are very similar to those the rest of Europe will likely face: an aging population and low birth rates, staff that will soon retire, and overwork. The aim of Estonia's government will be to focus on newer generations of its health workforce and adapt to the future!

SWITZERLAND

National Coordinator: Ines Trede
Exchange participants 2025: Daniela Matos, PORTUGAL
Leonie Penz, AUSTRIA

The HOPE Exchange team in Switzerland visited hospitals in Basel, the Universitätsspital Basel, Solothurner Spitäler, Rehab Basel, and Felix Platter Spital. The good practices they identified in health quality improvement focused on innovation and tools, organization and leadership, and person-centred care.

There are various dimensions to person-centred care implemented in Basel. First, there is importance of collaboration, for instance, strategic meetings are held to advance this approach beyond Basel. Concretely at Basel Rehab, health practitioners observe how specialists collaborate in a highly specialized clinic for neurorehabilitation and paraplegiology. At Felix Platter Spital, the geriatric department works closely with the Emergency Department the University Hospital of Basel to help address the specific care needs of aging populations.

Another dimension of person-centred care involves people themselves. Human resource departments conduct surveys to understand what employees need to support work-life balance and improve working conditions. Furthermore, assessments are conducted periodically to identify the added value of treatments and to optimize available resources. Finally, under this cluster of good practices, efforts are being made to take care of patients and employees through nourishment, by offering healthy and comforting meals.

In terms of organization and leadership, Basel's healthcare institutions have been focusing on strengthening sustainability at organizational levels, promoting shared leadership practices whereby medical doctors, nurses, and hospital managers collaborate, and building management capacity, focusing on treating the right patient at the right time with the right team at the right place. This latter component involves boosting skills in resource management.

In the third and final category, innovation and tools, the exchange team in Switzerland identified four areas in which digital and technological resources are being integrated in various healthcare institutions in Basel. These include:

- Implementing a rewards programme to incentivize innovation;
- Integrating robotics support in hospitals' logistical processes (i.e., helping employees carry heavy equipment via underground tunnels);

- Using a food scanner to make better estimates regarding food portions and reduce food waste; and
- Tailoring exercises and physical rehabilitation via virtual reality and gamification strategies.

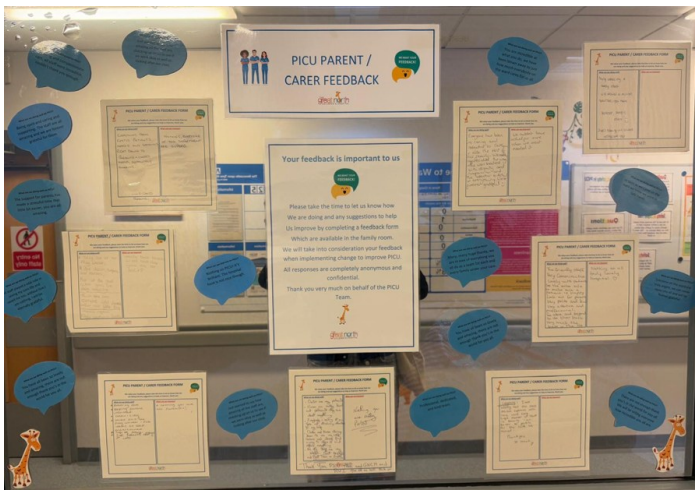
HOPE's exchange participants closed their presentation by offering a take-home message regarding quality improvement and patient satisfaction. Quality is not something that is given to an organization but rather built within it; it takes effort, trust and a shared direction.

UNITED KINGDOM

National Coordinator: Ian Buczynski
Exchange participants 2025: Dawid Budny, POLAND
Emily Naarits, ESTONIA
Martina Sapienza, ITALY
Mercedes Pérez, SPAIN

The HOPE Exchange team in the United Kingdom visited hospitals in England, specifically in Birmingham and Newcastle upon Tyne. They identified good practices along three overarching areas: quality, health workforce, and meaningful patient participation.

In terms of quality, the team noticed that in the hospitals they visited there were visual updated in the emergency departments to ease shift changes and flag high-risk patients. These triage updates are color-coded to indicate mental health conditions, mental disabilities, and/or high risk of falling. This is done to ensure the safety and security of patients and staff alike.



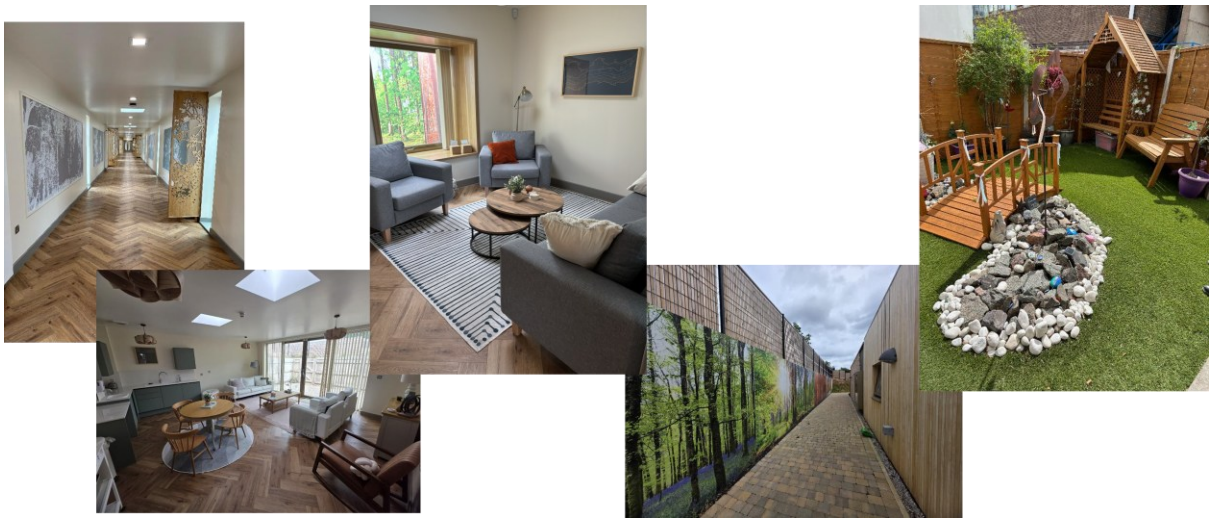
The exchange team also noted that patient and carer feedback is encouraged. There are boards with questions such as “What are we doing well?” and “What can we improve?”; all responses are anonymous. In addition, the UK’s Care Quality Commission run a national survey programme to consult patients receiving care and treatment. This is an independent procedure. The findings from these surveys can be used to build an understanding of the risk and quality of services and to help set priorities for delivering a better service for patients.

To improve patient safety, the maternity ward implements a procedure in case something goes wrong, or they encounter negative feedback. In such cases, discussions are held to draft prevention steps or plans, which are then consolidated in posters that staff can consult periodically.

The second overarching area exchange participants identified also involves patient safety. In this case, the hospitals they visited have installed a system to check each shower head and change it every three months. Each quarter represents a different colour. This helps ensure hygiene standards are maintained and helps prevent bacterial infections which can be very difficult to treat when acquired in hospital settings.

Finally, the last area the exchange team covered, patient and other stakeholder involvement, spotlights two special approaches. The first one, emphasizes the need to deliver clear information and creating welcoming environments with decorations, child-friendly areas, and introducing teams with pictures and wardrobe identifications, which help patients and carers identify who is who in each ward.

The second approach is for grieving parents who have lost their babies in stillbirths, traumatic births, or in non-viable pregnancies, etc. The bereavement space of Woodland House was developed with charity funds and designed in collaboration with patients. If gives families space to mourn their loss, receive psychological support, additional healthcare follow-up checks, and spend time with their lost one away from hospital.



THE NETHERLANDS

National Coordinator	Frido Kraanen
Exchange participants 2025:	Graziella Portelli, MALTA Laia Sos, SPAIN Sari Kulokivi, FINLAND Francesco Spelta, ITALY Amanda Doyle, IRELAND Heidi Bech Rasmussen, DENMARK Piret Vilborn, ESTONIA

The HOPE Exchange team in The Netherlands selected three good practices under the overarching theme of collaborative innovation in Dutch Hospitals.

First, they presented the mProve and Santeon hospital networks. While mProve focuses on digital and data-driven healthcare, the principles of appropriate care, AI-driven solutions, and labour-saving technologies, Santeon focuses on providing value-based healthcare and improving healthcare in general.

The collaborative culture exemplified in these two networks has had demonstrable results. Santeon and mProve joined forces on the Virtual Fracture Care project, which provides, among other things, a digital follow-up plan with video instructions and monitoring guides for cleaning and caring for fractures at home after discharge. In this case, the project has found there have been efficiency gains, a high-percentage decrease in additional ER imaging and follow-up consultations. There have also been moderate gains in patient satisfaction, with scores increasing from 7.9 to 8.1 (out of 10). The Virtual Fracture Care model will now be rolled out across The Netherlands.

Next, the exchange team how nurses, GPs, and multidisciplinary teams work together to improve Geriatric Emergency Medicine (GEM). This approach ensures that there are teams comprising ER nurses, specialist geriatric nurses, geriatricians, pharmacy assistants, and elderly care triage coordinators at hand in Emergency Departments. The GEM approach has led to great improvements, including, length-of-stay and re-admission reductions and increased medication safety.

To close their presentation, the HOPE Exchange team in The Netherlands presented collaborative efforts to improve patient nutrition, thereby offering holistic recovery and wellbeing. To this end, Dutch hospitals have introduced plant-based dishes designed by dieticians and

nutritionists, single suppliers, smaller and frequent meals, individualized ordering to decrease waste and help patients adhere to diet needs (e.g., patients with certain gastric conditions will only see gastric-friendly meals on their selection menus), as well as options for communal dining.

LATVIA

National Coordinator: Ieva Lejniece
Exchange participants 2025: Anne O'Rourke, IRELAND
Gaia Cetera, ITALY
Rainer Altenbeck, THE NETHERLANDS
Rob Hurley, UNITED KINGDOM

The HOPE Exchange team in Latvia began their presentation by providing a snapshot of Latvia and the country's healthcare system. With a population 1.84 million, Latvia is considered a very small country. The median age is 43.6 years, and there 55 hospitals, 4,195 Health institutions, and 1,201 general practitioners serving the population.

Latvia shares some of the same challenges other countries are facing, for instance, the population has shown a slight decline, birthrates are lower than they used to be, and the aging population is expanding. Other challenges are more unique to its geographic location and population density. The good practices the exchange team in Latvia identified respond to such general and unique challenges. They visited Latvia's Health Ministry and other healthcare institutions in Riga, as well as different types of healthcare provides across the country, from rehabilitation centres to general hospitals located in less populated areas.

The first good practice the team identified concerns the digitalization of the Front Office. Some hospitals have installed self-service registration columns. The displays show appointment times, clinic locations, and estimated waiting times. Moreover, monitors outside the waiting areas guide patients visually to their corresponding consultation rooms.

The second good practice involves patient-reported experience questionnaires. These are distributed at the national level in obstetrics, children's healthcare, mental health centres, and following inpatient care. The results are analysed to learn how to support patients and shared decision-making, improve discharge procedures and communication, increase comfort and trust, etc.

The third good practice relates partly to Latvia's geographic location. The country is working to build its resilience across the board, including in health care. Following Russia's invasion of Ukraine and increasing climate-related disasters across Europe, Latvia has gathered key institutions such as the Ministry of Health, the National Health Service, and Hospitals and Clinics, among others, to make risk assessments and create contingency plans. The approach is

interdisciplinary and includes a wide array of measure, for example, there are ongoing training and simulation exercises being undertaken in collaboration with Latvia's defence sector. These training and simulations take place in various scenarios: from a foreign enemy incursion to an environmental disaster.

The take-home messages on quality improvement in Latvia from the presentation of the HOPE Exchange team can be summarized thus:

- Empowering patients through digitalization.
- Protecting communities through coordinated preparedness.
- Listening to the experiences of service users.

ITALY

National Coordinator:	Marco Di Marco	
Exchange participants 2025:	Marta Luisa Mendes, PORTUGAL Sandra Matos, PORTUGAL Marta Bacelar, PORTUGAL Nona Schmidt, THE NETHERLANDS Anna Błachut, POLAND Pilar Cárdenas, SPAIN Antonio Figuerola, SPAIN Rocío Fernández Ojeda, SPAIN	Laura Redondo Robles, SPAIN Linda Barray, SWITZERLAND Kalliopi Mataragka, GREECE Artemisia Zioga, GREECE Poul Walsh Olesen, IRELAND Gerald Handl, AUSTRIA Natalia Chorhy, FRANCE

The HOPE Exchange team in Italy identified good practices at national and local levels. At the national level, they focused on policy approaches. For instance, the Italian Ministerial Decree 77/2022 shifts the hospital-centred model to a more proactive, community-based one. This decree has allowed for the formation of Territorial Operational Centres (COTs – *Casa della Communità*) and strengthened community hospitals, both of which are key to the shift. They are funded by Italy's National Recovery and Resilience Plan as part of Next Generation EU (4 billion euro allocated to territorial care modernization).

The COTs help ease the flow of patients into hospitals by helping those who can be treated at home; for instance, by monitoring patients via telemedicine where possible. The system also centralises access processes into a territorial service network. Furthermore, it integrates multidisciplinary teams to support patients, as well as their families and caregivers. Such teams can coordinate and find support in the overall territorial network.

Local initiatives include the use of 'Metaverse' tools in healthcare settings. Such used include measures to improve waiting times, such as that undertaken by Asl Toscana Sud Est, where

patients can go to a doctor's office in augmented reality where face-to-face contact can be simulated without leaving home.

Another good practice presented by the HOPE Exchange team in Italy concerns palliative care. The San Gennaro Hospital, one of the oldest in Naples, provides residential care for patients with advanced degenerative diseases. Care aims at controlling symptoms and improving the quality of life of residents. Hospice care teams are multidisciplinary, ranging from doctors and nurses to social workers and psychologists. The Local Health Unit (Asl) Napoli 1 Centro is also implementing home palliative care for those patients who can still manage their conditions at home. This model provides each patient with an individualized treatment plan, which addresses the physical, psychological, social, and spiritual needs of the patients, and their families and caregivers. Patients are monitored regularly to adapt treatments to changing needs over time.

The benefits of this model for palliative care include:

- Improvements in patients' quality of life.
- Reductions in hospital stays.
- Reductions in emergency admissions.
- Prompt identification of changing needs.

Finally, the exchange team closed their presentation with practical use of Patient Reported Experience Measures (PREMs), which led to the need for control noise levels in hospital and healthcare settings. By listening to patients, norms are changing, and poster reminders have been distributed to remind staff, families, and patients to turn down their phones, listen to music using headphones, and lowering their voices in various wards, among other things. Such measures have helped ease the anxiety levels of patients and increased their comfort.

The team's take-home messages underscore the importance of high-tech and low-tech measures, from telemedicine to help patients stay at home to finding ways to ease the anxiety of children undergoing MRI scans, as well as the importance of listening to patients to improve healthcare systems.

IRELAND

National Coordinator: Siobhán Regan
Exchange participants 2025: Tanja Würtz Rasmussen, DENMARK
Marije van Dijk, THE NETHERLANDS
Joana Faro, PORTUGAL
Miska Myllylä, FINLAND

The HOPE Exchange team in Ireland kicked off their presentation by presenting Sláintecare (the Gaelic name for Ireland's Healthcare System improvement plan) and its vision: To create a universal public funded healthcare system, with access based on need, not ability to pay. To achieve this, Irish health authorities are currently:

- Restructuring and decentralising the system, with focus on integration of the services and seamless transitions between providers as the means to improve quality.
- Developing primary and community care, in order to keep people healthy at home for as long as possible.
- Adhering to the guiding principles of providing the right care, in the right place, at the right time, and with the right team.

In practice, this has meant the alignment and integration of hospital-based services and community-based services to bring care closer to home. Furthermore, greater emphasis is being placed on propulation-based approaches, meaning that service planning and delivery aim to address health inequalities in conjuction with other priorities such as ensuring safety, quality, and transparency throughout the system.

Guided by the pyramid showcasing the different levels of care, the exchange team identified good practices under the second and third tiers corresponding to Community Specialist Care (CSTs) provision and Integrated Care Hubs.

Firstly, the quality of healthcare personnel rests on various pillars, including education, knowledgable and healthy staff, and a clear relation between theory and practice. To this end, Sláintecare is working to improve access to education in health professional fields and retaining their quality workforce.

The Nursing and Midwifery Board of Ireland (NMBI) is the regulatory body for nursing and midwifery in Ireland, whose mission it is to protect the public and the integrity of the professions of nursing and midwifery through the promotion of high standards in education,

training, and professsional conduct. Furthermore, universities such as the University College Cork and Trinity College Dublin, have set up internships for general pracitioners and consultants in different hospitals throughout Ireland and abroad. Finally, there are incentives to undertake studies and training in different settings across the country and in the UK. All this in an effort to address a decline in student enrolment in the healthcare sciences and medicine.

To retain quality staff, regulations have been introduced. In addition, staff are offered accessible ways to gain new competencies and to keep their knowledge updated. Nurses and doctors can also undertake in-depth specialization courses, and/or follow pathways to managerial positions.

Collaboration extends beyond the medical field. For instance, students at universities conduct research on developments in health institutions. And, where appropriate, the research feeds back into the system in the form of policy changes or recommendations.

Three examples that embody the approaches described above are:

- The Roma and Travellers' Health Initiative which is building trust through community health workers and increasing access by taking account of cultural differences and focusing on fairness.
- The Glen Resource Center works to improve care coordination by connecting hospital and community teams. This in turn has reduced delays and fragmentation in care delivery.
- The Irish Guide Dogs for the Blind inititiative, which is helping people with severe visual impairments move independently and safely.

Challenges remain, however, Sláintecare is working to keep professionals within their borders, reach less populated areas, provide healthcare services to vulnerable groups, and encourage student enrolment in the health sciences.

GREECE

National Coordinator: George Tsimopoulos
Exchange participants 2025: Fernando Sousa, PORTUGAL
Lorraine Chapman, UNITED KINGDOM
Lorenzo Isella, ITALY
Susanne Øllgaard, DENMARK

The HOPE Exchange team in Greece visited Papageorgiou Hospital in Thessaloniki and Venizeleio Hospital in Heraklion, Crete. classified the good practices they observed under three overarching themes: (1) Together for quality, (2) Integration for quality, and (3) Innovation for quality.

One of the ways in which members of the Greek healthcare services work together for quality is by instituting emergency colour codes. These are used to communicate different situations that require immediate attention. The coded messages announced publicly alert staff to an emergency or another type of significant event. These codes have been standardised and piloted in 10 sites across Greece. They are part of a broader 'Safe Hospitals' initiative to create shared situational awareness (within the hospitals, but also beyond when appropriate – police and fire departments), prompt quick and relevant responses, and ensure full collaboration of pertinent staff during an emergency. The rationale is that this is a way to achieve such responses without causing panic or chaos.

In terms innovating for quality, Papageorgiou Hospital has introduced social robots (NAO and Pepper). These robots are designed to engage in emotional and social interactions. So far, their use has been trialled in paediatric wards and neurorehabilitation settings. They are equipped with speech, gesture recognition, and interactive displays. In paediatric settings, they also engage in storytelling and playing games. In neurorehabilitation, they engage in guiding physical exercises and leading memory activities. Their use has helped standardize protocols in certain areas and for patients, it has also helped reduce hospital-related fear and stress. Observers have found it to be especially beneficial for children with neurological disorders.

In terms of integrating for quality, the exchange team focused on the introduction of an ICU Electronic Health Record, which is tailored to the needs of an ICU. The system collects data from bedside devices, and displays and stores measurements in a unified interface. Its key attributes include:

- Continuous and real-time monitoring.
- Decision-support tools.
- Integration of data from other hospital systems.
- Structured documentation for quality assurance.

The hospital workforce save time, possess good information to support their decisions (e.g., they can easily access workflows), communicate better and reduce errors. The hope is that with such measures, hospitals can optimize resources, harmonize documentation, and save money. For patients, such measures have been found to improve survival rates, strengthen coordinated care, reduce invasive monitoring, and deliver safer care.

SERBIA

National Coordinator: Đorđe Nikodinović
Exchange participants 2025: Adriana Jabczyńska, POLAND

The HOPE exchange participant in Serbia, Adriana Jabczyńska, began her presentation by offering an overview of the country's healthcare services in Serbia. While there is a private sector, the universal healthcare system to ensure that all citizens, regardless of their socioeconomic status, have access to healthcare without facing financial hardship. It is primarily state funded via the Republic's Health Insurance Fund.

Service levels are divided into tertiary care (specialized clinics and university hospitals), secondary care (hospitals and specialists), and primary care (health centres and general practitioners).

It is within this context of healthcare that Ms. Jabczyńska identified two case studies in good practice: (1) the digitalization and unification of healthcare data, and (2) the structure patient experience model. She traversed over 700 km to visit various hospitals, clinical centres, and medical research institutes, among others.

Serbia has digitalized and unified its healthcare data. This effort has helped implement a number of platforms, information systems, and projects to improve communication and create better access to healthcare, preventive measures, and information. For instance, the Moj Doktor nationwide digital platform introduced in 2015. Moj serves as a central electronic system where all medical and health-related data are stored and processed, including patient information, healthcare providers, institutions, interventions, electronic referrals, prescriptions, and appointment scheduling.

The system facilitates planning, service quality, and transparency in healthcare delivery. Modules for patients include e-Booking, e-Referral, e-Prescriptions, Medical Daybook, Disease Registers (for conditions such as cancer, diabetes, cardiovascular diseases, etc.). Healthcare workers can view reports and consult patient records across the three levels of care.

The availability of digitized data has also enabled the development of HELIANT's (leading software company in the Western Balkans) communication board where healthcare institutions (public and private) can communicate seamlessly.

Next, Ms. Jabczyńska, presented a hospital group's approach to patient experience and satisfaction support. Established in 2013, MEDIGROUP is a leading private healthcare provider in Serbia, operating 13 facilities across the country's major cities. They have introduced various

ways to reach out to patients and to integrate their feedback into their operations. For instance, they have a 24/7 call centre in operation, digital information readily available, and staff are trained to support patients during hospitalizations, outpatient care, and other clinical procedures. This 'Navigator' system assigns people to guide patients through screenings, diagnoses, treatments, and follow-up consultations.

PORTUGAL

National Coordinator:	Sofia Oliveira	
Exchange participants 2025:	Maria Chatzicharalampous, GREECE Tina Beck Guldager, DENMARK Aleksandra Wasilewska, POLAND Joe Skelton, UNITED KINGDOM Simona Filea, AUSTRIA	Francesca Palladini, ITALY Kevin Hamstra, THE NETHERLANDS Peter Södergren, SWEDEN Mary Tyrrell, IRELAND Óscar Cruz, SPAIN Xavier Buyse, SPAIN Emilia Di Girolamo, ITALY

The HOPE Exchange team in Portugal began their presentation by introducing their definition of quality in healthcare, which they understand as something beyond strict clinical metrics that incorporates patient safety, innovation, and equity – everything that contributes to world-leading patient care.

Next, participants offered an overview of the Portuguese healthcare system, which is funded by taxpayers, overseen by the Ministry of Health, and mostly delivered through Local Health Units. Like most healthcare systems in Europe, the Portuguese system is also facing various challenges, including the rise of multi-morbidities to demographic changes shifting towards old age.

To guide the audience through the good practices they identified during their stay in Portugal, the exchange participants presented a 'Luisa', the profile of an 84-year-old grandmother who is living a healthy and active lifestyle, but who is also being treated for hypertension, osteoarthritis, and diabetes. In this context, the first good practice relates to integrated primary care provided by Local Health Units, which are embedded into hospital systems.

Therefore, someone like Luisa, would receive care from a family doctor, specialists, and hospital services. Such care is overseen by 'Integrated Responsibility Centres' (CRIs) – multidisciplinary teams in the local health unit that provide healthcare to specific groups of patients.

The CRI system is designed to improve quality by fostering a culture of accountability and collaboration.

Next in Luisa's care journey, we encounter the meaningful integration of technology to improve certain treatments and support the independence of patients. Some centres, for instance, are using gamification principles in rehabilitation programmes to improve patient engagement, adapt to the diversity of patient profiles, and reduce pain. Someone like Luisa can benefit from this approach to maintain mobility via coordination and balance exercises. Furthermore, the modular nature of these programmes can easily adapt to her specific needs caused by osteoarthritis-related frailty.

On the surgical side, some hospitals are also integrating technology to strengthen surgical skills and to train young surgeons. An example of this is the 'Virtual Reality Surgical Simulator', which provides realistic environmental simulations, real-time performance feedback, and tracks the trainees' progress.

The team in Portugal closed their presentation with individual take-home messages:

POLAND

National Coordinator: Bogusław Budziński
Exchange participants 2025: Silvia Gallo, ITALY
José Gonçalves, PORTUGAL
Ignacio Diez López, SPAIN
Jalmiina Nummelin, FINLAND

The HOPE Exchange team in Poland began their presentation with a quick overview of Poland's healthcare system. The system is public and universal, supported by a robust legal framework, overseen by multiple layers at national, regional, and local levels, and has a special regulation office to ensure quality in healthcare, as well as compliance in the use of medical devices.

All hospitals must comply with quality standards to operate. The steps towards accreditation and monitoring are laid out in the 16 June 2023 national Act on Quality in Healthcare and Patient Safety.

It is within this context that the exchange team in Poland identified good practices in quality for healthcare. First, they presented the case of 'Molecolab', located in Łódź. The lab plays a crucial role in the healthcare landscape by providing advanced molecular diagnostics and supporting clinical trials to enhance precision and deliver quality patient care. To reinforce the latter, the teams at Molecolab collaborate not only with multidisciplinary clinical teams, but also with an ethical lab located in the same city. This helps ensure ethical standards are met to the benefit of patient care.

The next example of good practices covers the lifelong learning strategy to reinforce the skills and expand the competencies of the health workforce. Some of the areas covered by the continuous education programme include:

- Digital Skills Development
- Lifelong learning modules
- Microcredentials
- Continuous Quality Improvement

This strategy has been in place since 2013.

The final good practice example selected by the team in Poland relates to the integration of digital strategies in care. For instance, in medical education, students, researchers, and professionals participate in simulation centres and scientific projects.

In their conclusion, the exchange participants shared their personal views on what they are bringing home to their respective countries and institutions:

SPAIN

National Coordinator:	Ana de la Cruz	
Exchange participants 2025:	Simona Coladonato, ITALY Melania La Verde, ITALY Elisa Guidotti, ITALY Gabriela Festa, ITALY Sarah Laurent, BELGIUM Michela Dassani, ITALY Agata Lisiewicz-Kaleta, POLAND	Andrea Cortes, UNITED KINGDOM Danielle Della Peruta, ITALY Jane Brodthagen, DENMARK Corinda van Dijk, THE NETHERLANDS Katerina Vlachaki, GREECE

The HOPE Exchange team in Spain visited various regions in duos. They began their presentation by presenting the legal and policy framework that undergirds the Spanish healthcare system, particularly in relation to quality. For instance, since 2010, a plan has been in place to:

- Protect patients, promote health, and engage in preventive medicine;
- Build equity;
- Foster clinical excellence;
- Evaluate technologies and procedures;
- Integrate new technology;
- Plan resources;
- Promote transparency; and
- Evaluate results.

All these measures have been drafted with patients and users in mind.

Within this context, exchange participants selected three good practices. First, they presented the Sepsis Unit called 'BIAlert Spesis', which uses artificial intelligence to calculate the risk of sepsis based on patient data collected in real-time and fed into the system every 30 minutes. If the algorithm identifies a high risk for sepsis, it issues an alert. The outcomes of early detection and intervention have reduced mortality rates, lengths of stay in hospital, and

treatment costs. It has been so successful, the use of the system may be expanded to other hospital sites beyond Palma de Mallorca.

Another good practice the team identified relates to integrated care. The community of Navarra has implemented a programme to bridge hospital and community care, which aligns with decentralized nature of the healthcare system where autonomous communities manage both hospital and primary care services. Here, primary care serves as an entry point to specialist care. Electronic Health Records are shared amongst medical professionals to reduce duplication and enable collaboration, particularly in chronic disease management and continuity of care.

The specific objectives in the integrated care of patients with chronic diseases and multi-morbidities include:

- Improving health outcomes and technical quality;
- Enhancing patients' quality of life;
- Promoting patient and caregiver empowerment;
- Increasing patient and family satisfaction;
- Contributing to the sustainability of the healthcare system; and
- Promoting a culture of continuous improvement among professionals.

Other ways in which the integrated care approach is implemented in other autonomous communities such as Castilla y León, include providing hospital care at home and doing teledermatology consultations when appropriate. In Andalucía, integrated care is best exemplified in oncological care, which often necessitates coordination along the care pathway. All these examples rely on electronic health records.

The last good practice presented by the exchange team in Spain relates to Lean Management. EstimTrack is an intelligent system that helps ease the highly complex management of the use of operating theatres. The system organizes and visualizes workflows in the surgical department using LEAN principles. It has improved communication between teams and helps them coordinate patient pathways. The platform monitors operating rooms, post-operative units, patient transport, sterilization, and nursing coordination. The integration of this system has dramatically reduced internal calls and has improved working environments. In addition, it helps surgeons keep patients' family inform via screens and apps.

FINLAND

National Coordinator: Tarja Tenkula

Exchange participants 2025: Marie Christensen, DENMARK
Orla Fahy, IRELAND
Lelde Vancoviča, LATVIA
Mink Vossen, THE NETHERLANDS
Michał Sokół, POLAND

The Exchange team in Finland began their presentation by providing demographic and contextual information, which affect healthcare delivery, for instance, population density and distribution.

In 2023, Finland started to roll out the healthcare reforms adopted some time before. Today, the state guides, directs, and funds healthcare in a centralized manner. Healthcare delivery is now coordinated by 22 health, social, and rescue service organizations plus the Hospital district of Helsinki and Uusimaa. These 22 + 1 units fall under five collaborative areas that divide responsibilities and specialised services. The public sector plays a central role in coordinating public services, and the private and third sector utilities that complement them.

The exchange team's 'good practice' first stop was the University Hospital of Oulu, which serves the population in the north of Finland and is currently undergoing a complete overhaul. The Project Management team has used service design to help ensure high-quality across all areas in the new hospital. All team members have been included in the design planning process, from management to support services. And lean principles were applied, culminating in a simulation workshop that tested the space and other practicalities.

The next good practice relates to the meaningful integration of technological solutions in administering drugs. In this case, unit doses of drugs are distributed by robots. It has been found that this helped reduce the incidence of human errors, as well as waste, and increased the time professionals have to directly connect with patients. In more rural areas, such as Kainuun, healthcare services have developed a digital platform with a chat function to increase access.

Finally, in Kajaani and Oulu, hospital-related services provide rehabilitation, which blend approaches from in-person sessions to home-based exercises, assistive technologies, and adaptable modules for people with intellectual disabilities.

BELGIUM

National Coordinator: Jean Stoefs

Exchange participants 2025: Karin Trollmann, AUSTRIA
Sandra Dohr, AUSTRIA
Catherine McGauran, IRELAND
Merche Gabari, SPAIN

The HOPE Exchange team in Belgium visited hospitals in the southern Walloon region, namely, Centre Hospitalier EpiCURA in Mons, Hôpital Citadelle in Liège, and CHR Verviers.

The first example of good practice they shared refers to the patient centredness approach they observed Mons. The Centre Hopitalier EpiCURA is accredited by the 'Accreditation Canada', which recognizes the quality and safety offered to patients and requires the establishment of an official Patient Committee. This committee comprises medical professionals and patients willing to share their experiences in the hospital. The aim is to address various topics collaboratively and continuously improve patient care. One of the outcomes of this committee has been the publication of a guideline for patients and their families during a hospital stay.

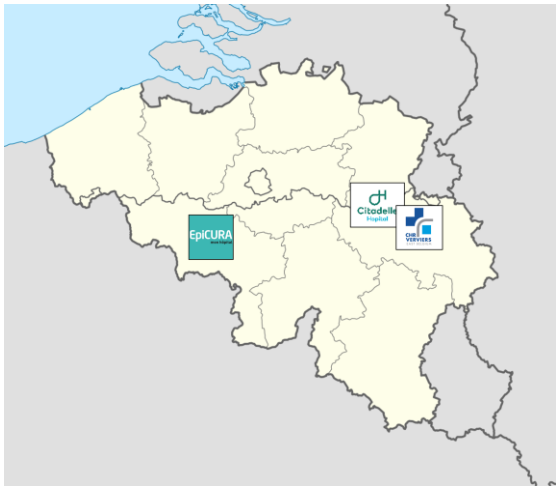
In Hôpital Citadelle, patient-centred practices include the social mediators and translators who form part of the hospital's workforce. They support patients from diverse cultural and linguistic backgrounds. They accompany patients to medical appointments within the hospital and help them understand the complex information they are being given in order to make informed decisions.

At CHR Verviers, patient complaints are managed through structured mediation processes aided by professionals. The process included the following steps:

- Preparation: One-on-one rules are held to clarify roles; explain procedures and rules.
- Explanation: Each party shares their perspective.
- Problem analysis: The mediator identifies root causes.
- Solution and agreement: Negotiations are held and a mutually-agreed written resolution is drawn up.

The second area where good practices were observed relates to innovative in-house solutions. For instance, in training and development, hospitals provide in-house courses

and coaching that are designed based on the specific needs of the institution. Another example is the gamification of the onboarding process and the use of Virtual Reality to develop risk management skills.



Finally, the exchange team in Belgium selected Wallonia and Brussels' region-wide benchmarking approach. Thirty-five hospitals participate in this initiative and distribute standardized patient surveys to measure satisfaction and learn more about patients' experiences in hospital. The data is available online and can be compared using the same platform. It is a publicly funded initiative; hospitals only need to purchase the software to implement it.

FRANCE

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Exchange participants 2025: Alain Didderen, BELGIUM
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The HOPE Exchange team in France presented the multi-layered complexity of the French healthcare system: it encompasses the various interests of political and professional stakeholders in the publica and private sectors, diverse territorial contexts and disparities (especially between urban and rural regions), and coordination and integration issues.

It is within this complex context that the exchange team identified good practices:

- First, the 'Dispositif d'Appui à la Coordination' (DAC). This system coordinates regional stakeholders by facilitating mutual understanding, supporting interprofessional practices and local initiatives, and analyzing needs and structuring complex health pathways.
- Next, 'L'Initiative Hôpital Ami de Bébés' (IHAB). This programme is supported by WHO and UNICEF and it promotes breastfeeding and the parent-child bond. Principles include personalized and family-centred care, integrated and networked work to provide continuity of care, and staff training to promote compliance.
- 'Unité Transversale d'Education Thérapeutique du Patient' (UTEP). This initiative works to improve the quality of life of patients with chronic illnesses and their families across their care pathway.
- '*La Responsabilité populationnelle'* (RESPOP). This is an initiative to promote collaboration and multidisciplinary approaches to health provision. It uses health data to stratify the population and design tailored interventions. Patients play a key role as it encourages them to understand their conditions and share in decision-making concerning their treatments. It is an effective approach to manage

chronic and long-term health conditions, but also to encourage prevention and screening, as it works best with up-to-date databases.

- And finally, 'Hospitalisation Á Domicile' (HAD). This programme promotes care closer to patients to reduce avoidable hospitalizations. HAD not only eases the burden on hospitals and outpatient services but helps meet a demand for complex care at home, as patients often prefer to stay in their residences as long as possible.

The HOPE Exchange team in France concluded with take-home messages:

- Ambitious, complex approaches are essential to address the current challenges of the French healthcare system.
- This is a change of mindset that requires: Communication and coordination, mobilisation and motivation, data, team and trust, culture and collaboration, pragmatism, and customisation.

MALTA

National Coordinator: Michelle Galea
Exchange participants 2025: Ger Walsh, IRELAND

HOPE Exchange participant, Ger Walsh from Ireland, closed this year's Agora with her presentation on good practices observed in Malta's healthcare system. Ms. Walsh identified good practices in primary care delivery, telemedicine, quality standardization, digital medical records, and oncology services.

There are 50 primary healthcare services nationwide: health centres, community clinics, centres of excellence, telemedicine (a 24/7 client support centre), and National Screening Services, all of which are provided free of charge. This complex array of primary healthcare delivery has been awarded ISO 1901s for Quality Management, Integrated Care provision, and Physiotherapy services. It has also been certified by an ISO 1701 for creating a culture of quality and continuous improvement to deliver, among various things, patient safety, timely and patient-centred care, etc. Quality is also monitored via patient surveys and feedback. QR codes are posted in healthcare centres and hospitals, which patients and their families can scan. This is part of Malta's Quality Service Charter.

Telemedicine also plays an important role in Malta's primary care sector. Since March 2020, the nationwide number provides service 24/7. To date 420,000 medical teleconsultations carries out; doctors manage 250- 300 calls per day. Each teleconsultation recorded on Electronic Patient Record (EPR), blood tests can be ordered and when necessary, nursing support is assigned. Due to the expansion of telemedicine, home visits have decreased by 85%, reducing the unnecessary burden on doctors and nurses.

To facilitate telemedicine and collaboration between medical professionals, electronic health records are important. Using the interactive digital portal, myHealth, Doctors and citizens can view upcoming appointments, consult lab and radiology test results and reports, check prescriptions and vaccination records, and gain a clearer perspective of patients' health journeys.

Finally, Ms. Walsh selected Malta's oncology services as one of flagship good practices she observed. In 2022, the World Health Organization singled out Malta's New Cancer Care System for its personalised-integrated care approach, both during and after treatment. One of its central functions is the Nurse Navigator role. Nurse Navigators guide

patients through services, protocols, and forms, fostering confidence in the system and enhancing patients' mental health. This model contributes to the quality of the overall therapeutic experience.

Even before undergoing treatment, the Malta's Cancer Care System encourages prompt diagnoses through early screening and preventive care. Timely diagnoses and prompt treatment improves survival rates. During treatment, the Action for Breast Cancer Foundation provides specially designed equipment and 15 free psychological support sessions, as well as other elements to support the quality of life of patients and their families.

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HOPE represents national public and private hospitals and healthcare associations, national federations of local and regional authorities and national health services from 30 European countries.

HOPE mission is to promote improvements in the health of citizens throughout Europe, high standard of hospital care and to foster efficiency with humanity in the organisation and operation of hospital and healthcare services.