# Patient safety,
# Patient experience

European Hospital & Healthcare Federation

# Report on the HOPE Agora

## Lisbon, 29-30 May 2026

# Contents


# Introduction

From 29 to 30 May 2026, around 200 healthcare professionals in management positions in different departments participated in a 4-week hospital exchange across 20 countries in Europe.

In line with this year's HOPE Agora theme, 'Patient Safety, Patient Experience', participants were asked to observe how hospitals and health care services are promoting patient safety cultures and minimising patient harm through communication, teamwork, learning from errors, and leadership, as well as through incident reporting systems and analyses of adverse events among other elements. They identified good practices, shortlisted examples, and shared them at HOPE's Agora in Lisbon.

HOPE President Eamonn Fitzgerald welcomed around 200 participants from across Europe. He was joined by HOPE Secretary-General, Pascal Garel and HOPE Governor, Eva M. Weinreich-Jensen, who moderated the rest of the event.

The conference started off with presentations by the coordinators and researchers of the SAFEST project, which HOPE is part of. Presenters shared the project's fieldwork, findings, and key outcomes, including 101 recommendations for patient safety in perioperative care. SAFEST also featured in some of the country presentations, as hospitals across Europe participated in the project's open phase assessments (see more below).

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. In addition, HOPE Exchange alums, Faizan Rana and Andrea Cortés, travelled to Lisbon to introduce a HOPE Exchange alumni network initiative to maintain collaboration beyond the programme. Former participants have already engaged in targeted, bilateral visits to be part of workshops on topics such as emergency resilience.

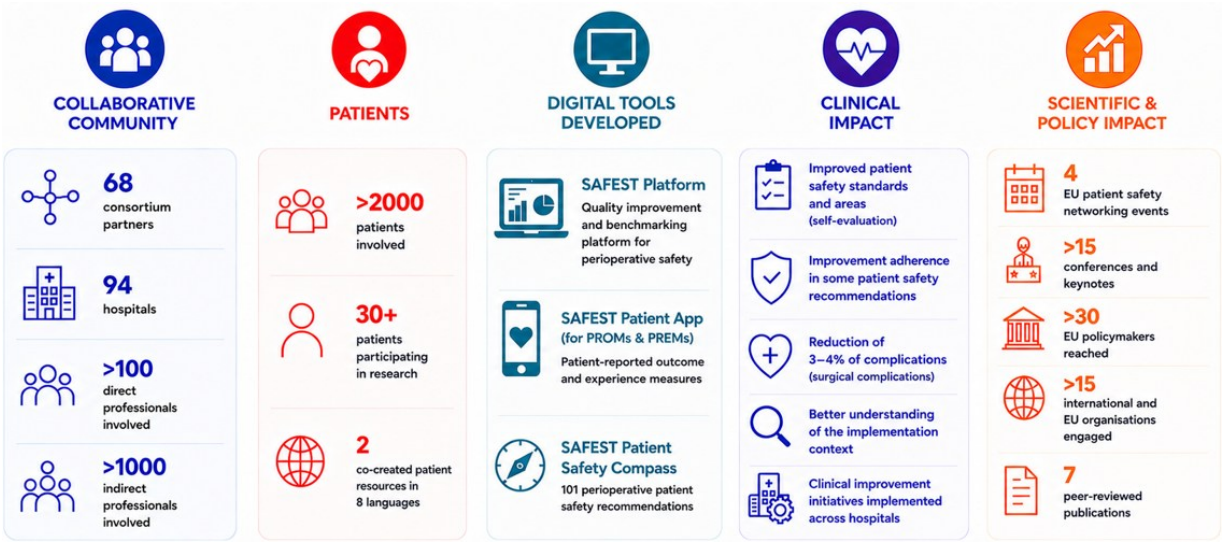
This document summarises the proceedings of the event. The presentations are **available online here**.

# Conference

## SAFEST Project Overview and Implementation of Perioperative Safety Standards in Hospitals Worldwide

**Dr. Carola Orrego and Dr. Claudia Valli (Fundación Avedis Donabedian)**

Dr. Carola Orrego opened the SAFEST portion of the conference by providing an overview of the project, which for over four years worked to improve patient safety in perioperative care – before, during, and after surgery. Initial steps included defining evidence-based practices to identify gaps, learn from existing approaches, and get a firmer grasp of the reality of perioperative safety.




Once SAFEST arrived at a list of recommendations through an iterative Delphi process (see more directly below), the ten partners worked to promote Europe-wide adoption of both, the assessment tool the project developed and the recommendations. Dr. Claudia Valli presented the development process of the **SAFEST Platform**.

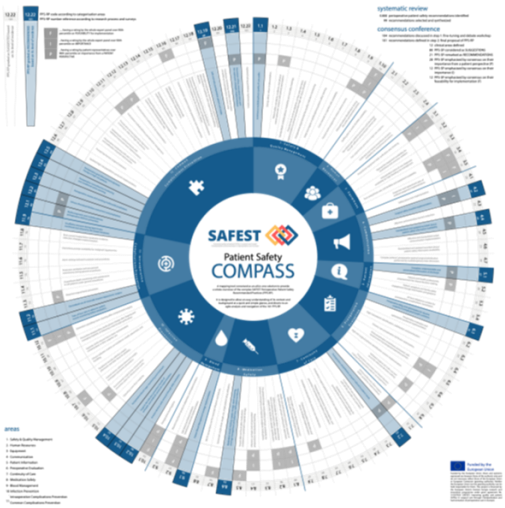
First, SAFEST's 10 partner hospitals in 5 European hospitals piloted the entire pathway. They each conducted a pre-intervention self-evaluation to determine baseline indicators. The next steps included the formation of Learning Quality Improvement groups to work on strengthening the gaps identified, using the SAFEST recommendation findings as guides for implementation. This process was followed by a post-intervention self-evaluation. During this period, the open phase was rolled out. Hospitals worldwide were able to conduct guided self-evaluations through the SAFEST platform and with the support of the project's researchers, as well as resources and training materials developed for this purpose.

## Perioperative Patient Safety Recommendations: A COMPASS to Head for Safety

**Dr. Daniel Arnal-Velasco (SENSAR)**

The process to reach the final 101 SAFEST Perioperative Safety Recommendations was rigorous and iterative. It began with an extensive systematic review of clinical practice guidelines, and a consensus process –after recruiting multidisciplinary advisory groups– consisting of a 2-round online modified-Delphi survey and a 2-day face-to-face Consensus Conference. Following the SAFEST process through the self-evaluation, prioritization, quality improvement collaborative, and the data collection stage, the feedback from researchers, hospital members and external reviewers were taken integrated to develop the final set of Perioperative Patient Safety Recommendations. Of the 4,588 references identified from the literature search, 267 were selected for further study; 4,665 perioperative patient safety recommendations were extracted from these. After searching for duplicates, categorizing the rest, and prioritizing them based on criteria such as feasibility, project researchers and clinicians shortlisted 99 for the first round of the Delphi survey.

Both iterations of the Delphi survey involved the 66-member Scientific Advisory Group, which reflected a balanced representation of gender, professional and geographical background balanced, and patient representative involvement. This group participated in two rounds, one online (modified-Delphi survey) and one face-to-face, a Consensus Conference held in Brussels. This is where a final set of 101 recommendations – including lay-language wording – was agreed on. The Consensus Conference participants also reflected on the patient perspective, equity considerations, feasibility barriers, and wording.




Finally, following their application in the SAFEST research process, the recommendations were reorganized into 12 thematic areas, following a logical temporal sequence, and some were rephrased to improve readability. A graphic representation was developed online and for download (the latter in different languages): **The Perioperative Patient Safety Compass**.

## From Measurement to Improvement and Implementation Experiences from the Field

**Dr. Hilly Calsbeek and Dr. Anita Heideveld-Chevalking (Radboudumc), Dr. Nuno Diogo (ULS São José), and Dr. Joana Mourão (ULS São João)**

The work that Dr. Hilly Calsbeek and her team at Radboudumc in the Netherlands coordinated involved prioritizing common improvement aims (common bundles) across all hospitals, and guiding hospitals in translating improvement aims into concrete action plans.

To this end, they developed a tool to set the criteria for prioritizing recommendations based on self-evaluation results, stated preferences, clinical perspectives and SAFEST research guidance, and finally, overall objectives. The common bundle criteria are:

1. Measurability – The only feasible way to collect the data to set baselines and evaluate primary outcomes is through hospital medical records.
2. Establishing association with surgical complications.
3. Setting a maximum and common room for improvement.
4. Making sure that at least one bundle builds on what is important to patients.

Following the prioritization process, improvement teams developed driver diagrams to support the implementation teams to systematically structure and plan their improvement priorities. Driver diagrams are living documents that evolved during implementation.

This process guided experiences in the field, which were presented by SAFEST hospital coordinators. Dr. Anita Heideveld-Chevalking shared the implementation of recommendation PPSR-020 on standardizing pre-surgery briefings for multidisciplinary teams. Radboudumc (The Netherlands), Hospital La Fe (Spain), and University Hospital Tartu (Estonia) all started to do this, especially before complex surgeries. What started in specific surgical units in each hospital has spread throughout, given how valuable it is to align teams regarding the specific considerations of the various patients scheduled for surgery any given day.

Dr. Joanna Mourão presented the global approach adopted at ULS São João. She walked the audience through the process of selecting the standards, based on the lowest scoring areas identified during the guided self-evaluation, narrowing down by the recommendations that could have the highest impact, and further selecting for those within their reach (contextual feasibility). Through testimonials and data, the hospital has observed early signs of improvement in areas such as patient information, continuity of care, infection prevention, and medication safety, among others.

## Building a Perioperative Quality Improvement Collaborative

### Dr. Caroline Schlinkert (NIVEL)

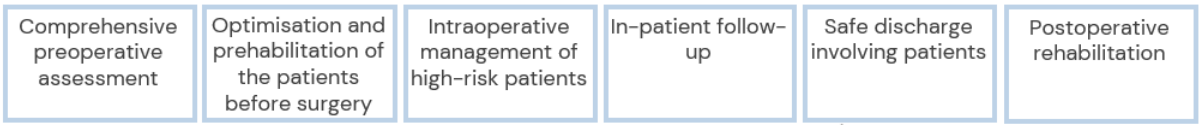
Dr. Caroline Schlinkert focused on the Perioperative Quality Improvement Learning collaborative, and its role in promoting adoption and buy in. Members were identified in each of the SAFEST implementing hospitals. Together with NIVEL and other researchers, they developed a toolbox comprising recommended actions based on barriers and needs identified during the self-evaluation processes. Another function of these teams was to assess contextual factors, plan, and document outcomes, including costs.

One important aspect of the learning collaborative was that patient representatives were also part of it. While SAFEST did not achieve the highest levels of direct participation, their voices were still part of the process, culminating in a '**Patient Checklist**' (translated into various languages) for perioperative care. This checklist is based on what patients say they need to know before, during, and after surgery. It is for adult patients having planned (elective) surgery, family members, partners, and caregivers who support the patient, or to be used together.

## Evaluating the SAFEST Intervention on Perioperative Safety Adherence and Surgical Complications

### Dr. Pedro Casaca Carvalho and Prof. Paulo Sousa (NOVA)

Dr. Pedro Casaca Carvalho presented the preliminary evaluation results. The aim has been to estimate the immediate and long-term effects of implementing the collaborative plans for perioperative patient safety, as well as adherence. For 30 months, SAFEST collected data on outcomes and other indicators related to complications, etc.: 12 months prior to intervention to set the baseline and 18 months post-intervention. Outcomes were sorted into primary and secondary. The former referring to adherence to SAFEST perioperative patient safety standards using a 6-measure composite indicator; the latter referring to frequency of surgical complications using the ISOS tool to evaluate incidence reporting during a 30-day period following elective inpatient surgery.




Data sources included medical, nursing, physiotherapy, nutritionist records, as well as administrative data. Collection was semi-automated through the SAFEST platform, though with a lot of support from IT departments (the unsung heroes) who supplemented all the data. SAFEST researchers found that immediate adherence increased, aligned with the self-evaluations performed by hospital, and a halving of cardiovascular complications. However, adherence remains uneven across the six bundle components.

## Costing and Sustainability of the SAFEST Initiative

**Dr. Janika Bloemeke-Cammin and Lennja Hama (Optimedis)**

Finally, Dr. Janika Bloemeke-Cammin and Lennja Hama closed the SAFEST session with their presentation on the project's sustainability. They concentrated on the costing exercise as a potential incentive for future adoption. First, they defined activity by bundles, grouped by care phase and professional group. Next, they surveyed clinical and administrative staff twice over the course of 2024 and 2025 (information on salaries, country-specific contextual factors, etc.). This data was used to calculate capacity cost rates.

Next, they covered paths for sustainability, including creating international accreditation models, creating international networks hospitals and individual professionals can join, and establishing SAFEST's Unique Selling Point, which is that it is a digital platform that combines a network of hospitals and professionals using standardized recommendations and ready-to-use tools for everyday perioperative practice.

# 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 patient safety and patient experience.

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 began 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 moved to different tables. Staying behind each table was the table host for the next round, who welcomed the following group and briefly filled them in on what happened in the previous round. Each round focused on questions/statements designed for the specific context and desired purpose of the session. Afterwards the individual group members were invited to share the insights of other results 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 following topics:

***From Blame to Learning: Building a Just Patient Safety Culture***

Participants discussed the importance of shifting the focus from individual blame to organisational learning. A just patient safety culture was described as one where professionals feel able to speak openly about mistakes, near misses and unsafe situations without fear of punishment, while still recognising the importance of professional accountability. Key takeaways:

- A just culture moves the focus from "Who is to blame?" to "What happened and how can we improve?"
- Incident reporting becomes useful when it leads to learning, feedback and visible change.
- Legal protection, mediation and transparent processes can reduce fear and support openness.
- Leadership behaviour is central to psychological safety.
- A just culture must balance learning with accountability.

***When Care Goes Wrong: Supporting Staff, Protecting Patients***

The second discussion focused on healthcare professionals involved in adverse events, often referred to as second victims. Participants agreed that supporting staff after an incident is not only important for staff wellbeing. It is also a patient safety intervention. Key takeaways:

- Supporting staff after incidents helps protect future patients.
- Staff need immediate, human and individualised support after adverse events.
- Peer support should be normalised and free from stigma.
- Fear of punishment reduces openness and learning.
- If staff are not supported, safety improvement is less likely to happen.

***After Harm: Rebuilding Trust with Patients and Families***

The third discussion focused on the patient and family experience after harm has occurred. Participants agreed that patients do not expect harm to happen in healthcare. When it does, their needs are often clear: acknowledgement, honesty, explanation, apology, timely communication and assurance that the organisation will learn and act to prevent recurrence. Key takeaways:

- After harm, patients expect acknowledgement, honesty, explanation and apology.
- Saying “sorry” is not enough without follow-up and visible improvement.
- Communication must be timely, compassionate and understandable.
- Patients and families can contribute to incident learning, but involvement must respect consent, confidentiality and individual needs.
- PREMs and patient feedback should be connected to safety improvement, not treated as separate data.

***Patients as Safety Partners: From Experience to Safer Care***

The fourth discussion explored how patients and families can contribute to safer care. Participants agreed that patients should not be seen only as passive recipients of healthcare. They can help prevent errors, identify risks, clarify information, notice deterioration and provide important feedback about their experience. Key takeaways:

- Patients and families can help prevent errors when they are informed, listened to and empowered.
- Speak-up culture requires trust, respect, humility and active encouragement from professionals.
- Medication reconciliation should be a shared practice involving patients, pharmacists, IT systems and primary care.
- Safety information must be understandable, timely and adapted to individual needs.
- Patient experience data should be used as a source of safety improvement.

In addition, ***SAFEST consortium*** partners hosted four roundtables on the Patient Safety Compass, participative processes with patients, collaborative models hospital teams practice, and sharing experiences implementing patient safety measures.

***Cross-cutting conclusions***

- Patient safety requires a culture of trust, not fear.
- Incident reporting must lead to learning, feedback and improvement.
- Staff involved in incidents need timely and compassionate support.
- Patients and families expect honesty, explanation, apology and follow-up after harm.
- Communication after an incident must be human, not only procedural.
- Patients can be active partners in preventing harm and improving care.
- Patient experience data should be integrated into safety improvement work.
- Leadership is essential in creating psychological safety for both staff and patients.

# 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 policies that help develop a patient safety culture and that prioritise minimising patient harm by focusing on open communication, teamwork, learning from errors, and prevention of healthcare-associated infections, among others things. The following summarises their presentations.

## PORTUGAL

**National Coordinator:** Sofia Oliveira

**Exchange participants 2026:**

Anitha Batamuriza-Almasi, BELGIUM
Maarja Hallik, ESTONIA
Miguel Castro Ropero, SPAIN
Beata Zimak, POLAND
Ingrid Buiter, THE NETHERLANDS
Inese Sviklina, LATVIA
Fatema Mamdani, UNITED KINGDOM
Eliane Otto, GERMANY
Giusy Casazza, ITALY
David Nadal, SPAIN
Chrysa-Artemis Fai, GREECE
Maria Messina, ITALY

After introducing themselves and where they were hosted (Porto, Lisbon, Coimbra, Santa Maria da Feira, and Vila Real), the HOPE Exchange team in Portugal began their interactive presentation with two use-case scenarios, Nunu and Maria. Through these two character-patients, the audience learned about the best practices the exchange team identified.

Maria and Nuno's journey through Portugal's healthcare system begins at home where Maria contact healthcare professionals 24/7 using SNS-24, a service available online, via telephone and application, and in-person. Carers like Maria can reach out on behalf of patients to seek advice, obtain medical referrals, and even perform triage. Thanks to this, patients can stay longer at home, reduce pressure on ER, and get prompt medical attention when required.

Next the audience met Nuno, Maria's husband. He is a 79-year-old male living at home with his wife in Porto. He has a history of chronic obstructive pulmonary disease and heart failure, and he periodically suffers from shortness of breath. In times like this, Maria's call to SNS-24 results in an ER referral, where a medical team can readily consult SClinico, a platform used across

Portugal to access all patient information, including their demographic background, all their medical history, their prescriptions, test results, previous appointments, and vaccination records.

As Nuno's healthcare path continued, the ER doctor draws up a treatment plan for Nuno. Maria notices that the doctor has consulted another patient's X-ray on the medical chart while assessing Nuno. She feels confident enough to point the error out to the doctor who thanks her and explains that he will record this near-miss event.

User-friendly systems like Notific@ and HER+ aid changes in organizational culture by making incident reporting and learning easily accessible. They allow patients, families, and healthcare professionals to report incidents, which are then analysed and investigated to improve patient safety and then act on this, helping to prevent future incidents of a similar nature. Such an approach supports goals such as patient-centred care, patient empowerment, family involvement, and supporting healthcare professionals.

Finally, the audience follows Nuno's discharge process. He did well during his hospital stay but will require ongoing care with antibiotics, thus, he is referred to the 'Hospital at Home' service. Physical and mental health outcomes tend to improve when patients are allowed to return home sooner. In this case, Nuno was anxious to get back to his home to see his garden.

'Hospital At Home' is a service that already exists in many regions of Europe. In Portugal, it has been well established since 2011 (some regions in 2015). Through this system, Nuno receives his intravenous antibiotics at home, where nurses visit twice a day to support administration until the course is complete.

'Hospital At Home' reduces length of stay and the risk of hospital-acquired infections, it also improves recovery times and helps preserve patient mobility. The HOPE Exchange team in Portugal concluded by referring to patient questionnaires, which are sent after outpatient treatment or hospital discharge. This feedback is used by national public health authorities to shape its healthcare policies and improve patient safety. Participants noted that many of the measures they picked demonstrate a culture of quality improvement.

# POLAND

**National Coordinator:** Bogusław Budziński

**Exchange participants 2026:** Veronika Stefanik, AUSTRIA
Orlagh Harrington, IRELAND
Rita Beja Neves, PORTUGAL
Elise van Oppenraaij, THE NETHERLANDS
Angelo Del Vicario, ITALY
Edmund Ng, UNITED KINGDOM

The HOPE Exchange team in Poland began the presentation by providing a snapshot of the country's healthcare system, followed by the three good practices they identified during their stay.

The first good practice identified concerns cancer patients undergoing treatment at the Copernicus Hospital in Gdansk where its Centrum Onkologii provides diagnostics and oncological treatment using what they call the 'DiLO model' (short for Diagnostyki i Leczenia Onkologicznego – Oncological Diagnosis and Treatment).

The Centrum Onkologii provides conventional and surgical cancer treatments, supportive care, including rehabilitation and psychology services, outpatient clinics, as well as prevention programmes, including colonoscopy and mammography. Patients undergoing treatment are assigned medical case managers and are placed on a fast-track cancer pathway. One element of this pathway involves the 'DiLO' card, which replaces all other medical referral processes and places oncology patients on a special lane in the public health system for follow-up scans and other necessary testing.

Furthermore, patients receive prehabilitation support such as nutrition and movement guides to strengthen them before their surgeries. The Centrum Onkologii has three dedicated DiLO coordinators, employed specifically to support patients throughout their cancer treatment, from diagnosis to remission. The DiLO Coordinators are the administrative and logistical bridge between healthcare providers and their patients. They also serve as patient advocates, explaining treatment plans, arranging psychological support, and helping to navigate administrative documentation.

The second good practice identified by the exchange team in Poland concerns cardiac healthcare, which in the cardiac pre-habilitation programmes in Krakow begins weeks before treatment and/or surgery. At the John Paul II Specialist Hospital, a team is assembled to provide physiotherapy, psychological support, and nutritional recommendations. This team

works together cardio surgeons and cardiologists to strengthen patients and ease anxieties, both of which are very common and can affect health outcomes.

Results provided by the John Paul II Specialist Hospital indicate that the pre-habilitation programme has shown a measurable improvement in patient safety and outcomes, particularly comparative reductions in the incidences of postoperative pneumonia, surgical site infection, and in-hospital death.

In terms of rehabilitation following cardiac treatment and/or surgery, the Wojewodzki Rehabilitation Hospital in Zakopane (near Krakow) provides a heart-centred healing facility in the mountains.

The third and final good practice identified by the Poland team relates to pediatric oncology at the University Hospital of Wroclaw. The hospital provides comprehensive clinical services, including major trauma, transplant, ECMO, haematology, oncology, and more. It is also an important teaching and research centre.

In 2015, the Cape of Hope building opened for paediatric haematology and oncology patients. This centre houses Poland's largest paediatric oncology unit, and the third largest bone marrow transplant centre in Europe. The paediatric oncology unit also has what they call the 'Snoezelen Room', a multisensory environment catered to young patients undergoing long-term care to help ease anxiety and stress associated with testing and treatment.

# MALTA

**National Coordinator:** Michelle Galea
**Exchange participants 2026:** Deirdre Mulligan, IRELAND
Paola Sorrentino, ITALY


The HOPE Exchange duo in Malta kicked off their presentation by providing an overview of the country's healthcare system and contextualizing their experience with a brief comparative table of their own countries' systems and demographic compositions. For instance, overlapping priorities include focusing on patient safety and patient experience and developing ways to monitor and evaluate these. Some of the challenges all three countries share (Malta, Ireland, and Italy) include increasing demand for healthcare and nurse shortages.

However, the team also observed some marked differences, including strong governance structures at all levels in Italy and Malta, differences in practices related to primary healthcare provision, etc.

It is within this context that the participants identified three best practices in different settings, starting the SAMOC, the fast-track unit at the Sir Anthony Mamo Oncology Centre (inpatient and outpatient services). The SAMOC fast-track system is a specialized urgent referral pathway, which allows GPs to digitally submit electronic cancer referrals. Urgent, suspected cancer symptoms get a priority referral to the hospital to expedite diagnoses. Unlike screening programmes, which are preventive and target asymptomatic cases, this service addresses a gap in the diagnostic pathway: symptomatic cases that need to be addressed as a matter of priority.

The electronic referral system focuses on the following symptomatic cancer cases: colon, lung, breast, prostate, upper GI, head and neck, skin, gynaecological, and haematological. The Fast-Track Unit comprises dedicated doctors and nurses who organize the referrals and treatment pathways for each patient. If cancer is diagnosed, patients are placed in the care of multidisciplinary teams at Mater Dei Hospital. If the results are negative, patients are referred to primary care.

The second good practice identified involves the Medical Devices Incident reporting at Mater Dei Hospital. The process is digitized so that doctors, nurses, and other healthcare professionals can report critical issues with medical devices. The Advisory Committee on Vigilance follows up on the reports to review, categorize, and analyse these to reduce the use of unsafe devices.

The third and final good practice identified by the HOPE Exchange participants in Malta involves the government-run Primary Health Centres. There are 10 Primary Health Centres (PHCs) (plus their satellites – approximately two per centre) across Malta. They offer community support, telemedicine 24/7, screening services, and occupational health support. Approximately 1 million residents visit these PHCs per year.

The PHCs are staffed with GPs, nurses, pharmacists, social workers, and physiotherapists, among others. Furthermore, the centres' clinics offer antenatal and postnatal support, as well as paediatric, diabetic, and orthopaedic care. In terms of prevention, the centres undertake national colon, breast, cervical, prostrate, and AAA screenings.

To help address some of the Maltese system's patient safety risks associated with overburdened emergency departments, health authorities are piloting a triage system set in the Primary Health Centres. The South African Triage Scale (SATS) has been adapted to the Malta and is divided into three main pillars:

1. The Triage Early Warning Score: A way to quickly assess and calculate risk by measuring vital signs (heart rate, systolic blood pressure, respiratory rate, temperature, level of consciousness, and mobility).
2. The Discriminators List: A list of specific symptoms or trauma mechanists (e.g., chest pain, burns, hypoglycaemia, etc.). If a patient presents with a 'discriminator', their priority code is automatically upgraded, regardless of their vital signs score.
3. The Senior Clinical 'Filter': The system calls on experienced healthcare professionals to assess a patient and to help determine their state if they appear to be more critical than the previous calculations suggest.

Priority-of-care is then set to a color-coded system: red (requires immediate emergency care), orange (requires urgent care), yellow (semi-urgent), green (non-urgent). This pilot study aims to identify high-risk patients requiring immediate care and determine which cases can be diverted to non-urgent care, thereby reducing waiting times and the burden on emergency departments.

# AUSTRIA

**National Coordinator:** Klemens Pokorny

**Exchange participants 2026:** Christina Michno, DENMARK
Marta Krysiak, POLAND
Grzegorz Witkowksi, POLAND
Anniina Ahola, FINLAND
Pasquale D. Mirizzi, ITALY
Scott Vandepeear, UNITED KINGDOM
Dumitru Cernobrov, MOLDOVA
Ilze Renemane, LATVIA
Dominique Oudhuis, THE NETHERLANDS


Styled after Eurovision ('EuroHOPEvision'), the HOPE Exchange team in Austria presented the good practices they identified by awarding points and engaging everyone in the auditorium to clap for the top practice.

The Austrian Healthcare system is currently guided by providing hospital-centred care, high access, and patient satisfaction. Recent reforms aim to integrate digital tools and strategies in a meaningful way, under the motto "Digital before Outpatient before Inpatient."

The first good practice the team shared involved patient experience apps. Many hospitals are developing apps to manage care planning, appointments, and patient information. The innovation lies not in the tech, but in the content of these apps. However, one of the reasons this good practice is not yet a 'winning' practice is because these apps are all created in isolation.

The second good practice focused on projects that are trying to shift organizational cultures. These include those that provide psychological safety, enabling staff to confidently raise concerns and challenge risky behaviour or decisions; peer support and buddy schemes to help staff recover after critical incidents (second victim); and speak-up initiatives that encourage proactive reporting of concerns and risks to patient safety. These projects are working because they are no longer peripheral, they are endorsed by hospital leadership, and they represent a renewed push to decrease staff burnout, which is a risk to patients and other staff.

Before proceeding to the audience voting (clapping), the third and last good practice concerned simulation centres. These centers in Graz simulate more or less 50 scenarios and safe environments for patients and clinicians to test technologies. For instance, simulated geriatric rooms include family members and/or other caretakers to improve spatial understanding of the obstacles to and support of patient mobility. The judges 'aka the HOPE exchange team in

Austria' deemed this third example to be the most complete practice and therefore the winner of the EuroHOPEvision competition.

# LATVIA

**National Coordinator:** Ieva Lejniece
**Exchange participants 2026:** Laura Ringel, AUSTRIA
María Jesús Caballero, SPAIN
Susan Arminen, FINLAND
Jean-Louis Pepin, BELGIUM

The HOPE Exchange team in Latvia provided a snapshot of Latvia, a small country of 1.8 million people. The life expectancy is 76.7 years, which is five years below the European average. Health spending represents about 11% of its GDP (against 12% defence).

Despite being a small country with the challenges this entails (low density areas, etc.), Latvia's public health policy has adapted patient safety and patient experience solutions to its context. The first good practice the exchange team shared relates to the patient experience. The new Children's Hospital in Riga has been tailored to children, to help distract them and to make space for diverse activities, which are sometimes personalized depending on whether a child is in long-term care or in outpatient care. For instance, the hospital designed a music room for young neurological patients.

The second good practice identified also relates to the patient experience: digital tools in waiting areas. These digital tools not only keep patients and their carers informed about waiting times but also provide pre- and post-care digital checklists to ensure patients fast when they need to or alleviate any uncomfortable side effects following tests and treatments. Patients and carers can also report digitally on their experiences and/or the outcomes (PREMs and PROMs).

Finally, in terms of patient safety, the team in Latvia identified other digital tools that help forecast staff needs in low density areas where the need for nurses may become acute. Furthermore, in the ICU, surgeons and anaesthesiologists have a tool to quickly calculate dosage based on weight and other important input. The dosage prescriptions are then printed and placed next to the patient in case prompt action is needed. These digital tools help diminish risks by making staff available and reducing medication administration errors.

# BELGIUM

**National Coordinator:** Emmanuelle Ceysens

**Exchange participants 2026:** Indira Holub, AUSTRIA
Domitille Leclerc-Lajoinie, FRANCE
Amelie Schweiger, GERMANY
Sabrina Tavares, PORTUGAL


The HOPE Exchange team in Belgium spent time in hospitals in Mons, Verviers, and Liège. The first good practice the team identified has been developed in response to strains on hospitals, and it is becoming increasingly common across Belgium: self-service kiosks. These kiosks are located at different hospital entryways. Patients use their national identity cards to print their pre-admission labels, which register the patients in the system for the day and print labels describing the routes to the department where they have their appointment(s).

Once in the department, the patient then scans the barcode on the label, alerting the physicians and other medical staff that they have arrived. If a patient does not have a national identity card, are not comfortable with the digital pre-admission procedure, or have an issue with their appointment, they still have the option of doing the process in person. This mixed system helps ease the burden on staff and provides a safe and reliable alternative many patients are comfortable with.

The second good practice the HOPE team in Belgium identified involves pre-operative care. Patient safety in perioperative care starts before a patient is admitted, and the pre-operative passport system at Citadelle helps patients and their surgical teams to navigate pre-surgical care. To receive a 'passport', a patient must complete a health questionnaire, inform healthcare staff of any medications they are receiving, and undergo a pain and anxiety assessment. They will also complete an inform consent statement for surgery and anaesthesia, giving them an additional opportunity to ask questions and raise concerns.

Nursing staff will likewise review a checklist of all pre-operative steps and prepare any information that may be needed to administer anaesthesia. The anaesthesiologist will be able to decide on the type of anaesthesia needed based on all the information compiled in the pre-operative passport system and may request additional tests if needed.

The third and final good practice relates to the patient experience. Special needs patients, identified in advance during pre-admissions, can count on a dedicated service that will

accompany and support them throughout their visit or stay in hospital. Some examples include separate quiet rooms for patients with autism, pick-up services for patients with physical disabilities, and tablets for patients with hearing impairment.

# SPAIN

**National Coordinator:** Ana de la Cruz

**Exchange participants 2026:**

Mirella Selimovic, AUSTRIA
Echezona Anthony Anakor, UNITED KINGDOM
Lino Barros, PORTUGAL
Kirsten von Feldmann, GERMANY
Elena Sciurpa, ITALY
Lisa Hughes, UNITED KINGDOM
Martina Dalla Bona, ITALY
Signe Meldere, LATVIA
Annika Leitis, SWEDEN
Alessandro Benvegnú, ITALY
Odete Marisa dos Santos, PORTUGAL
Joseph O'Connor, IRELAND


The HOPE Exchange participants in Spain were split into teams of two and visited hospitals across different cities and regions in Spain, including in Madrid, Santander, Palma, Málaga, Barcelona, and Sevilla.

The presentation started with a summary of the newly unveiled national Patient Safety Strategy 2025-2035 launched by the Spanish Ministry of Health. This is the fourth iteration of such strategies, and it focuses on seven overarching elements covering 17 autonomous communities:

- Safety Culture, Human Factors, and Training
- Safe Clinical Practices
- Risk Management and Incident Reporting
- Patient, Family, and Citizen Participation
- Research and Innovation
- International and National Participation
- Patient Safety in All Care Settings

The Patient Safety Strategy informs policies across the country. The exchange team identified good practices at a more granular level, in specific hospitals and regions. The first example of good practice they identified involves 3D Printing in Mallorca. This technology is used for education, surgical case preparation, and to tailor implants and equipment. Data from X-rays, CT, and MRI feed the process. It takes about 4-5 hours to prepare each element.

The second example of good practice involves wearables. Many patients and carers experience anxiety and are sometimes confined to certain spaces, forcing them to sacrifice mobility in favour of safety. Wearables help respond to complex patient pathways and support patient

mobility without sacrificing safety as these can promptly alert the right people when there is risk of disorientation or falls occur. For families and carers, some hospitals in Spain provide geolocation support and a virtual waiting room. They are informed in real-time of at patients' care pathway and receive automatic and manual updates. This allows families and carers who await news from their loved ones undergoing treatment or surgery to take walks, eat, and take breaks without missing any information. In addition, they can return promptly if something comes up.

Finally, the third example of good practice is increasingly being rolled out across Europe: hospital services at home. The Spanish Society of Home Hospitalization (SEHAD) is a multidisciplinary network of healthcare professionals dedicated to providing and expanding home hospitalization. There are several elements of the perioperative pathway that can be done at home before admissions and after discharge: tests, treatments, and respiratory therapies, as well as administrative procedures such as social assessments, caregiver training sessions, and information provision, among other things.

Not only have patients have expressed high rates of satisfaction of hospital-at-home alternatives in Cantabria, but SEHAD has found that home hospitalization is a cost-effective way to reduce incidence of hospital-acquired bacterial infections, delirium, depression, etc.

# UNITED KINGDOM

**National Coordinator:** Ian Buczynski

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Stephanie Mifsud, Malta
Theodora Kampouroglou, GREECE
Viktors Linovs, LATVIA


The HOPE Exchange participants in the United Kingdom visited hospitals in England in pairs, specifically in Birmingham, Newcastle upon Tyne, Northumbria, Manchester, Nottingham, and Harlow. They shortlisted three examples in Birmingham, Northumbria, and a country-wide patient safety mechanism introduced in 2024.

The first example of good practice the team in the UK presented relates to patient experience at the Birmingham Children's Hospital. To provide some level of normalcy for children, the hospital has created 'The Escape' a movie theatre tailored to meet young patients' needs. It is a place to be safe and be children, a vital mental health break from illness. Hospitalized kids can watch films with their families, friends, and classmates. Moreover, the space is designed so that bedridden patients can be wheeled in, and trained healthcare staff are present throughout the entire movie to ensure safety.

The second example presented also relates to patient experience. Across England and surely in many other countries, food is often ranked lowest by patients. In Northumbria, one of the main hospitals has improved how food is served and what food is served. Patients receive menus and can choose up to 11 dishes, considering dietary requirements, from allergies to religious prescriptions. Each meal is served in color-coded plates to signal need for assistance, portion restrictions, etc. For instance, food for children and the elder will be served in smaller dishes but will contain high volumes of protein and vitamins.

The third and final example of good practice has gained importance in recent years. A recent patient safety mechanism named 'Martha's rule' requires hospital staff to seek a second opinion if family members and/or carers request it. This rule is named after Martha Mills who died in 2021 at the age of 13. Her parents expressed concerns over her rapid deterioration while in hospital and were repeatedly ignored by hospital staff. Knowing Martha well, they felt

something was not right. A follow up investigation determined that she would have probably survived had she been transferred to the ICU sooner. Her parents campaigned to persuade ministers and healthcare authorities to institute the right to request a review of a patient by a different treatment team. Not only does Martha's Rule promote a cultural shift and early intervention, but since it was rolled out across all acute hospitals in England, hundreds of lives have been saved.

# SWEDEN

**National Coordinator** Erik Svanfeldt
**Exchange participants 2026:** Gary Timmons, IRELAND
Maria Schembri, MALTA


The HOPE Exchange pair in Sweden began their presentation by profiling the Swedish health system, which is publicly funded through taxes, giving all residents access and maintaining low fees. Responsibility is split between 21 regions and municipalities. Each region oversees hospitals and overall primary care delivery, while municipalities are in charge of only a limited number of primary care services.

The good practices the exchange team selected exemplify values such as emphasis on community, patient involvement, and patient experience, among others. The concept of 'Care Close to the Patient' captures the Swedish healthcare goal of designing facilities and policies to increase accessibility, enhanced patient participation, and improved integration across all levels of care. This concept feeds into initiatives such as 'Hospital at Home', Mental Health Ambulance, and 1177 (remote triage guidance).

In Region Skåne, the 'Hospital at Home' system is well developed. The principle is that "no patient should be hospitalized if equivalent care can be provided in their home." This can include acute care where possible. The system is based on doctor referral (primary care, emergency department, and/or inpatient unit), suitability of care at home, and patient acceptance of treatment in their home environment. If admission is required at any stage, the patient will bypass the emergency department, which helps alleviate the strain on such services.

The second example, the Mental Health Ambulance, provides acute mental health crisis support from 15h00 to 01h00 every day. Three fully equipped ambulances are staffed with mental health and emergency nurse responders who provide de-escalation techniques and administer medication to alleviate acute distress in situ. Approximately 50% of patients do not require hospitalization.

The third example provides 24/7 telephone advice and multilingual web portal services to make primary care appointments, access medical records, and file reports to the Patient advisory Committee. This committee guides patients through complaints or requests processes, follows up with healthcare providers, publishes themed reports, and provides info sessions with members of the community. They serve as a link between patients, their families, and healthcare providers.

Finally, the fourth example involves the Flexible Assertive Community Treatment (FACT) for children and adolescent mental health. FACT teams provide mental care for children and adolescents with complex psychiatric issues. This approach (1) targets high-risk populations to reduce risky behaviour, (2) provides care when and where a patient needs it, (3) emphasizes community involvement, and (4) provides a structured approach that is recovery oriented. FACT teams exist beyond Sweden, however, they are looking to expand to settings where youth have already faced criminal charges or as an alternative to juvenile detention.

# GERMANY

**National Coordinator:** Doris Voit

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Gabriele Schumnik, AUSTRIA


The HOPE Exchange team in Germany were split into smaller groups to visit various hospitals in Germany. Following their 4-week stay they came back together to shortlist three good practices. The first example came from St Elisabeth Gruppe – Katholische Kliniken Rhein Ruhr, where they conducted the SAFEST self-evaluation to confirm the impact their institutional surgical safety list has had on patient safety. This improvement in surgical safety is largely due to the introduction of a tailored surgical safety checklist using the WHO version as a baseline.

Various steps have been added to reflect the importance of what happens before and after surgery. Whereas the WHO checklist focuses on the surgical phase only, St. Elisabeth Gruppe's (first developed at the Katholische Kliniken Rhein Ruhr) checklist covers the process before the patient is brought into the operating room, the transfer into the OR, and the sign-out process as the patient enters recuperation. Such steps help reduce errors and minimize risks to patients in an environment with high turnover where language barriers, patient identification, communication failures, and incomplete patient documentation can occur.

The hospital's Quality and Management Department found in 2023 high acceptance and adherence. Since then, the checklist has been introduced across all St. Elisabeth Gruppe hospitals, covering multiple surgical specialties, including cardiothoracic surgery and endoscopic procedures.

The next example comes from Westküstenklinike – Heide and Brunsbüttel, a large hospital that introduced interactive training exercises based on real-world scenarios (based on a Swiss model). The Escape Game forms multidisciplinary teams of four comprising diverse backgrounds, including quality management officers, physicians, nurses, technicians, etc. They undergo a briefing and then start the simulation. Their task is to look for mistakes in the room or scenario (e.g., dosage mistakes, expired medication, risky and preventable elements in the

environments, etc.). Each task is followed by a debriefing session to understand *why* such errors happen and *what* measures can be taken to prevent them.

Follow-up questionnaires have revealed that the 'Escape Room' promotes safety awareness among healthcare professionals and that acceptance is high.

The third and final example was observed at Pfalzklinikum – Klingenmünster, a specialized mental health hospital. It involves the Flexible Assertive Community Treatment (FACT), an international and national approach to mental health care. FACT serves as a way to facilitate a mix of in-patient and out-patient care. The process is multi-stepped: pre-admission is followed up by a specialist consultation, determining which care pathway the patient will continue. Another pathway leads directly to a clearing centre where patients stay approximately 5 working days. Afterwards they are seen by specialists in an acute hospital, in an outpatient clinic, in a closed ward, in an open ward, or they receive home treatment (FACT).

The innovation is the mixed approach for geriatric patients. Those who qualify for a mix of inpatient/outpatient care, are hospitalized in moments of acute crisis when home care cannot be delivered safely. Another feature of the mixed approach is resource flexibility; some staff can visit patients at home. The evaluation of the first cohort of older adults is ongoing and will be published sometime this year.

The HOPE team in Germany closed their presentation with the following take-home messages:

- Checklists are an example of how small changes can improve patient safety, teamwork, and communication;
- Training in identifying errors in a simulated environment can encourage patient safety awareness among healthcare teams;
- If we adapt our systems, we can improve patient experience.

# FRANCE

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Helen Brock, UNITED KINGDOM


The HOPE Exchange team in France started off their presentation by providing context, specifically a recent history of patient involvement in the French healthcare system. On 4 March 2002, Kouchner's Law came into force, which protects patients' rights. It helped establish patient representative groups, and mandatory training among other things. France also has an accreditation system (*Haute Autorité de Santé*) that requires patient input, and other patient-centred approaches, as well as periodic national satisfaction surveys.

The good practices identified include national, regional, and organizational approaches and measures. At the national level, France uses the *e-Satis* system to collect Patient-Reported Experience Measures (PREMs) information. The online platform allows all hospitals to access detailed results in real-time. The questionnaires are validated by the French National Authority of Health and then results are made available to all users in the healthcare system. PREMs data feed into broader performance and improvement reports, which are used to determine financial allocation and incentivize competition based on patient safety records.

The next good practice refers to the specific implementation approach to collecting PREMs and Patient-Reported Outcome Measures (PROMs) data in Nancy and Blois Hospitals. Their regional approach feeds into therapeutic education programs and feeds into programmes that support patients in the self-management of long-term conditions. These hospitals have also incorporated PREMs for hospitalized paediatric patients and adult psychiatric outpatients. Results are used to improve quality in nurse-patient communication and care.

In Nancy, the general hospital has developed a virtual hospital simulation centre to reinforce patient safety procedures. The centre offers high-fidelity simulations of common situations for students and experienced clinicians. In live simulation scenarios, actors are brought in to

practice difficult conversations and interactions (e.g., psychiatric emergencies). The teams that participate in the simulations are multidisciplinary and patients actively shape the different training scenarios.

Blois Hospital has introduced common management of patient falls after observing different healthcare professionals were handling falls very differently; to the detriment of patient safety. Training to harmonize the care and management of patient falls targets health units, physiotherapists, nurses, and physical activity instructors. Additionally, healthcare professionals can consult a flow-chart to assess patients, report, control, and provide secondary prevention where needed.

Finally, at AP-HP Nord – Université Paris Cité, HOPE exchange participants selected the *Maisons des patients* in Beaujon and Bichat Hospitals as the last example of good practice. These *maisons* are physical spaces for patients with chronic conditions and multi-morbidities. They have been created in collaboration with patients and patients' representatives. Activities include the *Ateliers Thérapeutiques* where patients receive practical support in managing diseases. Another example is the 'patient identity vigilance' which ensures the correct identification of patients using bracelets with unique codes assigned to each person. Patients can also form part of the greater care community by participating in sports activities, among others.

Participants concluded that French healthcare providers strengthen patient safety and the patient experience by empowering hospitals to innovate and develop tailored approaches to improve safety at local levels and providing a strong national framework that incentivizes safety.

# GREECE

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Tina Grøn Henriksen, Denmark


The HOPE Exchange team in Greece contextualized their presentation by explaining how Greek public health authorities have worked systematically to improve overall quality in healthcare, but also specifically patient safety and patient experiences via collaboration between hospitals, the national Ministry of Health, the WHO, EU, and national quality organizations.

The Greek team categorized the good practices they identified according to three thematic areas. First, Digital Care, Human Impact. This example is not necessarily high-tech; however, it does exemplify how digital technologies can be integrated meaningfully into certain parts of a patient care paths. In this case, patients receive an SMS for their Biopsy Results, as well as an invitation to participate in an online patient experience survey. This helps reduce some of the anxiety associated with the wait for results of such nature. It also shows the importance of collaboration between clinical and non-clinical staff; in this case, the IT department.

The next example falls under the theme of Patient Protection and Infection Control. This practice was observed in Crete, where hospitals have introduced a tool to record and monitor antibiotic-resistant infections. The tool allows clinicians to across eight public hospitals to alert others of the presence of drug-resistant infections, an early detection system that helps save lives by taking preventive measures. Everyday, hospital staff receive information about new and active infections (considered so during 6 months of detection. This, coupled with basic practices, such as the widespread adoption of WHO's '5 Moments of Hand Hygiene' help prevent and/or mitigate serious outbreaks.

Finally, under the heading of Governance and Safety, the HOPE Exchange team in Greece ended their presentation with a policy-related good practice. The country has made a significant effort to align its quality of care and patient safety measures with WHO recommendations. In this context, Greek health authorities developed a nationwide strategy (2025-2030) to address fragmentation. The strategy was developed in collaboration with WHO/Europe, the European Union, and broader stakeholder involvement.

The strategy includes various goals, such as implementing correct patient identification, strengthen communication, ensure medication safety and safe surgery, prevent infections

and falls, etc. The overall strategy also informs projects like the Health IQ Project to build capacity for quality improvement, which trains healthcare professionals, builds clinical governance frameworks, and encourages the collection of PREMs.

The Greek team concluded that patient safety and patient experience are closely linked. When patients feel safe, heard, and well cared for, the quality of treatment and the healthcare system improve.

# FINLAND

**National Coordinator:** Tarja Tenkula

**Exchange participants 2026:** Ilona Rāvete, LATVIA
Anita van Lohuizen, THE NETHERLANDS
Luis Castro, SPAIN
Lars Eldgård Pedersen, DENMARK
Stephen Lambert, UNITED KINGDOM


The HOPE Exchange team in Finland focused first on the main challenges the Finnish healthcare sector faces, namely, an aging population, staff shortages, long waiting time, financial deficit, regional inequalities, and long distances. In response to these challenges, as well as other needs, Finland rolled out a major Health reform recently. Today, the country is split into 23 wellbeing services counties and there are five major university hospitals that coordinated regional activities.

This reform adds to Finland's strengths, including in patient safety and patient experience. For instance, the country has good health infrastructure and very practical implementation of plans, it is in known for its advanced use of digital health systems, including the national patient database. Furthermore, there is a strong focus on evidence-based care, as well as registries that contain data for quality improvement and research.

In this context, the first good practice the exchange team identified relates to learning and competencies. Finland has long been known for taking great pride in education and it is not an exception in the healthcare sector, where students, physicians, and other healthcare professionals take part in simulation-based training and education. These simulations are not only meant for early-career professionals, but also for experienced clinicians who want to learn something new or practice new techniques or methods.

The next example relates to digital health in Pohde, a vast county towards the north of Finland with small populations. There are wellbeing structures that provide in-person care; however, many residents rely (approx. 79%) heavily on digital guidance and triage support. Patients can talk to professionals, schedule video appointments and in-person appointments via this platform. The service is advanced enough to provide complex triage support where possible.

The third and final example relates to Finland's national client and patient safety strategy. This policy established the Finnish Centre for Client and Patient Safety, which publishes tools to improve communication and patient safety, hosts webinars on the principle of 'No Harm',

delivers in-person seminars, and implements the ‘Second Victim’ programme. This strategy works in tandem with existing mechanisms such as the Finnish Patient Insurance Centre, whose objectives are to create a system that makes it easy for patients to seek compensation independently from the treating organization, and to avoid lawsuits related to healthcare injury. It is meant to safeguard both patients and healthcare professionals, and it is not a punitive organization.

# ESTONIA

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Irene Giacchetta, ITALY


The HOPE Exchange participants in Estonia kicked off their presentation by providing a snapshot of the country's healthcare landscape. It is funded primarily through a mandatory payroll tax. Family doctors are function as gatekeepers for specialist referrals to ease the burden on hospitals. The team underscored how digital health if the nodal point of the system, which falls in line with Estonia's push towards digitizing various services in recent years.

The three good practices reflect Estonia's uniqueness as a small country in a vulnerable area. The first example the exchange team identified involves patient safety in crisis management. Due to man-made climate change and increasing tensions between Russia and the EU, Estonian authorities have assessed that the threats of disasters and conflict have heightened significantly over the past few years. Thus, hospitals are holding joint exercises with the military regularly. In addition, Estonia has built new infrastructure with conflict/crisis scenarios in mind, as well as instituted alert and management systems. For instance, an ambulance garage they visited can be repurposed into a ward, there is now a nuclear lockdown system in place, and in general, there is a renewed culture of preparedness.

The second good practice identified involves patient safety regulation. Public Health authorities have established the POHAK system (a national patient safety reporting system). As part of the regulations linked to the system, the law prevents prosecuting whistleblowers as well as medical staff who made mistakes. The underlying idea is to encourage openness and improvement by removing overly punitive mechanisms. Furthermore, medical staff increasingly have access to psychological support as 'second victims'.

Finally, in terms of patient experience, the exchange team in Estonia picked the Haapsalu Neurological Rehabilitation Centre, which provides inpatient and outpatient rehabilitation for a whole range of neurological conditions and trauma. Staff help patients identify goals and support self-management to improve outcomes and empower people.

# SWITZERLAND

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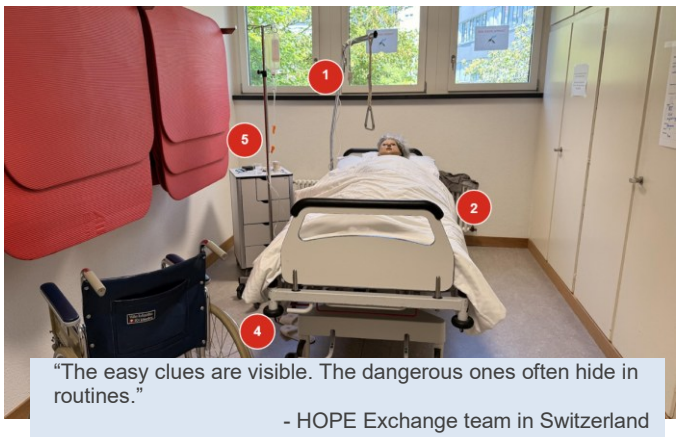
The HOPE Exchange team in Switzerland gamified their presentation by making it an investigation starring some famous fictional detectives: (Nicola) Poirot, Sherlock (Rehkli), and Inspector (Maria). Each example of good practice was presented as a case, and the audience was invited to follow them through a journey of clues.

The first example involves making rounds safer by observing, listening, acting, and closing the loop. Most exacerbations are caught through observation, listening to feedback, and being closer to the patients. Safety rounds help achieve this. They are also followed up by brief conversations at the bedside, in corridors, and during transitions in care. Questions are not punitive, singling out staff mistakes, but rather constructive, trying to identify what environmental, timing, and other factors contributed to safety challenges that day. Debriefings become learning and improvement vehicles.

The next 'case' was given the title of the 'Room of Horrors'. This good practice involves simulations; scenes filled with mistakes that put patients and staff at risk. Medical professionals are put in a room where they must identify what things are wrong, not up to standard, or risky. Each simulation is followed up by a debriefing session.

The third and final example creates partnerships with patients. Patients and their families notice subtle signals that clinicians don't, simply because they know their kin and themselves best. They understand delays, experience uncertainty, and see changing symptoms that need to be communicated promptly. A culture where patients and their families are kept informed, involved, and empowered, facilitates such communication by providing various opportunities to reach out to medical staff – digitally, in-person, via white boards, etc.




"The easy clues are visible. The dangerous ones often hide in routines."
- HOPE Exchange team in Switzerland

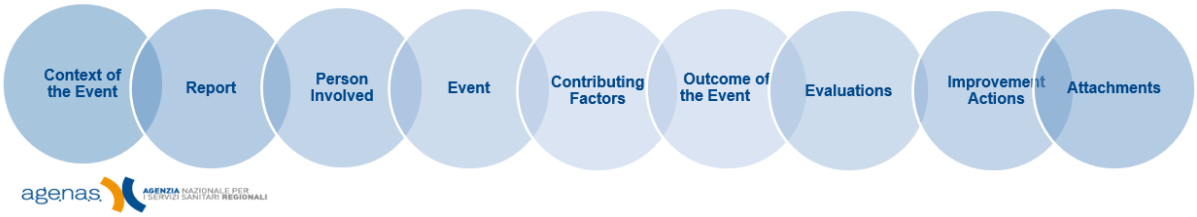
Each of these cases shows that in Switzerland safety is written into organizational policies but also practiced day-to-day.

# ITALY

| | | |
|---|---|---|
| **National Coordinator:** | Marco Di Marco | |
| **Exchange participants 2026:** | Alexandra Lioka, GERECE<br>Marjo Sinijärv, ESTONIA<br>Claudine Muscat, MALTA<br>Anna Kjellbom, SWEDEN<br>Anna Bielinskà, POLAND<br>Viktoria Gerharz, GERMANY | Olga Rubio, SPAIN<br>Ģirts Aleksejevs, LATVIA<br>Begoña Ibañez, SPAIN<br>Katja Linnavuori, FINLAND<br>Elisa Bucho, PORTUGAL |


The HOPE Exchange team in Italy selected one good practices under the heading of patient safety and two under the heading of patient experience. The first example showcases AGENAS hospitals' incident reporting system. This system categorizes events under the following levels of severity: (1) near-miss, (2) event without harm, (3) adverse event, and (4) sentinel event – a serious event requiring immediate emergency response.

Once the seriousness of the event has been determined, it is placed on a reporting pathway, providing context, contributing factors, and ending with recommendations for improvements and follow-up actions (below full reporting pathway).




The next step is to determine the incident reporting chain, from the people responsible for reporting the event to the people in charge of following up on it. This involves agents such as the operator who drafts the report, the manager who completes the report and validates it, the company contact points who take charge of the pathway, and the regional contact point who follow-up on the report; at this point, all sensitive data is withheld. These pathway reports feed into simulations for training purposes but also supports accountability in healthcare provision.

The second example of good practice relates to both safety and experience. The 'Casa della Comunità' aims to the fragmentation of care for patients with chronic diseases and/or complex clinical conditions. It is designed to provide 24/7 nursing care and on call medical

personnel in hub facilities. Not only does this act as a safety mechanism, but if comforts patients and their families to know that out-of-hours immediate care is available without relying on ER visits, which are stressful and where staff may be less familiar with the patients' medical histories. The hubs also provide comforts that reduce the clinical aspects of medical facilities, e.g., green areas, soft acoustics, etc.

The hubs integrate health and social care and provide spaces for patients and their families. They help reduce the burden on Emergency Rooms and help build bridges to safe discharge. Each patient is community nurses who continue to support them in their homes with a mix of telemedicine and in-person visits.

The third and final good practice is very important and often overlooked in other care settings: how patients experience care after being victims of domestic violence. 'Codice Rosa' is a protocol that originated in Tuscany and is now being implemented across Italy. Understanding the re-traumatizing effects of having to tell domestic and sexual abuse stories repeatedly, victims only tell their story once. Medical staff trigger to 'Codice Rosa' to "eliminate or reduce waiting times, provide private rooms for assessment and confidential support, and activate a taskforce that connects hospital services, anti-violence centres, social services, and law enforcement to ensure the victim's safety after discharge."

# MOLDOVA

**National Coordinator:** Olga Schiopu
**Exchange participants 2026:** Vincent Ory, FRANCE
Phil Brough, UNITED KINGDOM

The HOPE Exchange team of two in Moldova began their presentation by providing demographic and contextual information, which affect healthcare delivery, for instance, population density and distribution. All citizens have access to essential services through the mandatory insurance system; however, 10-15% of the population remain uninsured. Moldova's process of accession to the EU is driving ambitious reforms, including in the healthcare sector where a 1.9 billion Euro overhaul is underway. Two of the main challenges the country's healthcare system faces involve health workforce migration and healthcare deserts in rural areas.

In this context, and despite such challenges, Moldovan hospitals are continuously working towards quality and safety improvement. The case studies reflect this. First, in terms of sharing data, Chisinau's MedPark International Hospital gathers quality indicators and patient feedback in real-time via an automated system. They then share their indicators for local appraisal.

In terms of linking services and education, the Stroke Network coordinates between primary care, hospitals, and the National Emergency Center to reduce variation in timely access to care. This network aims to reduce delays in urban and rural areas, understanding that in stroke care, time is essential. Reductions have been achieved partly by training dispatchers to manage triage during emergency calls.

Under the same heading, Moldova's National University Simulation Centre provides high-quality practice for students across the country. Students work together and adopt various roles from attending physicians to patients. There are currently 92 simulation training courses, and at least 7,000 students and staff take part in them annually.

Finally, in terms of patient experience, Moldova's approach is simple and transparent. In all hospitals (public and private) patients and their families can see clear displays of 'Patients' Rights'. Human interaction is still key as well. Some things are digitized, such as displays with waiting times and patient feedback is collected via multiple channels, including social media. However, reception areas are staffed too, and patients can read and ask questions concerning the triage system.

The exchange team in Moldova summarized their key takeaways in five points (written and synthesised by Phil Brough and Vincent Ory):

1. **One team culture drives delivery -** strong collaboration across organisations, with a shared focus on patient care over institutional silos.
2. **Visible leadership supports staff wellbeing -** senior leaders stayed close to front-line teams, fostering staff wellbeing, and shared ownership
3. **Investment in people drives improvement –** a strong culture of training, development, and mentorship, alongside use of national and international standards, supported quality improvement
4. **Simplicity enables pace -** less complex governance often allowed quicker decisions and faster implementation.
5. **Don't digitise chaos -** digital transformation should support well-designed pathways and improve care, not replicate inefficiency.

# THE NETHERLANDS

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The Exchange team in The Netherlands delved directly into the good practices they selected. Hospitals and healthcare providers in the country, which has shortest hospitals stays in Europe, averaging 4.5 days, work to provide good care close to home. Short stays matter because they lower the risk of infections and other complications and improve the patient experience. In this context, the first example showcases the patient's care journey the healthcare system strives for. During a patient's hospital stay, clinical staff follow safety protocols before and after treatments. They encourage early mobilization as well as avoiding unnecessary invasive interventions.

Once a patient is discharged under supervision, they have access to the 'virtual war', which helps the patient and their families monitor their vitals remotely by giving them user-friendly tools and providing questionnaires to assess their progress. Patients can also reach out to hospital teams and can be supported further by home-visits. A patient is only discharged once they have fully recovered.

The second example relates to medication safety and provision. Prescribing is now fully digitized, this makes prescriptions portable using the national identity cards, but more importantly, it standardizes the process to minimize dosage and transcription errors. The prescriptions also carry barcode verification alerts, especially for high-risk medications. Clinical pharmacists support medicines provision by reviewing patient-reported side effects, therapies, among other issues.

The third and final example also integrates technology. Part of ensuring patient safety involves learning and development. Dutch hospitals are using 3D-printed anatomical parts for surgeons to practices before tricky surgeries or clinicians undertaking other difficult interventions. Hospitals have also set up simulation training rooms containing with subtle errors in acute care settings.

The Netherlands team's key takeaways include very recognizable elements, from centering the patient to encouraging care at home through collaboration between the different stages of care provision.

# DENMARK

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Katharina Mayer, AUSTRIA
Manuel Cabra Fernández, SPAIN
Mauro Gallitelli, ITALY
Rachel Stephens, IRELAND
Rebecca Leszczynski, UNITED KINGDOM


The HOPE Exchange team in Denmark set the tone of their presentation underscoring one of their key observations, that the Danish healthcare system is not just patient-centred, but people-centred. Hospitals and other healthcare providers care as much about involving patients and their families (patient involvement is a key element of recent healthcare reform goals) as they do about clinicians and the staff involved in health and social care provision.

In this context, they chose two good practices. The first one involves a digital caregiver application available 24/7. It provides patient guides, appointment planning, checklists for diagnostic tests and treatment plans, notifications, as well as a direct message function to ask questions to medical professionals and express concerns. The digital caregiver app also offers perioperative guidance, from pre-rehabilitation requirements (e.g., exercises, fasting and medication, etc.) through hospitalization, to discharge and recovery recommendations and necessary support.

According to preliminary findings in the Central Jutland region, the app has had a positive impact on patient experience. It has helped reduce patient anxiety and a tendency to consult less reliable information. Patients are less likely to be re-admitted, and it has helped reduce the length of some hospitalization stays.

For staff, there is a renewed push to address the reality and consequences of 'second victim'. As the presenters explained, healthcare errors have multiple victims:

The focus on second victims does not mean being complacent with errors but rather creating a culture of psychological safety and encourages learning from mistakes. Social media has created further challenges for healthcare staff who can become targets of bullying campaigns. This adds to what clinicians' own feelings of shame, uncertainty, guilt, fear, and diminished confidence. Such feelings undermine confidence and create stress that can make further error more likely. Denmark seeks to support its medical professionals by following a pathway to stop threats, check in on all parties involved, address event promptly, and conduct a debriefing after an incident.

# IRELAND

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The HOPE Exchange team in Ireland has been working to implement its Sláintecare blueprint, moving from a hospital-centric model to community-first healthcare delivery. The result is that by last year, 2025, 92% of patients with chronic diseases are routinely managed in primary care. The four pillars of this approach are:

- Right care – universal, accessible, high-quality
- Right place – Closer to home where possible
- Right time – Based entirely on clinical need
- Right team – Appropriate, flexible, supported workforce

In this context, the exchange team selected three examples that reinforced the general policy from the bottom-up. The first good practice they selected underscores the patient's voice in the Irish healthcare system, which is working to cultivate systemic trust. To this end, public health authorities conduct national inpatient experience surveys across 40 acute hospitals. The results of these surveys are not only disclosed publicly, but they help shape healthcare service provision and national policies

The second good practice the team selected involves medication safety. To support an overwhelmed workforce in a safe manner, clinicians at St. James's Hospital have developed a microlearning tool to reduce how medication information is dispensed, especially in situations with extreme clinical workloads.

The third and final example of good practice refers to the 'virtual ward'. This is not ambulatory support but rather the physical relocation of acute care to the home, whilst maintaining full specialist legal responsibility and continuous monitoring. Two hospitals launched the pilot in 2024, and so far, patient verdict has been positive. This has been achieved through monitoring kits that stream continuous data, dedicated nursing teams that conduct daily rounds via calls and videos. Eligibility is determined only in certain clinical scenarios, heart failure, AF, and

COPD. While it could be extended to other conditions, it is not appropriate for all acute care delivery.

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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.**