# NEWSLETTER

N° 118 – September 2014

CONTENT

***12-13 March 2015 – Brussels (Belgium)***

***PASQ JOINT ACTION FINAL CONFERENCE***

***31 May-2 June 2015 – Warsaw (Poland)***

***HOPE AGORA 2015***
*HOSPITALS 2020: HOSPITALS OF THE FUTURE, HEALTHCARE OF THE FUTURE*

## *NEW COMMISSIONERS AND PORTFOLIOS UNVEILED*

On 10 September, the names of the new Commissioners and respective portfolios have been unveiled.

**Mr Vytenis Andriukaitis** from Lithuania has been appointed new Commissioner for Health and Food Safety. Graduated in medicine and history, since December 2012 he held the position of Minister of Health in Lithuania.

The organisation of the Health Directorate General was also affected by some changes: the units dealing with the topics of medical products, health technologies and cosmetics have been moved to the newly shaped Directorate General for Internal Market and Industry. This raised important concern among the EU Health Stakeholders including HOPE and among several Member States (see following article).

Other important changes to be underlined involve the move of the Consumers Affairs portfolio to the Commissioner for Justice, which will be assigned to Věra Jourová from Czech Republic and the merge of the Internal Market end Enterprise Directorates General for which the new Commissioner will be Elżbieta Bieńkowska from Poland.

The European Parliament has been in the process to give its consent to the entire College of Commissioners, including the President and the High-Representative of the Union for Foreign Affairs and Security Policy. This is preceded by hearings of the Commissioners-designate in the relevant parliamentary committees.

The hearing of the Commissioner for Health and Food Safety Vytenis Andriukaitis took place on 30 September. In its opening statement, Mr Andriukaitis indicated the priorities during his mandate, which are:

- the pooling of Member States' efforts to invest in health
- the implementation of the cross-border healthcare and tobacco legislations
- a new procedure to deal with GMOs.

The statement was followed by some questions and answers between MEPs and the Commissioner-designate. MEPs made several questions on a wide range of issues such as cloning of animals, access to health, impact of the Transatlantic Trade and Investment Partnership (TTIP) on health standards. Hearings will continue until 7 October and the final plenary vote on the college of Commissioners will take place on 22 October.

## *MEDICINAL PRODUCTS AND HEALTH TECHNOLOGIES MOVE TO INTERNAL MARKET AND INDUSTRY– JOINT LETTER FROM STAKEHOLDERS*

When on 10 September the names of the new Commissioners and respective portfolios have been unveiled, one of the most striking changes in the Health and Food Safety Directorate General was the move of the medicinal products and health technologies portfolios as well as the European Medicines Agency from the Commissioner for Health and Food Safety to the Commissioner for Internal Market, Industry, Entrepreneurship and SMEs.

In response to such a change, HOPE together with other 35 EU health stakeholders, signed a joint open letter to the new Commission's President Jean-Claude Juncker expressing their concern.

The letter stresses that the main driver of EU policies concerning pharmaceuticals and health technologies should be promoting and protecting health and patient safety. A shift of these portfolios to the internal market and industry would mean that market considerations and the foster of competitiveness would prevail over EU citizens' health promotion.

EU health stakeholders are not alone in their opposition against this reorganisation. During the last informal meeting of the EU Ministers of Health, which took place on 23 September, the Belgian Minister of Health declared her concern about this planned change and the intention to address a letter to the Commission's President and the European Parliament. This concern was shared by other Member States: France, Cyprus, Austria, Greece, Bulgaria, Slovakia, Lithuania, Portugal and Romania.

***The Joint Letter is available at:***
***http://www.epha.org/IMG/pdf/FINAL_joint_letter_EU_pharma_policy_Juncker_Commission_-_FINAL-FINAL_ok-2.pdf***

## *INFORMAL MEETING EU MINISTERS OF HEALTH*

On 23 September the informal meeting of the EU Ministers of Health took place in Milan, Italy. Several important items were listed in the agenda such as cancer prevention, price of innovative medicines and the Ebola outbreak.

The discussion about the price of innovative therapies was initiated by France during the June Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council held in Luxembourg. Member States agreed more exchange of information and cooperation is needed to guarantee patients' access to innovative medicines which might be threatened by high prices of drugs.

The discussion also focused on cancer prevention, a very important topic since a third of all forms of cancer could be prevented by changing lifestyle and eliminating risk factors. Ministers concluded that more informative campaigns are needed as well as additional efforts should be directed towards the intensification of vaccination and screening.

Finally, Ministers also held a session about the Ebola virus, reiterating the need for a more coordinated approach with the United Nations and international NGOs working to stop the outbreak. The EU has already made available 150 million Euros to help the affected countries and deployed three mobile laboratories in the region.

## *CROSS-BORDER HEALTHCARE – REASONED OPINIONS TO CZECH REPUBLIC, ROMANIA AND SLOVENIA*

On 25 September, the European Commission sent a reasoned opinion to Czech Republic, Romania and Slovenia asking to notify the measures taken to fully implement the Directive on patients' rights in cross-border healthcare (2011/24/EU). The Directive lays down patients' rights to choose to receive healthcare in another Member State, and claim reimbursement for it at home. It also requires health systems and healthcare providers to ensure patients are given the information they need to make an informed choice about their treatment. A reasoned opinion in this matter was also sent in July to Austria, Belgium, Bulgaria, Germany, Estonia, Greece, Finland, France, Ireland, Luxembourg, Poland, and the United Kingdom.

The deadline for the transposition of the Directive into national law was 25 October 2013. However to date, the legislation has only been partially transposed in these Member States. These three countries have now two months to inform the Commission about the measures they have taken to fully implement the Directive. If they fail to do so, the Commission may refer them to the Court of Justice of the EU.

## *MEDICAL PRESCRIPTIONS – REASONED OPINION TO ROMANIA*

On 25 September, the European Commission sent a reasoned opinion to Romania inviting the country to notify the measures taken to fully transpose the Directive laying down measures to facilitate the cross-border recognition of medical prescriptions (2012/52/EU). A reasoned opinion in this matter was also sent in July to Belgium, Ireland, Luxembourg and Portugal.

The Directive aims to increase the ability of pharmacists to understand and dispense prescriptions issued in another EU country to patients who are exercising their right to cross-border healthcare. It requires Member States to ensure that prescriptions to be used in another Member State contain a certain number of elements described in the Annex of the Directive.

Romania has now two months to communicate to the Commission the measures taken to fully transpose the Directive. Failure to do so might lead the Commission to refer Romania to the Court of Justice of the EU.


## *PASQ – 4TH COORDINATION MEETING*

On 18 and 19 September HOPE attended in Rome the fourth coordination meeting of the European Union Network for Patient Safety and Quality of Care (PaSQ Joint Action).

The meeting, aimed at updating partners on the work carried out since the last meeting in January 2014. Giving the fact that the Joint Action is coming to an end in March 2015, part of the debate rotated around the issue of sustainability and next steps to achieve this objective. A proposal for the continuation of the Network was published in April 2014, which also contains a description of future working areas.

Specific working sessions were also organised for Work Package 4, 5, 6, respectively dedicated to Patient Safety Good Clinical Practices, Patient Safety Initiative Implementation and Quality Healthcare Systems Collaboration in the EU. Discussions also continued within Work Package 7, dedicated to the issue of Network Sustainability after the end of the Joint Action.

Some important results already achieved by the Joint Action were highlighted during the meeting, such as the implementation of four safe clinical practices (WHO Surgical Safety checklist, Hand Hygiene, Medication Reconciliation and Paediatric Early Warning Scores) in some 300 healthcare organisations in 18 Member States. HOPE was deeply involved in this task as responsible for the recruitment process.

Another important result is the database of good practices, launched at the beginning of 2014. It currently contains more than 500 good practices from 22 Member States. All the practices were reviewed twice before their display to ensure their completeness and to facilitate their understanding and transferability. HOPE contributed to this work, being part of the team of reviewers.

Finally, during the meeting partners discussed the possibility to reply together to the public consultation on the preliminary opinion on patient safety prepared by the Commission's Expert Panel on Effective Ways of Investing in Health. The reply will stress the benefits of the collaborating approach which is at the heart of PaSQ Joint Action.

***More information on PaSQ: http://pasq.eu***

## *MOMENTUM – RELEASE OF VALIDATED CRITICAL SUCCESS FACTORS IN TELEMEDICINE*

The Momentum project released on 25 September five key documents that follow the release of the 18 critical success factors (CSFs) for the deployment of telemedicine last May.

Four of the documents represent a further development and refinement of the 18 CSFs, coming after critical feedback from stakeholders and experts from within and outside the network. The documents, subtitled "blueprint validated by 'doers' and stakeholders", provide more context for each success factor and illustrate how they have applied in selected successful telemedicine deployments examined by Momentum.

The fifth document, *Momentum test methodology* (D3.3), delivers an action plan for testing Momentum in a real life setting. The region of southern Norway will apply the critical success factors, in combination with the Telemedicine Readiness Assessment Tool (TREAT), including both an online self-assessment and a facilitated workshop involving all key players.

Momentum is a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). It is about creating a platform across which the key players can share their knowledge and experience in deploying telemedicine services into routine care. One of the outcomes of the project will be the development of a Blueprint for telemedicine deployment.

***The validated critical success factors and the plan for testing them in practice are available at:***
***http://telemedicine-momentum.eu/resources-documents/***

***More information about Momentum:***
***http://telemedicine-momentum.eu/***

## *eHEALTH – NEW HORIZON 2020 CALLS FOR PROPOSALS PUBLISHED*

Four new Horizon 2020 calls for proposals related to eHealth have recently been published. The calls specifically address the following topics:

- self-management of health and disease and patient empowerment supported by ICT;
- self-management of health and disease and decision support systems based on predictive computer modelling used by the patient him or herself;
- public procurement of innovative eHealth services;
- digital representation of health data to improve disease diagnosis and treatment.

**The deadline to submit proposals is 21 April 2015.**

***More information:***
***http://ec.europa.eu/information_society/newsroom/cf/dae/newsletter-item-detail.cfm?item_id=18219&newsletter_id=102***

## *HEALTH C – FINAL CONFERENCE*

The final conference of the Health C project took place in Brescia (Italy) on 30 September 2014. The conference, which was attended by around 100 participants, addressed the role of communication in health crisis management and provided an overview of the topics covered by the three modules composing the training course: competences and processes of crisis communication, the use of traditional media and the use of social media.

At the end of the conference, an overview was provided about the results of the pilot which took place in Germany, Italy, Portugal and Spain. The face-to-face sessions organised in these countries with the aim to kick-off the training course were attended by 51 participants. The online part of the course was attended by 111 participants, who had the possibility to provide feedback on the training course. In general, participants were satisfied with the modules and found the training course useful. Some comments for improvement were also provided and will be taken into account by the consortium in order to highlight lessons learned and recommendation for the future improvement of the course.

The training course produced by the project and the respective training materials will remain available for free after registration at the project e-learning platform: **http://healthcmoodle.eu/**. Through the platform it is possible to access the e-learning materials in seven different languages: English, German, Portuguese, Spanish, Italian, French and Danish. The enrolment key for the English course is: ENHealthC2014.

***More information on the Health C project: http://healthc-project.eu/en/***

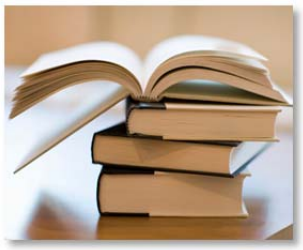
## *UNITED4HEALTH – POLICY ADVISORY BOARD*

On 25 September HOPE attended the launch meeting of the United4Health Policy Advisory Board.

United4Health is a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). The project will utilise the results and good practices from previous projects and trial, including the Renewing Health project, and provide scaled up solutions. The programme will involve approximately 12,000 patients affected by Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Cardiovascular disease.

Since United4Health will build from the results of the previous project Renewing Health, the objective of the meeting was to discuss Renewing Health's results from a policy perspective and their relevance from the point of view of EU stakeholders representing patients, healthcare professionals, healthcare providers and payers. Four further meetings of the Policy Advisory Board will take place in the course of 2015 with the objective to produce a report containing policy messages on telehealth, especially in relation to the three chronic diseases investigated by the project.

***More information on United4Health: http://united4health.eu/***



## *SMART GOVERNANCE FOR HEALTH AND WELL-BEING – WHO REPORT*


Governance for health describes the attempts of governments and other actors to steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being. This study tracks recent innovations to address the priority determinants of health and categorises them into five strategic approaches to smart governance for health. It relates the emergence of joint action by the health and non-health sectors, public and private actors and citizens, all of which have increasing roles to play in achieving seminal changes in 21st-century societies.

The chapters presented here were initially commissioned as papers to provide the evidence base for a study to support the new European policy framework for health and well-being, Health 2020. Calling for a health-in-all-policies, whole-of-government and whole-of-society approach, Health 2020 uses governance as a lens through which to view all technical areas of health. This book provides access to background papers for the study on governance for health in the 21st century, published by the WHO Regional Office for Europe in 2012. Prepared by eminent experts, the chapters provide further detail on the issues raised, and culminate in a comprehensive depiction of what constitutes smart governance for health in the 21st century

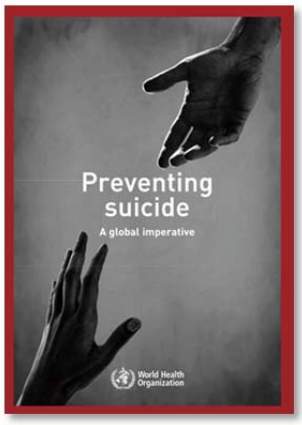
***More information:***
***http://www.euro.who.int/__data/assets/pdf_file/0005/257513/Smart-governance-for-health-and-well-being-the-evidence.pdf?ua=1***

## *PREVENTING SUICIDE: A GLOBAL IMPERATIVE – WHO REPORT*

This report is the first WHO publication of its kind and brings together what is known in a convenient form so that immediate actions can be taken. It aims to increase the awareness of the public health significance of suicide and suicide attempts, to make suicide prevention a higher priority on the global public health agenda and to encourage and support countries to develop or strengthen comprehensive suicide prevention strategies in a multisectoral public health approach.

For a national suicide prevention strategy, it is essential that governments assume their role of leadership, as they can bring together a multitude of stakeholders who may not otherwise

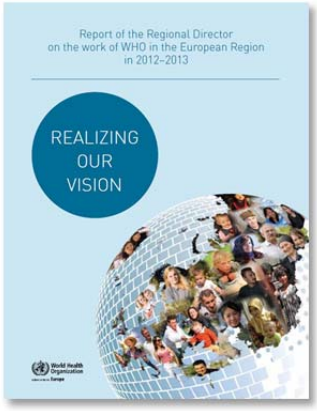
collaborate. Governments are also in a unique position to develop and strengthen surveillance and to provide and disseminate data that are necessary to inform action. This report proposes practical guidance on strategic actions that governments can take on the basis of their resources and existing suicide prevention activities. In particular, there are evidence-based and low-cost interventions that are effective, even in resource-poor settings.




The report is intended to be a resource that will allow policy-makers and other stakeholders to make suicide prevention an imperative. Only then can countries develop a timely and effective national response and, thus, lift the burden of suffering caused by suicide and suicide attempts from individuals, families, communities and society as a whole.

***More information:***
***http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1***

## *REALIZING OUR VISION – REPORT OF THE WHO REGIONAL DIRECTOR*




In 2010, the WHO Regional Committee for Europe adopted an ambitious five-year vision of better health in the WHO European Region. The WHO Regional Office for Europe and the 53 countries it serves therefore agreed to follow a roadmap with specific milestones, to enable the Regional Office to respond to the changing European environment and to further strengthen it as an evidence-based centre of health policy and public health excellence that could better support the Region's diverse Member States.

The work and achievements over the last four years required commitment and cooperation from all parties: the Secretariat and Member States that comprise WHO in Europe, which in turn is part of one WHO worldwide, and all WHO's partners in the Region. The publication covers the second two years (2012-2013), which include the halfway point of the period covered by the vision. It describes how all parties are making their vision a reality, to secure better health for everyone in Europe.

***More information:***
***http://www.euro.who.int/__data/assets/pdf_file/0017/251207/RDs-Report-2012-13-Eng.pdf?ua=1***

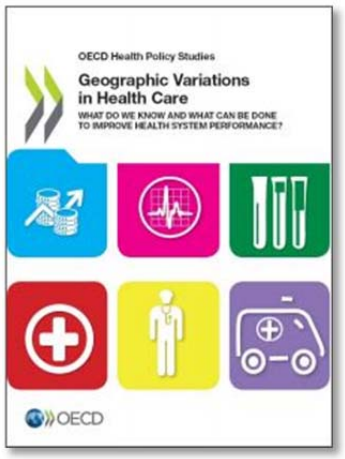
## *ECONOMIC CRISIS, HEALTH SYSTEMS AND HEALTH IN EUROPE – EUROPEAN OBSERVATORY POLICY SUMMARY*

This new document summarises the findings of a joint study by WHO Europe and the Observatory analysing the impact of health policy responses to the crisis in Europe from 2008 to 2013.
It is a key part of a wider initiative to monitor the effects of the crisis on health systems and health, to identify the policies most likely to sustain the performance of health systems facing fiscal pressure and to gain insight into the political economy of implementing reforms in a crisis.

The conclusions from the study highlight that the crisis in Europe was multifaceted, varied in the way it played out across countries and did not affect all countries equally. This crisis confirms what we knew from previous experience: economic shocks pose a threat to health and health system performance.

***More information:***
***http://www.euro.who.int/__data/assets/pdf_file/0008/257579/Economic-crisis,-health-systems-and-health-in-Europe-impact-and-implications-for-policy.pdf?ua=1***

## *GEOGRAPHIC VARIATIONS IN HEALTHCARE – OECD PUBLICATION*




Health care use varies widely across countries but can also vary as much or more within countries. Governments should do more to improve their health systems to prevent unnecessary interventions and ensure that everyone has the same access to quality healthcare, wherever they live.

Geographic Variations in Health Care analysed the geographic variations across a range of high-volume and high-cost health care activities. Some of the variations observed in the 13 OECD countries are unwarranted and ought to be tackled so that high-quality health systems deliver the care patients need. The number of patients admitted to a hospital for a reason other than surgery, for example, is twice as high in Australia, Germany and Israel than in Canada, Portugal and Spain. Admission rates also vary widely within countries: in some parts of Australia, Canada, England, Finland, Italy or Portugal, a patient is two to three times more likely to be admitted to hospital than in other parts of those countries. A patient is also three times more likely to undergo cardiac revascularisation procedures in Germany and Israel than in countries with the lowest levels of intervention. In most countries, these procedures have the highest level of variation across geographical areas. Knee replacement rates vary by more than five-fold within Canada, Portugal and Spain, and by two-to three-fold across geographic areas in most OECD countries. Caesarean section rates are on the rise. The probability to give birth by C-section is 50% higher in Italy, Portugal, Australia, Switzerland and Germany than in the other participating countries. C-section rates vary little within countries, except in Italy where they vary by six-fold across provinces.

To tackle unwarranted variations in health care use, governments should put in place:

- Public reporting and target setting
- Policies targeting providers
- Patient centred approaches

The report's main findings were presented at a joint conference held by the OECD and the Bertelsmann Foundation on 16 September 2014 in Berlin (www.faktencheck-gesundheit.de).

***More information:***
***http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/geographic-variations-in-health-care_9789264216594-en#***

## *DATA QUALITY MONITORING AND SURVEILLANCE SYSTEM EVALUATION – ECDC HANDBOOK*


In 2010, the European Centre for Disease Prevention and Control (ECDC) conducted a survey among national surveillance coordinators which revealed substantial differences in practices with regard to monitoring data quality in EU Member States. A proposal to improve data comparability in the EU was presented to the ECDC Advisory Forum on 5 May 2011. Subsequently, a working group of 22 disease surveillance experts from 16 countries was established, with a mandate to develop a handbook on data quality monitoring and surveillance system evaluation.

The overall objective of this project was to support processes for monitoring data quality and evaluating surveillance systems in EU/EEA Member States in order to provide accurate and timely information for decision-making. This handbook is aimed to support the daily work of public health professionals working with surveillance data on communicable diseases.

***More information:***
***http://www.ecdc.europa.eu/en/publications/Publications/Data-quality-monitoring-surveillance-system-evaluation-Sept-2014.pdf***

## *IMPLEMENTING ELECTRONIC HEALTH RECORDS IN HOSPITALS – SYSTEMATIC LITERATURE REVIEW*

The literature on implementing Electronic Health Records (EHR) in hospitals is very diverse. The objective of this study was to create an overview of the existing literature on EHR implementation in hospitals and to identify generally applicable findings and lessons for implementers. A systematic literature review of empirical research on EHR implementation was conducted. Of the 364 initially identified articles, this study analysed 21 articles that met the requirements. From these articles, 19 interventions were identified that are generally applicable and these were placed in a framework consisting of the following three interacting dimensions: (1) EHR context, (2) EHR content, and (3) EHR implementation process.

Although EHR systems are anticipated as having positive effects on the performance of hospitals, their implementation is a complex undertaking. This systematic review reveals reasons for this complexity and presents a framework of 19 interventions that can help overcome typical problems in EHR implementation. This framework can function as a reference for implementers in developing effective EHR implementation strategies for hospitals.

***More information:***
***http://www.biomedcentral.com/content/pdf/1472-6963-14-370.pdf***

## *IMPROVING PATIENT DISCHARGE AND REDUCING HOSPITAL READMISSIONS BY USING INTERVENTION MAPPING – STUDY*

There is a growing impetus to reorganise the hospital discharge process to reduce avoidable readmissions and costs. The aim of this study was to provide insight into hospital discharge problems and underlying causes, and to give an overview of solutions that guide providers and policy-makers in improving hospital discharge.

The Intervention Mapping framework was used. First, a problem analysis studying the scale, causes, and consequences of ineffective hospital discharge was carried out. The analysis was based on primary data from 26 focus group interviews and 321 individual interviews with patients and relatives, and involved hospital and community care providers. Second, improvements in terms of intervention outcomes, performance objectives and change objectives were specified. Third, 220 experts were consulted and a systematic review of effective discharge interventions was carried out to select theory-based methods and practical strategies required to achieve change and better performance.

Ineffective discharge is related to factors at the level of the individual care provider, the patient, the relationship between providers, and the organisational and technical support for care providers. Providers can reduce hospital readmission rates and adverse events by focusing on high-quality discharge information, well-coordinated care, and direct and timely communication with their counterpart colleagues. Patients, or their carers, should participate in the discharge process and be well aware of their health status and treatment. Assessment by hospital care providers whether

discharge information is accurate and understood by patients and their community counterparts, are important examples of overcoming identified barriers to effective discharge. Discharge templates, medication reconciliation, a liaison nurse or pharmacist, regular site visits and teach-back are identified as effective and promising strategies to achieve the desired behavioural and environmental change. This study provides a comprehensive guiding framework for providers and policy-makers to improve patient handover from hospital to primary care.

***More information:***
***http://www.biomedcentral.com/content/pdf/1472-6963-14-389.pdf***

## *FACTORS ASSOCIATED WITH THE UTILISATION OF PRIMARY CARE EMERGENCY CENTERS IN A SPANISH REGION WITH HIGH POPULATION DISPERSION – STUDY*

Adequate access to primary care emergency centres is particularly important in rural areas isolated from urban centres. However, variability in utilisation of emergency services located in primary care centres among inhabitants of nearby geographical areas is understudied.

The objectives of this study were twofold: 1) to analyse the association between the availability of municipal emergency care centres and utilisation of primary care emergency centres (PCEC), in a Spanish region with high population dispersion; and 2) to determine healthcare providers' perceptions regarding PCEC utilisation. A mixed-methods study was conducted.

Having PCEC as the only emergency centre in the municipality was directly associated with its utilisation ($p < 0.001$). Healthcare providers perceived that distance to hospital increased PCEC utilisation, and distance to PCEC decrease its use. PCEC users were considered to be predominantly workers and students with scheduling conflicts with rural primary care opening hours. Increasing access to primary care by extending hours may be an important step toward optimal PCEC utilisation. Further research would determine whether lower PCEC use by certain groups is associated with disparities in access to care.

***More information:***
***http://www.biomedcentral.com/content/pdf/1472-6963-14-368.pdf***

## *TRENDS OF PRE-HOSPITAL EMERGENCY MEDICAL SERVICES ACTIVITY OVER 10 YEARS – A POPULATION-BASED REGISTRY ANALYSIS*

The number of requests to pre-hospital emergency medical services (PEMS) has increased in Europe over the last 20 years, but epidemiology of PEMS interventions has little been investigated. The aim of this analysis was to describe time trends of PEMS activity in a region of western Switzerland.

Data was routinely and prospectively collected for PEMS intervention in the Canton of Vaud, Switzerland, from 2001 to 2010. We observed a 40% increase in the number of requests to PEMS

between 2001 and 2010. The overall rate of requests was 35/1000 inhabitants for ambulance services and 10/1000 for medical interventions (SMUR), with the highest rate among people aged ≥ 80. Most frequent reasons for the intervention were related to medical problems, predominantly unconsciousness, chest pain respiratory distress, or cardiac arrest, whereas severe trauma interventions decreased over time. Overall, 89% were alive after 48 h. The survival rate after 48 h increased regularly for cardiac arrest or myocardial infarction.

The results add to the understanding of determinants of PEMS use and need to be considered to plan use of emergency health services in the near future. More comprehensive analysis of the quality of services and patient safety supported by indicators are also required.

***More information:***
***http://www.biomedcentral.com/content/pdf/1472-6963-14-380.pdf***

## *MONITORING AND PREVENTING PATIENT SAFETY INCIDENTS FOR PEOPLE WITH INTELLECTUAL DISABILITIES IN NHS ACUTE HOSPITALS – STUDY*

There has been evidence in recent years that people with intellectual disabilities in acute hospitals are at risk of preventable deterioration due to failures of the healthcare services to implement the reasonable adjustments they need. The aim of this paper was to explore the challenges in monitoring and preventing patient safety incidents involving people with intellectual disabilities, to describe patient safety issues faced by patients with intellectual disabilities in NHS acute hospitals, and investigate underlying contributory factors.

This was mixed-method study involving interviews, questionnaires, observation and monitoring of incident reports to assess the implementation of recommendations designed to improve care provided for patients with intellectual disabilities and explore the factors that compromise or promote patient safety. Staff did not always readily identify patient safety issues or report them. Incident reports focused mostly around events causing immediate or potential physical harm, such as falls. Hospitals lacked effective systems for identifying patients with intellectual disabilities within their service, making monitoring safety incidents for this group difficult. The safety issues described by the participants were mostly related to delays and omissions of care, in particular: inadequate provision of basic nursing care, misdiagnosis, delayed investigations and treatment, and non-treatment decisions and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. The events leading to avoidable harm for patients with intellectual disabilities are not always recognised as safety incidents, and may be difficult to attribute as causal to the harm suffered. Acts of omission (failure to give care) are more difficult to recognise, capture and monitor than acts of commission (giving the wrong care). In order to improve patient safety for this group, the reasonable adjustments needed by individual patients should be identified, documented and monitored.

***More information:***
***http://www.biomedcentral.com/content/pdf/1472-6963-14-432.pdf***

## *THE USE OF DISCRETE CHOICE EXPERIMENTS TO INFORM HEALTH WORKFORCE POLICY – SYSTEMATIC REVIEW*

Discrete choice experiments have become a popular study design to study the labour market preferences of health workers. Discrete choice experiments in health, however, have been criticised for lagging behind best practice and there are specific methodological considerations for those focused on job choices. A systematic review of the application of discrete choice experiments to inform health workforce policy was performed.

Twenty-seven studies were included, with over half set in low- and middle-income countries. Doctors or medical students were the most studied cadre. Studies frequently pooled results from heterogeneous subgroups or extrapolated these results to the general population. Only one third of studies included an opt-out option, despite all health workers having the option to exit the labour market. Just five studies combined results with cost data to assess the cost effectiveness of various policy options. Comparison of results from similar studies broadly showed the importance of bonus payments and postgraduate training opportunities and the unpopularity of time commitments for the uptake of rural posts. This was the first systematic review of discrete choice experiments in human resources for health. Specific issues relating to this application of which practitioners should be aware to ensure robust results were identified. In particular, there is a need for more defined target populations and increased synthesis with cost data. Research on a wider range of health workers and the generalisability of results would be welcome to better inform policy.

***More information:*** ***http://www.biomedcentral.com/content/pdf/1472-6963-14-367.pdf***

## *DO LARGE-SCALE HOSPITAL AND SYSTEM-WIDE INTERVENTIONS IMPROVE PATIENT OUTCOMES – SYSTEMATIC REVIEW*

While health care services are beginning to implement system-wide patient safety interventions, evidence on the efficacy of these interventions is sparse. We do not know the factors that affect uptake or how the interventions establish change and, in particular, whether they influence patient outcomes.

A systematic review was conducted to identify how organisational and cultural factors mediate or are mediated by hospital-wide interventions, and to assess the effects of those factors on patient outcomes. Empirical, peer-reviewed studies reporting randomised and non-randomised controlled trials, observational, and controlled before and after studies were included in the review. Six studies met the inclusion criteria. Improved outcomes were observed for studies where outcomes were measured at least two years after the intervention. Associations between organisational factors, intervention success and patient outcomes were undetermined: organisational culture and patient outcomes were rarely measured together, and measures for culture and outcome were not standardised. Common findings show the difficulty of introducing large-scale interventions, and that effective leadership and clinical champions, adequate financial and educational resources, and dedicated promotional activities appear to be common factors in successful system-wide change.

***More information:*** ***http://www.biomedcentral.com/1472-6963/14/369/abstract***

## *DRUG SHORTAGES IN EUROPEAN COUNTRIES: A TRADE-OFF BETWEEN MARKET ATTRACTIVENESS AND COST CONTAINMENT? – STUDY*

This study aimed to collect and present data about drug shortages in European countries. A reporting template for the collection of data about drug shortages was designed based on a literature search with the inclusion of Belgium, the Netherlands, England, Italy, France, Germany and Spain in the study. Data about the characteristics of the drugs in shortage and the causes of the shortage were collected from publicly available online reporting systems. Drug shortages included in the considered reporting systems can be characterised as branded, oral drugs that affect different disease domains. When considering essential medicines and oncology drugs, generic injectables are more involved.

Causes for drug shortages are largely underreported. In case the cause is known, production problems take the lead. Reporting of drug shortages in Europe needs to be standardised and more transparency about the reasons for drug shortage is required to investigate the problem. A link between production problems and market attractiveness and market capacity is recognised to be at the root of drug shortages in U.S. Such insights are highly lacking in Europe. Monitoring of the effect of national and European health policies on the sustainability of the drug market is required to present fundamental solutions and to tackle the problem of drug shortages in Europe.

***More information:***
***http://www.biomedcentral.com/content/pdf/1472-6963-14-438.pdf***

## *THE EUROPE WE WANT – ARTICLE*

A recently published article in the European Hospital Journal reports an interview with EU Commissioner for Health Tonio Borg on issues regarding health in Europe today and previous achievements in the health sector. The Commissioner emphasised that in health matters Europe is not yet a Union. He also mentioned the importance of sustainability of health systems regardless of the party occupying the European Parliament and pointed out the burden of chronic diseases on health budgets and the widening gap in equality in health care.

It was stressed that more money needs to be spent on prevention and that cross-border healthcare strategy including the second eHealth Action Plan 2012-2020 needs to be pushed further. The Plan focuses on supporting research, promoting international cooperation and achieving wider interoperability of e-health services. The Commissioner agreed with the right of full freedom of movement regarding migration of healthcare professionals, however, at the same time, he showed his concern about the issues of shortages in healthcare staff and possible solutions to the problem. Among his contributions to up-to-the-present achievements T. Borg numbered: Tobacco Directive, Clinical Trial Regulation, Cross-border healthcare Directive, joint procurement agreement on vaccines, various awareness campaigns on inequality and discrimination and chronic disease prevention. He underlined that there is still a lot to be achieved, for instance, in fields like healthy food and anti-microbial resistance.


## *EUROPEAN IPF PATIENT CHARTER – MEETING*

Idiopathic Pulmonary Fibrosis (IPF) is a rare, progressive and fatal disease of lung. The survival time is two to five years and no cure and only limited treatment are available. Each year around 35000 people in Europe are newly diagnosed with IPF.

The European IPF Patient Charter called for great awareness of IPF and for better access to care in the European countries. The call for rights for IPF patients and their families include: early and accurate diagnosis, equal access to care, a holistic approach of standardised IPF management, comprehensive and high quality information about the condition, better access to palliative care and end-of-life care.

The meeting attended by HOPE kicked off with the statements of European Parliament Members and a call for dialogue between the EU institutions and eleven organisations present during the meeting. Then, two patients diagnosed with IPF talked about their problems and daily challenges and their current involvement in IPF organisations. Further, a Policy Officer from Programme Management and Diseases, DG SANCO introduced EU policy and actions that have been so far undertaken in the field of rare diseases. That included most of all: rare disease standardised definition, national plans on Research and Development, Commission Expert Group on Rare Diseases formed in 2014, Orphanet establishment, research financing, plan to create European Platform on Rare Disease Registration, empowering patients and organisations by mutual dialogue, governance and coordination at EU level. A call for support in the development of European Reference Networks in the area of rare diseases was made by a Head of Healthcare Systems Unit, DG SANCO. The importance of specialist nurses' presence in managing rare diseases was emphasised by the Secretary General of the European Federation of Nurses. The meeting was closed with questions mostly on future collaboration in the field of IPF and other rare diseases, but also the issue of data protection and medical research was raised.

***More information:*** ***www.ipfcharter.org***

## *OPPORTUNITIES AND CHALLENGES OF HOSPITAL PERFORMANCE PUBLIC REPORTING AT THE NATIONAL LEVEL – WORKSHOP*

On 26 September 2014, HOPE participated to the workshop "Opportunities and challenges of hospital performance public reporting at the national level: international experience and future perspective" organised by Agenas – Italy (National Agency for the Regional Healthcare Services), in collaboration with the OECD and the support of "Progetto Mattone Internazionale".

The aim of the event was to compare the main experiences of performances public communication implemented in different countries and to explain the recent tendencies in Italy. Speakers from Europe, United States, Korea and Canada were invited to present the outcomes achieved in their own countries, through the implementation of systems able to measure the performances and the quality of HC services. The audience was invited to interact with the panel and to ask questions.

***More information:***
***http://www.progettomattoneinternazionale.it/servizi/eventi/cerca_faseo3.aspx?ID=2442***

## *HEAD AND NECK CANCERS – FOLLOW UP CONFERENCE*

During the second *European Make Sense Campaign Head and Neck Cancer Awareness Week* taking place 22–26 September 2014 in the premises of the European Parliament, a follow-up collaborative meeting on head and neck cancers was co-hosted by MEP Daciana Sarbu (S&D, Romania), together with the European Head and Neck Society (EHNS) and the European Cancer Patient Coalition (ECPC).

The meeting followed on from last year's conference, which marked the launch of a White Paper *'Head and Neck Cancer: The 'curable' cancer that kills over half of all sufferers – it is time to do something about it.'* During this conference MEPs, representatives of the European Commission, experts in head and neck cancer and cancer patient had the opportunity to engage in a dialogue with the European Commission to agree on a stepwise plan in order to ensure early diagnosis and increased awareness of a disease that claims 70,000 European lives each year. National best practices related to head and neck cancers were showcased along with key achievements of the Make Sense Campaign to date. The two-hour meeting was complemented by a statement from a neck cancer survivor, which brought human perspective of a patient and enhanced the message of the conference: *"it is time to do something about it"*.

***More information on the head and neck cancer Make Sense Campaign is available at:***
***http://makesensecampaign.eu/***

## *EUROPEAN ALLIANCE FOR PERSONALISED MEDICINE CONFERENCE*

On 9-10 September, HOPE attended the European Alliance for Personalised Medicine's (EUAPM) second annual conference aimed at raising awareness among policymakers about the needs of modern-day patients and how personalised medicine has the potential to change healthcare for the better. The conference and European Parliament hosted dinner had the goal of stimulating informed debate, interaction and collaboration over the vital health issues that face us all, now and into the future.

The conference consisted of six plenary sessions:

- Why Personalised Medicine adds value to EU healthcare
- Cost-efficiency and the road to investment in the era of Personalised Medicine
- Personalised Medicine and the Commission – Integration into the EU strategy
- Personalised Medicine and the Parliament – Reshaping healthcare for patients
- Research frameworks and Big Data
- Early access and healthcare delivery

During the 1st session Pascal Garel, HOPE Chief Executive, was invited to participate as a stakeholder at the high level panel discussion and illustrated HOPE activities which can have relevance and contribute to the debate on personalised medicines.

## *EUROPEAN PUBLIC HEALTH ALLIANCE 5TH ANNUAL CONFERENCE*

On 4-5 September 2014, HOPE attended in Brussels the European Public Health Alliance 5th Annual Conference dedicated to the topic "*Tectonic tensions - wealthy Europe`s fear of commitment".*
Coinciding with the start of business of the new European Parliament and Commission and the review of the EU's long-term objectives, EPHA's 5th annual conference gathered high level speakers and thought leaders to engage in a constructive debate on the priorities of the EU for the next five years.

The Conference was composed of different panels brought together to discuss:

1. the role of health policy in the internal market and the nexus between the EU's economic competence and health;
2. what the EU can do to secure adequate food systems, housing, poverty reduction and other social determinants of health, as well as reduce the health gap;
3. the dichotomy between public health, economic and corporate interests - the boundaries of a free market for health;
4. what steps need to be taken to achieve social cohesion as different divisions emerge in the EU: North-South, East-West, "New" vs "Old" Member States.

The two-day discussions evolved to large extent around the question of how to reduce health gaps between and within European countries. European Commissioner for Health Tonio Borg emphasised that in health matters European Union is not yet a true Union. Under statement that health is not only a consequence of growth, but also a condition for growth, the experts also discussed the future of public health and its role in Europe – in securing adequate food systems, housing, poverty and discrimination reduction and other social determinants of health. The closing session looked at the wider picture of health at the EU level and asked whether trade agreements like TTIP cater to a Union for citizens, consumers or corporations.

# AGENDA

## UPCOMING CONFERENCES

### *COCIR-HOPE-AER DEBATE AT THE OPEN DAYS 2014*

*THE IMPORTANCE OF USING EUROPEAN STRUCTURAL AND INVESTMENT FUNDS TO DRIVE SUSTAINABLE HEALTHCARE SYSTEMS*

***7 October 2014 – Brussels (Belgium)***

Good health is recognised as an important asset for regional development and competitiveness. Yet health inequalities are increasing across Europe's regions, as shown by the WHO. The European Association COCIR and its partners, the Assembly of European Regions (AER) and the European Hospital and Healthcare Federation (HOPE) offer a debate demonstrating the critical role European Structural and Investment Funds can play in achieving sustainable healthcare models, with better access for and inclusion of patients. Under the new EU Structural and Investment Funds rules, these can still support Member States and their regions in transforming and modernising their healthcare systems. The debate will discuss how investment in health infrastructure and eHealth, in innovative care delivery models and in qualitative training of health professionals represent an effective use of EU Structural and Investment Funds.

### *APDH 5TH INTERNATIONAL HOSPITAL CONGRESS*

*THE NATIONAL HEALTH SERVICE - (RE)COGNISE THE CHANGES*

***20- 22 November 2014 – Lisbon (Portugal)***

The Portuguese Association for Hospital Development (APDH) is preparing its "5th International Hospital Congress", this year under the theme "*The National Health Service - (Re)Cognise the Changes*" taking place on 20, 21 and 22 November 2014 in Lisbon.

On 20 November, the 8th edition of the Best Practices for Health Award will take place. At the same time, participants will be invited to participate to roundtables and workshops.

On 21 November, the conference will be opened by eminent speakers, representatives of Portuguese Institutions and European Organisations. One of them will be Mrs.Dr. Sara Pupato Ferrari, HOPE President. The topics presented during the day will be: reforms of the National Health

System: different perspectives; 40 years history of the public hospitals in Portugal and the evaluation of the Patient Safety culture in the health organisations.

On 22 November, the discussion will be on the role of hospital in the society and the acknowledgement of changes in the NHS. At the end of the conference the winner for the Best Practices for Health and the Scientific Poster of the 5th International Congress of Hospital will be nominated.

***More information and registration: http://5cih.url.ph/?lang=en***

## *PASQ JOINT ACTION FINAL CONFERENCE*

***12-13 March 2015 – Brussels (Belgium)***

The final conference of the European Union Network for Patient Safety and Quality of Care (PaSQ Joint Action) will take place in Brussels on 12-13 March 2015.

The Joint Action, which started in April 2012, aimed to improve Patient Safety and Quality of Care through sharing of information, experience, and the implementation of good practices.

During the final conference, the results of the Joint Action will be showcased and there will an opportunity for participants coming from all over Europe to share experiences and good practices on patient safety. The conference will also represent an opportunity to discuss about future work on patient safety at EU level.

***More information will soon be available at: www.pasq.eu***

## *HOPE AGORA 2015*


*HOSPITALS 2020:*

*HOSPITALS OF THE FUTURE, HEALTHCARE OF THE FUTURE*

***31 May-2 June 2015 – Warsaw (Poland)***

In 2015, HOPE organises its exchange programme for the 34th time. This 4-week training period is targeting hospital and healthcare professionals with managerial responsibilities. They are working in hospitals and healthcare facilities, adequately experienced in their profession with a minimum of three years of experience and have proficiency in the language that is accepted by the host country.

During their stay, HOPE Exchange Programme participants are discovering a different healthcare institution, a different healthcare system as well as other ways of working.

The HOPE Exchange Programme 2015 starts on 4 May and ends on 30 May, followed by the closing conference "HOPE Agora" in Warsaw (Poland) from 31 May to 2 June 2015. The closing conference is considered as part of the training and all professionals should attend it.

Each year a different topic is associated to the programme. "**Hospitals 2020: hospitals of the future, healthcare of the future**" will be the topic for 2015.

**Submission of applications for the 2015 programme will be open from 1 July to 31 October 2014.**

***More information and application forms for the HOPE Exchange Programme are available on:***
***http://www.hope.be/04exchange/exchangefirstpage.html***


***www.hope-agora.eu***